Grant Thornton

NHS Ayrshire and Arran Integrated Joint Boards

Internal Audit Report 2022/23

Delayed Discharge Performance Indicators

June 2023

Final Report

Contents

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For action:

- Recorded within the management action plan.

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- North Ayrshire IJB Performance Committee
- South Ayrshire IJB Performance Committee
- East Ayrshire IJB Performance Committee

Closing meeting (IJB Chief Internal Auditors): 30/03/2023

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This report is confidential and is intended for use by the management and directors of NHS Ayrshire and Arran. It forms part of our continuing dialogue with you. It should not be made available, in whole or in part, to any third party without our prior written consent. We do not accept responsibility for any reliance that third parties may place upon this report. Any third party relying on this report does so entirely at its own risk. We accept no liability to any third party for any loss or damage suffered or costs incurred, arising out of or in connection with the use of this report, however such loss or damage is caused.

It is the responsibility solely of the Board's management and directors to ensure there are adequate arrangements in place in relation to risk management, governance, control and value for money.

Executive Summary

Objective

The objective of our audit was to consider the controls (design and operation) in place at NHS Ayrshire and Arran and at North, South and East Ayrshire health and Social Care Partnerships in relation to delayed discharges. In particular, we focused on the control measures in place around the accuracy of delayed discharge related data within TrakCare as the master of all patient data.

Background

In accordance with our internal audit plan for 2022-23, we have undertaken a review on delayed discharge performance indicators. Specifically looking at the controls in place to ensure reliability of the data which is presented at the Integrated Joint Board Performance Committees.

Delayed discharges are required to be documented in line with the Delayed Discharges Definitions Manual, effective from May 2016 (published by NHS NSS ISD Publications). The manual splits delays into four categories: social care reasons; healthcare reasons; parent/carer/family related reasons; other reasons. Detailed definitions for the four categories are included in the manual.

Approach

Our audit approach was as follows:

- We performed a walkthrough of the process for collating delayed discharge data
- Obtained understanding of the key areas outlined in scope above, through discussions with key personnel, review of management information and walkthrough test, where appropriate.
- Identified the key risks relevant within Performance Indicators – Delayed Discharges.
- Evaluated the design of the controls in place to address the key risks.
- Tested the operating effectiveness of the controls in place.

It is Management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit should not be seen as a substitute for Management's responsibilities for the design and operation of these systems.

Scope

The review looks at controls at NHS Ayrshire and Arran and at the IJBs which include North HSCP, East HSCP and South HSCP.

We have identified control and performed testing in relation to the following identified risk areas:

- NHS Ayrshire and Arran does not provide all required delayed discharge performance information to the IJBs, including statutory performance measures and compliance with directions, in line with agreed schedules.
- The controls in place within NHS Ayrshire and Arran do not ensure that information provided to the IJBs is accurate and complete.

Limitations in Scope

Limitations and areas out of scope: The delayed discharge indicators which will be tested are limited to:

- Hospital discharge (over 2 weeks) as at the end of the month
- Bed days lost to delayed discharge (All Reasons, 18+ age group)
- Number of delayed discharges over 2 weeks (Health and Social Care (HSC) patient and family reasons)
- Number of delayed discharge bed days (excl. code 9)
- Number of delayed discharge bed days (code 9)
- Referral to social work in week before fit for discharge %
- Percentage of discharges within 72 hours
- Information and Communications Technology (ICT) - % of ICT referrals that were early discharge

Our review is limited to the scope as set out above.

Please note that our conclusion is limited by scope. It is limited to the risks outlined within the scope section. Other risks that exist in this process are out with the scope of this review and therefore our conclusion has not considered these risks. Where sample testing has been undertaken, our findings and conclusions are limited to the items selected for testing. This report does not constitute an assurance engagement as set out under ISAE 3000.

Acknowledgements

We wish to thank management for their support during our review.

Summary of Findings

Partial Assurance with Improvement Required

We have raised three medium rated, one low rated and four improvement rated recommendations and as such we have concluded that the controls in place in respect of Delayed Discharge Performance Indicators provides a level of **Partial assurance with improvement required**. The ratings assigned are based on the agreed internal audit rating scale (**Appendix 3**).

The risks reviewed are set out below with the number of recommendations raised. We have reported by exception against the areas where we consider that Management should focus their attention. Detailed findings, recommendations and agreed management actions are found in Section 2 of this report, with a summary provided below.

