Internal Audit Report
For
York Teaching Hospital

Y1917
Delayed Transfer of Care
## Contents

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Report Author: Lesley McLean  
Report Version: Final  
Report Date: 13 November 2018
Section 1: Executive Summary

Context

The Trust requires a robust system to manage and forecast its patient flow to ensure patients are discharged in a timely manner.

Internal Audit undertook a Control Improvement Audit to review the arrangements in place to manage complex discharges and provide a supported Action Plan. The audit does not provide an overall opinion on the systems in place but identifies the actions required to improve control for any weaknesses or risks identified.

The Control Improvement Audit will be followed up at a later date by a standard audit to review the progress of the actions and provide an audit opinion.

Background Information

The majority (80%) of discharges from hospital are classed as ‘simple’ discharges however a number are complex and require additional support or care package to be put in place before the patient can be deemed medically fit and safe for discharge.

The term ‘delayed transfer of care’ (DToC) is applied to those patients who have recovered from the acute phase of illness and are awaiting transfer from an acute or community NHS bed to the next most appropriate level of care. These delays can be caused by a number of factors, including patients who are awaiting transfer to their chosen care home (Home of Choice). This applies to adult patients over 18 years irrespective of diagnosis and in any NHS Acute Hospital/Community Hospital setting.

‘NHS England is responsible for monitoring delayed transfers of care nationally and defines a patient as being ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer, and
- a multidisciplinary team has decided that the patient is ready for transfer, and
- the patient is safe to discharge/transfer.

As soon as a patient meets these three conditions and remains in a bed, the ‘clock’ starts and they are classified as ‘a delayed transfer’.

All hospitals are required to collect delayed transfer data for adults (aged over 18 years) and provide it to NHS England, together with the reasons for these delays. The ‘clock’ for measuring delayed transfers only begins when a full multidisciplinary team has assessed the patient’s needs to determine if a patient needs further therapy or social care input – before deciding when the patient can be discharged. Patients in
hospital who have been assessed by a consultant or other clinician as being ‘medically fit for discharge’ are not counted as a delayed transfer before this fuller assessment takes place.’

<table>
<thead>
<tr>
<th>Acute and Non Acute Care</th>
<th>2017/18</th>
<th>2018/19</th>
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<tr>
<td>Number of days delayed within a month for all patients delayed throughout the month -</td>
<td>Q1 1599</td>
<td>Q1 2024</td>
</tr>
<tr>
<td>attributable to NHS</td>
<td>Q2 1614</td>
<td>Q2 2200</td>
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<tr>
<td></td>
<td>Q3 1500</td>
<td>Q3 2406</td>
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<tr>
<td></td>
<td>Q4 1785</td>
<td>Q4 1854</td>
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<tr>
<td></td>
<td>Total</td>
<td>6498</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>2612</td>
</tr>
<tr>
<td>Number of days delayed within a month for all patients delayed throughout the month -</td>
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<td>Q1 3738</td>
</tr>
<tr>
<td>attributable to Social Care</td>
<td>Q2 226</td>
<td>Q2 4040</td>
</tr>
<tr>
<td></td>
<td>Q3 106</td>
<td>Q3 4012</td>
</tr>
<tr>
<td></td>
<td>Q4 33</td>
<td>Q4 3672</td>
</tr>
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<td></td>
<td>Total</td>
<td>480</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>54</td>
</tr>
<tr>
<td>Number of days delayed within a month for all patients delayed throughout the month -</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attributable to Both</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total number of patient delays</strong></td>
<td>3738</td>
<td>15462</td>
</tr>
<tr>
<td></td>
<td>4040</td>
<td>4308</td>
</tr>
<tr>
<td></td>
<td>4012</td>
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</tr>
<tr>
<td></td>
<td>3672</td>
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The Department of Health mandate to NHS England in 2017/18 set a target for delayed transfers to be reduced to no more than 3.5 per cent of all hospital bed days by September 2017.

**Key Risks**

Key risks associated with this area include:

- The Joint Protocol for the Transfer of Care does not align with legislation or reporting guidance.
- Lack of awareness of Trust performance.
- Performance measures are not met.
Section 1: Executive Summary

Objectives & Scope

The aim of this review was to review the arrangements in place to manage complex discharges to prevent patients encountering delays in the process. In order to meet this objective, the audit focussed on the following key control objectives:

- The Joint Protocol for the Transfer of Care (the protocol) aligns with legislation and current reporting specifications laid down in the Care Act 2014.
- Adequate governance arrangements are in place to monitor and report on Trust performance against the requirements of the protocol.