Risk Area 1 – NHS Ayrshire and Arran does not provide all required delayed discharge performance information to the IJBs, including statutory performance measures and compliance with directions, in line with agreed schedules.

We raised four improvement rated findings against this risk area:

Improvement rated (Recommendations 1, 2 and 3): There is no agreement between the IJBs and NHS Ayrshire and Arran on the delayed discharge data which will be provided, when it will be provided and to whom.

Improvement rated (Recommendation 4): Delayed discharge reporting is not used effectively at all levels for management of delayed discharges, without this monitoring control the data within TrakCare is not kept accurate.

Risk Area 2 – The controls in place within NHS Ayrshire and Arran do not ensure that information provided to the IJBs is accurate and complete.

We raised three medium and one low rated findings against this risk area:

Medium rated (Recommendation 5) : Patient data within TrakCare is not kept up to date due to pressures and shortcuts in record keeping practices, as a result the quality of data has decreased over time.

Medium rated (Recommendation 6 and 7): Documented procedures for the processing of delays and submitting referrals is not up to date and does not include all services which contribute to this process. As a result, responsibilities are unclear and not fulfilled.

Low rated (Recommendation 8): The process undertaken by HSCPs to cleanse delayed discharge data (contributing to the accuracy of the data) and to submit the monthly census report/submission to SG is not documented by all HSCPs and we could not confirm they process carried out is consistent across North, East and South.

Risk Areas	Number of Recommendations			
	H	M	L	Imp
Risk Area 1 - NHS Ayrshire and Arran does not provide all required delayed discharge performance information to the IJBs, including statutory performance measures and compliance with directions, in line with agreed schedules.	-	-	-	4
Risk Area 2 - The controls in place within NHS Ayrshire and Arran do not ensure that information provided to the IJBs is accurate and complete.	-	3	1	-
	-	**3**	**1**	**4**

Management Action Plan

Risk Area 1 - NHS Ayrshire and Arran does not provide all required delayed discharge performance information to the IJBs, including statutory performance measures and compliance with directions, in line with agreed schedules.		Improvement
Finding 1 – (IJB) Operational Level requests for data from NHS Ayrshire and Arran	**Recommendations**	**Agreed Management Actions**
Background: In order for the HSCPs to report progress on their deliverables, they require information from the NHS Ayrshire and Arran systems. With regards to delayed discharges, to evidence improvements in delays, the HSCPs require to be sent extracts of data from the patient management system, TrakCare. This data is provided in the form of reports from the Planning and Information Team within the Transformation and Sustainability Team at NHS Ayrshire and Arran. **Control:** There is an agreement in place between NHS Ayrshire and Arran and the HSCPs which outlines the specific data required, when this is required and to whom it should be shared with. **Observation:** We noted that currently NHS AA work closely with the IJBs to provide the necessary delayed discharge data and to ensure that the data which is provided to Scottish Government is accurate. However there is no formal/documented agreement between the HSCPs and NHS Ayrshire and Arran which states what data specifically is required, how often this is required and to whom it should be sent. Without an agreement which outlines in detail the reports which should be run, the frequency they should be run at and to whom they should be sent, individuals who need information to report to management may not receive this in the form required and at the frequency required. As a result, the HSCPs may be unable to report progress against strategic objectives.	Recommendation 1 North Ayrshire IJB should consider a more formal agreement with NHS AA to ensure that the delayed discharge data required will always be received when and by whom it should be.	**Actions** Relevant parties to meet to discuss the need, scope and content of a potential formal agreement for delayed discharge data, distribution and frequency. If deemed as required, develop a formal delayed discharge data agreement. **Evidence required to confirm implementation** Note of meeting between relevant parties. Production of formal data agreement, if deemed necessary. **Responsible Officer** Kerry Logan – Senior Manager North Ayrshire HSCP **Due Date** 30 September 2023

Management Action Plan

Risk Area 1 - NHS Ayrshire and Arran does not provide all required delayed discharge performance information to the IJBs, including statutory performance measures and compliance with directions, in line with agreed schedules.	**Improvement**
Recommendations	**Agreed Management Actions**
Recommendation 2 East Ayrshire IJB should consider a more formal agreement with NHS AA to ensure that the delayed discharge data required will always be received when and by whom it should be.	**Actions** Relevant parties to meet to discuss the need, scope and content of a potential formal agreement for delayed discharge data, distribution and frequency. If deemed as required, develop a formal delayed discharge data agreement. **Evidence required to confirm implementation** Note of meeting between relevant parties. Production of formal data agreement, if deemed necessary. **Responsible Officer** Erik Sutherland – Head of Health and Community Care East HSCP **Due Date** 30 September 2023
Recommendation 3 South Ayrshire IJB should consider a more formal agreement with NHS AA to ensure that the delayed discharge data required will always be received when and by whom it should be.	**Actions** Relevant parties to meet to discuss the need, scope and content of a potential formal agreement for delayed discharge data, distribution and frequency. If deemed as required, develop a formal delayed discharge data agreement. **Evidence required to confirm implementation** Note of meeting between relevant parties. Production of formal data agreement, if deemed necessary. **Responsible Officer** Lisa McAlpine – Senior Manager South HSCP **Due Date** 30 September 2023

Management Action Plan

Risk Area 1 - NHS Ayrshire and Arran does not provide all required delayed discharge performance information to the IJBs, including statutory performance measures and compliance with directions, in line with agreed schedules.		Improvement
Finding 2 (NHS AA) – Use of PMS Reports and monitoring	**Recommendation 4**	**Agreed Management Actions**
Background: There are a range of automatic reports set up to extract data from TrakCare at agreed intervals and send to agreed individuals. These reports vary in content, frequency extracted and the individuals receiving the data. **Control:** The reports extracted from TrakCare which include delayed discharge information are all necessary and are used by those who receive them for monitoring purposes. **Observation:** We were unable to obtain a definitive list of all reports which are set up to run automatically and which extract delayed discharge information from TrakCare. We confirmed with management that there are several reports including PMS182, PMS178 and PMS145. We confirmed anecdotally that the PMS182 report is being used for the submission of information to Scottish Government, in addition, there are reports which are useful to staff on wards which are not being used for monitoring purposes as they were set up for.	There is a need to re-evaluate the reports which are required for all levels of monitoring across NHS AA, including the needs of the IJBs. This evaluation should include discussions with various stakeholders to ensure all who contribute to the accuracy of delayed discharge data receive the data they require for monitoring. In addition, support should be given to staff across NHS AA to ensure they are aware of reports available and how they can use them for monitoring purposes.	**Actions** • Perform an audit to identify all scheduled reports which relate to delayed discharges • Liaise with key stakeholders to identify required suite of reports moving forward • Delete all unnecessary scheduled reports **Evidence required to confirm implementation** • Detailed list of all reports • Agreed actions from stakeholders to confirm required reports • New list of reports, scheduled timings and to whom • Confirmation of deleted reports **Responsible Officer** Gillian Arnold – Head of Planning and Information **Due Date** 31 December 2023

Management Action Plan

Risk Area 2 - The controls in place within NHS Ayrshire and Arran do not ensure that information provided to the IJBs is accurate and complete.	Medium

Finding 3 (NHS AA) – Inaccurate data in TrakCare	Recommendation 5	Agreed Management Actions
Background: Two systems are currently in use to track patient progress, the first is TrakCare which is the patient management system used by NHS Ayrshire and Arran, this contains the master data for all patients throughout their life. The second system is called Whiteboard, this system is essentially an electronic version of the old fashioned white boards in each ward used to monitor the patients in the ward at any one time and their progress through treatment. The Whiteboard system is shown on the television screens in the wards and is updated by the ward staff as changes occur. These two systems do not interface and therefore there is a need, when updating one system, to update the other. **Control:** Both TrakCare and the Whiteboard system are updated to reflect the developments in the patient care journey on an ongoing basis by nurses and ward staff. **Observation:** We completed detailed testing onsite at both Ayr and Crosshouse Hospitals, detailed testing results can be found at **Appendix 2**. We have summarised our findings as follows: - The Whiteboard system is used in the first instance by ward staff, updates are made within this system and not transferred to TrakCare. - The Whiteboard system is not always kept up to date, while staff on the wards were able to confirm the patient status in terms of treatment, medical fitness and delays, this was not always documented in the system. - The use of PDD is not consistent across all wards, as a result there are inconsistencies when considering if a delayed discharge exists. This has a huge impact on the quality of the data within TrakCare and therefore the information submitted to SG. TrakCare holds patient master data and is used to extract information to be returned to Scottish Government, if this is not updated as a priority over other systems, the information used by management and submitted to SG could be inaccurate and not reflect actual delayed discharges.	TrakCare and the Whiteboard System should be updated simultaneously to ensure the systems are in agreement. Where, for some reason there is insufficient time or resource to complete both systems, the updating of TrakCare should be prioritised and the Whiteboard System caught up at a later date. The DWD team should ensure a daily check is completed on the discrepancies between the two systems and make changes as necessary.	**Actions** • Provide PMS refresher training to clinicians on how to set PDDs on Trak. • Home first practitioners to review PDDs twice a day and update as required in collaboration with ward clinical staff. • Continue to use the daily report depicting PDD vs eWhiteboard mismatches to identify areas of improvement. **Evidence required to confirm implementation** Reduction in the number of PDD mismatches between Trak and the eWhiteboard as depicted by the daily report on mismatches. **Responsible Officer** Zockey Musembya, Discharge without Delay Lead – UHA Aaron Bruce George, Discharge without Delay Lead - UHC **Due Date** 01 October 2023