Methodology

The objectives of this review were achieved through discussions with key staff to gain an understanding of the system and reviewing the protocol against guidance and legislation.

- Care Act 2014
- National Framework for NHS Continuing Healthcare (CHC) and NHS-funded Nursing Care
- Care and Support Statutory Guidance
- Monthly Delayed Transfer of Care Situation Reports (NHSE)
- Emergency Care Improvement Programme (NHSI)

Limitations

The assurance given is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Follow Up date

The findings and agreed actions will be revisited in April 2019 as part of the three stage CIA approach once the revised protocol is in place.
Section 1: Executive Summary

Areas of Good Practice

- A joint protocol is in place which outlines the process to enable safe and equitable transfers of care. The protocol incorporated all aspects of the Care Act 2014.
- A Discharge Liaison Team (DLT) has been established to provide advice and review those patients whose discharge is considered to be complex and may need additional support to leave hospital.
- Regular meetings are held with Social Workers and members of the DLT to discuss those patients whose discharge is delayed.

Key Areas for Development

- The protocol does not evidence the agreement from the Clinical Commissioning Group (CCG) and does not document expectations in relation to performing and managing Continuing Healthcare assessments.
- A timeframe for submission of Assessment Notices is not documented in the protocol and there may be a reluctance to report Expected Discharge Dates (EDD) early in the patient journey.
- A system is not in place to identify those patients due to be discharged within 48 hours but have not had Needs Assessment performed.
- Escalation procedures, for those patients who are delayed more than seven days and not through choice, require documenting.
- Key Performance Indicators listed in the protocol are not monitored and reported against.
- The Trust had not achieved the target for delayed patients of 3.5% mandated by NHS England 2017/18.
Section 2 : Report Circulation

Report Circulation

<table>
<thead>
<tr>
<th>Draft</th>
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<th>Recipient Title</th>
</tr>
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<tr>
<td>✓</td>
<td>✓</td>
<td>Steven Reed</td>
<td>Joint Head of Strategy</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>Melanie Liley</td>
<td>Deputy Chief Operating Officer</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>Gillian Younger</td>
<td>Project Manager Out of Hospital Care</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Wendy Scott</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Andrew Bertram</td>
<td>Finance Director and Deputy Chief Executive</td>
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</tbody>
</table>

Acknowledgement

The auditor is grateful for the assistance received from management and staff during the course of this review. The following members of the Audit Yorkshire team were involved in the production of this report:

- Head of Internal Audit: Helen Kemp-Taylor
- Audit Manager: Jonathan Hodgson
- Assistant Audit Manager: Emma Shippey
- Senior Auditor: Lesley McLean

Date: 13 November 2018
Section 3: Analysis of Current Position

<table>
<thead>
<tr>
<th>Control Objective</th>
<th>Current Position</th>
<th>Areas for Further Development</th>
</tr>
</thead>
</table>
| 1. The Joint Protocol for the Transfer of Care aligns with legislation and current reporting specifications laid down in the Care Act 2014.                                                                                                                                     | ✓ The Joint Protocol for the Transfer of Care (the protocol) sets out responsibilities for those who are responsible for the care of a patient whilst they are in hospital. The protocol included all of the elements of the Care Act 2014.  
 ✓ Local arrangements are in place for those patients who are awaiting transfer to a residential care home which allow for a decision on the choice of care home within a seven day period.  
 ✓ Although the protocol included all of the elements of the Care Act 2014, the timescales which should be adhered to, to facilitate a timely discharge, are not documented.  
 ✓ An Assessment Notice is issued to the Local Authority when a patient may require community care services post discharge. This is specified within the Care Act 2014 and they can be issued up to seven days before admission. The joint protocol includes the arrangements for these notices to be submitted to the Local Authority, but it was reported these are not generally issued until several days after a patient is admitted. This would impact on the timeliness of the needs assessments performed by the Local Authority.  
 ✓ The template document for Assessment Notices includes a field to record the EDD but these were reported to be rarely complete.  
 ✓ A system was not in place to identify those patients due to be discharged within 48 hours but had not yet received a needs assessment (following the receipt of an Assessment Notice). The Care act specifies the Local Authority has, as a minimum, two days’ notice to address the requirements of an assessment notice.  
 ✓ From review of the protocol, there was no evidence to                                                                                                                                       | 1. Assessment Notice  
 2. EDD and Needs Assessments  
 3. Continuing Healthcare Funding |
## Section 3: Analysis of Current Position