Management Action Plan

Risk Area 2 - The controls in place within NHS Ayrshire and Arran do not ensure that information provided to the IJBs is accurate and complete.	Medium

Finding 4 (NHS AA) – NHS Ayrshire and Arran control over accuracy of data	Recommendations	Agreed Management Actions
Background: The responsibility for maintaining accurate patient data within TrakCare is spread across various individuals and services. **Control:** Roles and responsibilities with regards to upkeeping the accuracy of data in TrakCare should be clearly documented and communicated. **Observation:** We ascertained that the PDDs are set by the clinical team, the senior charge nurse of each ward are then responsible for keeping TrakCare up to date with correct Planned Dates of Discharge (PDDs) and noting the date when the patient becomes medically fit. There is a range of documented training slides and reference guides for staff on how to record a delayed discharge and submit a referral, these include: Delayed Discharge Recording – Training for Nursing Staff (2019); Sending Referrals – Training for Nursing Staff (2019); Quick Reference Guide Recording Delayed Discharges (2019); Quick Reference Guide Making a Referral (2019); Basic TrakCare (PMS) Guide for Discharge Planning (2022). Four of the documents above were created in 2019 and have not since been reviewed. We were unable to see evidence that these have been shared with current staff and are used in the ward setting. We recognise there was training provided to staff by the Digital Services Project Manager, however this was in 2019 when the documents were produced. In addition to the responsibilities of the clinical teams, senior charge nurse of the wards, there are some other mechanisms used to improve the accuracy of TrakCare delayed discharge data which are not included in any of the documents as noted above : • There are Home First Practitioners who follow up on those patients which are medically fit but which cannot be discharged. • The HomeFirst Team is in place to “check, chase and challenge – any pending referrals and interventions precipitating delays in discharging patients”. Ward clinical staff are responsible for Ensuring that the referrals are done timely.	Recommendation 6 Suite of documented procedures should be updated to include all mechanisms for ensuring data in TrakCare is accurate. This should include clear segregation of responsibilities across all staff involved. The documents should include the processes for inputting data, monitoring and reporting controls. Updates to TrakCare should be reflected within this suite of documentation.	**Actions** • Liaise with ward managers to ensure that ward staff are up to speed with relevant procedures pertaining to updating Trak. • Liaise with the Trak team to support the development of documented procedures for updating Trak. **Evidence required to confirm implementation** Evidence of communications with ward managers and Trak Team. Documented procedures for updating Trak. **Responsible Officer** Zockey Musembya, Discharge without Delay Lead – UHA Aaron Bruce George, Discharge without Delay Lead - UHC **Due Date** 01 September 2023

Management Action Plan

Risk Area 2 - The controls in place within NHS Ayrshire and Arran do not ensure that information provided to the IJBs is accurate and complete.	Medium

Finding 4 (NHS AA) – NHS Ayrshire and Arran control over accuracy of data (Cont'd)	Recommendations	Agreed Management Actions
Observation (Cont'd): • The Social Care Team ensures the necessary steps have been taken from a social perspective for discharge of patients when they are fit. We also noted that reports received by these teams are not being used most effectively to make changes to TrakCare and increase the accuracy of the data. Therefore, there are ways in which data can be kept accurate, however these are not all documented . As a result responsibilities are not made clear, are not communicated and in some instances are not accepted for reasons such as prioritisation of patient care. If the data cannot be kept accurate, there is a risk that the information downloaded from TrakCare and returned to Scottish Government is inaccurate.	Recommendation 7 The new procedures should be shared with all staff involved in the process and training provided to ensure adequate support has been given to those completing the processes.	**Actions** Roll out updated procedures to all wards. **Evidence required to confirm implementation** • Reduction in PDD mismatched between Trak and the eWhiteboard • Reduction in the number of patients without a PDD on Trak **Responsible Officer** Zockey Musembya – UHA Aaron Bruce George - UHC **Due Date** 01 September 2023

Management Action Plan

Risk Area 2 - The controls in place within NHS Ayrshire and Arran do not ensure that information provided to the IJBs is accurate and complete.	Low

Finding 5 (IJB) – HSCP reconciliation documented procedure	Recommendation 8	Agreed Management Actions
Background: It is known to both NHS Ayrshire and Arran and the HSCPs that the data within TrakCare is not up to date. As a result, secondary controls have been put in place within the HSCPs to ensure that the data they submit to SG is accurate. The HSCPs take delayed discharge data sent from NHS Ayrshire and Arran on a daily basis, reconcile this to the referrals systems used for community care and ensure the delays should be classed as delays in line with the Delayed Discharge Definitions Manual 2016 (Published by Scottish Government). On a monthly basis, for the return to SG, the data is reconciled by North, East and South HSCPs separately, all are sent to East to collate and then sent to SG. **Control:** Each of the three HSCPs have a documented procedure which outlined the process undertaken on a daily basis for the reconciliation of delays to the community care system and to the Delayed Discharge Definitions Manual. There is a further procedure documented for the monthly return of delayed discharge data to SG. **Observation:** We enquired of the Performance Data Assistants (or equivalent) for each of the HSCPs who are allocated the responsibility to reconcile delayed discharge data and ensure TrakCare is as accurate as possible daily and for the monthly return to SG. We found that the processes carried out by North, East and South HSCPs are similar and that there is some documentation of the processes. However, the documentation is not complete, up to date and consistent across the three HSCPs. Therefore we were unable to determine whether the processes applied at each of the HSCPs are consistent. If there are inconsistencies between the HSCPs, the data which is submitted to SG could be skewed/inconsistent within Ayrshire overall.	A collaborative approach should be undertaken by the HSCPs to create a more consistent approach to delayed discharge processing. This approach should include review of process documents and the addition of regular collaboration meetings between North East and South.	**Actions** HSCP Senior Managers undertake a review of delayed discharge data quality processes and documentation. HSCP Senior Managers agree common delayed discharge data quality documentation (noting necessary information system variation). Common documentation is disseminated. Delayed discharge data quality is included as an Agenda item at an appropriate forum. **Evidence required to confirm implementation** Record of data quality review. Production of common delayed discharge data quality documentation and dissemination. Delayed discharge data quality as a standing Agenda Item at appropriate Forum. **Responsible Officer** Kerry Logan, Senior Manager, North Ayrshire HSCP Marie Furniss, Senior Manager, East Ayrshire HSCP Lisa McAlpine, Senior Manager, South Ayrshire HSCP **Due Date** 30 September 2023

Appendices

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Appendix 1 - Health and Social Care Integration statutory guidance – (Extract)

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) places a duty on Integration Authorities to develop a strategic plan, also known as a strategic commissioning plan, for integrated functions and budgets under their control for which we have published statutory guidance: https://www.gov.scot/publications/strategic-commissioning-plans-guidance/pages/9/. Integrated functions and budgets are those delegated by the Health Board and Local Authority. The legislation sets out what functions and budgets must be delegated and those that may be delegated: http://www.legislation.gov.uk/asp/2014/9/contents/enacted.

1.2 Each Integration Authority must produce a strategic commissioning plan that sets out how they will plan and deliver services for their area over the medium term, using integrated budgets under their control. Stakeholders must be fully engaged in the preparation, publication and review of the strategic commissioning plan, in order to establish a meaningful co-production approach, to enable Integration Authorities to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration.

1.3 Integration Authorities require a mechanism to action their strategic commissioning plans and this is laid out in sections 26 to 28 of the Act. This mechanism takes the form of binding directions from the Integration Authority to one or both of the Health Board and Local Authority. Directions are also the means by which a record is maintained of which body decided what and with what advice, which body is responsible for what, and which body should be audited for what, whether in financial or decision making terms.

1.4 In the case of an Integration Joint Board (IJB), a direction must be given in respect of every function that has been delegated to the IJB. In a lead agency arrangement, the Integration Authority may issue directions or may opt to carry out the function itself. In either case, a direction must set out how each integrated function is to be exercised, and identify the budget associated with that. Not unexpectedly, only IJBs have made directions to delivery partners to date and this guidance is therefore mainly aimed at IJBs and their delivery partners in Health Boards and Local Authorities.

1.5 Put simply, directions are the means by which an IJB tells the Health Board and Local Authority what is to be delivered using the integrated budget and for the IJB to improve the quality and sustainability of care, as outlined in its strategic commissioning plan.

1.6 Directions are also the legal basis on which the Health Board and the Local Authority deliver services that are under the control of the IJB. If directions are not being provided or they lack sufficient detail, Health Boards and Local Authorities should be actively seeking directions in order to properly discharge their statutory duties under the Act.

1.7 This guidance sets out how to improve practice in the issuing (by IJBs) and implementation (by Health Boards and Local Authorities) of directions issued under the Public Bodies (Joint Working) (Scotland) Act 2014. It supersedes the Good Practice Note on Directions issued in March 2016.

Appendix 2 – Detailed Testing Results

University Hospital Ayr: We selected a sample of 18 patients across 4 wards at University Hospital Ayr, we compared the planned discharge date (PDD) within the Whiteboard system and the Estimated Discharge Date (EDD) within TrakCare which should be the same. We found that for 13 patients (Table A), the discharge dates did not match. We then noted from the Whiteboard system whether patients selected had been marked as medically fit and therefore should be discharged. Of those marked as medically fit, we discussed reasons for this with the Senior Charge Nurse/Ward Manager, we found no issues during these discussions. Where they were not marked as medically fit, we checked the PDD and discussed this with the Senior Charge Nurse/Ward Manager to ensure it was an accurate date, after these discussions and some further analysis, we concluded that 6 patients in our sample were marked as not medically fit for discharge, however their PDD was a date in the past, therefore this was not an accurate date for discharge.

University Hospital Crosshouse: We selected a sample of 20 patients across 4 wards at University Hospital Crosshouse, we compared the planned discharge date (PDD) within the Whiteboard system and the Estimated Discharge Date (EDD) within TrakCare which should be the same. We found that for 12 patients (Table B) the discharge dates did not match. We then noted from the Whiteboard system whether patients selected had been marked as medically fit and therefore should be discharged. Of those marked as medically fit, we discussed reasons for this with the Senior Charge Nurse/Ward Manager , we found no issues during these discussions. Where patients were not marked as medically fit, we checked the PDD and discussed this with the Senior Charge Nurse/Ward Manager to ensure it was an accurate date. Our discussions and further analysis show that 9 patients in our sample were marked as not medically fit for discharge, however their PDD was in the past, therefore this was not an accurate date for discharge.

Appendix 2 – Detailed Testing Results

Table A – University Hospital Ayr

Sample number	Date of testing	Whiteboard PDD	TrakCare EDD	DD match?	DD in past?*
1	22/02/2023	19/01/2023	16/01/2023	No	No
2	22/02/2023	22/02/2023	22/02/2023	Yes	Yes
3	22/02/2023	31/01/2023	31/01/2023	Yes	No
4	22/02/2023	22/02/2023	22/02/2023	Yes	Yes
5	22/02/2023	24/02/2023	15/02/2023	No	No
6	22/02/2023	22/02/2023	No date	No	No
7	22/02/2023	10/02/2023	10/02/2023	Yes	No
8	22/02/2023	24/02/2023	No date	No	No
9	22/02/2023	27/01/2023	23/01/2023	No	No
10	22/02/2023	24/02/2023	No date	No	No
11	22/02/2023	31/01/2023	14/11/2022	No	No
12	22/02/2023	08/12/2022	09/12/2022	No	No
13	22/02/2023	20/02/2023	No date	No	Yes
14	22/02/2023	30/01/2023	18/01/2023	No	No
15	22/02/2023	No date	No date	Yes	Yes
16	22/02/2023	30/03/2023	No date	No	No
17	22/02/2023	21/02/2023	No date	No	Yes
18	22/02/2023	21/02/2023	30/01/2023	No	Yes

*Marked **Yes** where the patient is marked as not medically fit and their planned discharge date is in the past. This means that the date has not been kept up to date throughout the patient journey and the patient is marked as a delay when they are not (as they are not medically fit).

Table B – University Hospital Crosshouse

Sample number	Date of testing	Whiteboard PDD	TrakCare EDD	DD match?	DD in past?*
1	13/02/2023	30/01/2023	30/01/2023	Yes	Yes
2	13/02/2023	26/02/2023	No date	No	No
3	13/02/2023	No date	No date	Yes	No
4	13/02/2023	17/02/2023	No date	No	No
5	13/02/2023	14/02/2023	14/02/2023	Yes	No
6	13/02/2023	24/01/2023	24/01/2023	Yes	Yes
7	13/02/2023	08/02/2023	08/02/2023	Yes	Yes
8	13/02/2023	16/02/2023	No date	No	No
9	13/02/2023	No date	No date	Yes	Yes
10	13/02/2023	13/02/2023	No date	No	Yes
11	13/02/2023	17/02/2023	07/02/2023	No	No
12	13/02/2023	14/02/2023	13/02/2023	No	No
13	13/02/2023	09/02/2023	10/02/2023	No	Yes
14	13/02/2023	06/02/2023	09/02/2023	No	No
15	13/02/2023	10/02/2023	10/02/2023	Yes	Yes
16	13/02/2023	09/02/2023	08/02/2023	No	Yes
17	13/02/2023	08/02/2023	08/02/2023	Yes	Yes
18	13/02/2023	20/02/2023	14/02/2023	No	No
19	13/02/2023	29/11/2022	10/02/2023	No	No
20	13/02/2023	15/02/2023	14/02/2023	No	No

Appendix 3 - Our IA Report assurance levels

The table below shows the levels of assurance we provide and guidelines for how these are arrived at. We always exercise professional judgement in determining assignment assurance levels, reflective of the circumstances of each individual assignment.

Rating	Description
Reasonable assurance	Overall, we have concluded that, in the areas examined, the risk management activities and controls are suitably designed to achieve the risk management objectives required by management. These activities and controls were operating with sufficient effectiveness to provide significant assurance that the related risk management objectives were achieved during the period under review. Might be indicated by no weaknesses in design or operation of controls, only LOW rated recommendations or only IMPROVEMENT recommendations.
Reasonable assurance with some improvement required	Overall, we have concluded that in the areas examined, there are only minor weaknesses in the risk management activities and controls designed to achieve the risk management objectives required by management. Those activities and controls that we examined were operating with sufficient effectiveness to provide reasonable assurance that the related risk management objectives were achieved during the period under review. Might be indicated by two or more minor weaknesses in design or operation of controls resulting in one MEDIUM rated recommendation and other recommendations being LOW rated
Partial assurance with improvement required	Overall, we have concluded that, in the areas examined, there are some moderate weaknesses in the risk management activities and controls designed to achieve the risk management objectives required by management. Those activities and controls that we examined were operating with sufficient effectiveness to provide partial assurance that the related risk management objectives were achieved during the period under review. Might be indicated by moderate weaknesses in design or operation of controls and more than one MEDIUM or HIGH rated recommendations.
No assurance	Overall, we have concluded that, in the areas examined, the risk management activities and controls are not suitably designed to achieve the risk management objectives required by management. Those activities and controls that we examined were not operating with sufficient effectiveness to provide reasonable assurance that the related risk management objectives were achieved during the period under review Might be indicated by significant weaknesses in design or operation of controls and several HIGH rated recommendations.

The table below describes how we grade our audit recommendations based on risks:

Rating	Description	Possible features
High	Findings that are fundamental to the management of risk in the business area, representing a weakness in the design or application of activities or control that requires the immediate attention of management	▪ Key activity or control not designed or operating effectively ▪ Potential for fraud identified ▪ Non-compliance with key procedures / standards ▪ Non-compliance with regulation
Medium	Findings that are important to the management of risk in the business area, representing a moderate weakness in the design or application of activities or control that requires the immediate attention of management	▪ Important activity or control not designed or operating effectively ▪ Impact is contained within the department and compensating controls would detect errors ▪ Possibility for fraud exists ▪ Control failures identified but not in key controls ▪ Non-compliance with procedures / standards (but not resulting in key control failure)
Low	Findings that identify non-compliance with established procedures, or which identify changes that could improve the efficiency and/or effectiveness of the activity or control but which are not vital to the management of risk in the business area.	▪ Minor control design or operational weakness ▪ Minor non-compliance with procedures / standards
Improvement	Items requiring no action but which may be of interest to management or which represent best practice advice	▪ Information for management ▪ Control operating but not necessarily in accordance with best practice

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