<table>
<thead>
<tr>
<th>Control Objective</th>
<th>Current Position</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Adequate governance arrangements are in place to monitor and report on Trust performance against the requirements of the protocol.</strong></td>
<td>Daily and Weekly Situation Report (SitRep) meeting are held and include a member of the Discharge Liaison Team (DLT) and the Local Authority. Weekly meetings are attended by member of the Clinical Commissioning Group (CCG).</td>
<td>4. Governance Arrangements 5. Key Performance Indicators (KPI)</td>
</tr>
<tr>
<td>confirm that an agreement had been reached between the Trust and the CCG in relation to the timescales for completing such assessments to prevent unnecessary delay.</td>
<td><strong>NHS England’s mandate (2017/18) stated ‘Working with NHS Improvement and local government partners, reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care to 3.5% by September 2017’. The Trust had not achieved the target for delayed patients of 3.5% as mandated by NHS England.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>The Complex Discharge Task and Finish Group (CDTFG) replaced the Strategic SitRep meeting. This group receives performance figures for those patients who experience a delayed discharge but does not receive patient level detail.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>The Trust’s monthly Performance Report includes information on DToC, this is reported to both the Quality and Safety Committee and the Board of Directors.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Key staff reported they are not assured that a robust Multi-Disciplinary Team (MDT) escalation process is in place to discuss patients who are delayed for more than seven days and formulate action plans to ensure their timely discharge.</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Section 3: Analysis of Current Position

<table>
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</thead>
<tbody>
<tr>
<td>! Weekly SitRep meetings are not attended by Directorate Managers (DM). The protocol states DMs have the responsibility for provision of support and advice to the Multidisciplinary Team (MDT) regarding DToC which cannot be resolved at ward level.</td>
<td>! NHS England’s mandate (2017/18) stated ‘Working with NHS Improvement and local government partners, reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care to 3.5% by September 2017’. The Trust has not achieved the target for delayed patients of 3.5% as mandated by NHS England.</td>
<td>! The Key Performance Indicators listed in the protocol are currently not monitored or reported against and in some cases not meaningful.</td>
</tr>
</tbody>
</table>
# Section 4: Action Plan - Areas for Development

<table>
<thead>
<tr>
<th>Area for Further Development</th>
<th>Agreed Actions</th>
<th>Management Response</th>
<th>Responsible Officer</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Assessment Notice</strong></td>
<td>The joint protocol will be revised and re-launched.</td>
<td>The ‘Why not home, why not today?’ Task Force has been set up following a workshop to discuss the joint delayed transfers of care protocol. The task force will develop a project plan, charter and timeline and will cross reference with the contents of this report. This group will report progress to the Complex Discharge Steering Group on a monthly basis and will include progress against the action plan. Updated guidance is due to be published later in the year on coding and counting delayed patients which will need to be included. The revised protocol will be published in April 2019.</td>
<td>Gillian Younger, Project Manager Out of Hospital Care.</td>
<td>30 April 2019</td>
</tr>
<tr>
<td><strong>2. EDD and Needs Assessments</strong></td>
<td>This forms part of the SAFER Bundle.</td>
<td>We have a local SAFER Operating Framework that provides a framework against which each directorate and ward are asked to deliver their SAFER work against. EDD forms one of the core elements. We manage</td>
<td>Louise Parker, Head of Service Improvement.</td>
<td>NA</td>
</tr>
</tbody>
</table>

Nurses are responsible for issuing Assessment and Discharge Notices.

An Assessment Notice is a notification issued to the Local Authority in regard to patients who are likely to need community care services to facilitate discharge. They can be issued to the Local Authority up to seven days before a patient is admitted.

These timescales are not included within the protocol and, from discussion with key staff, it was found that these are not routinely issued in advance. For elective patients, these could be completed following attendance at a pre-assessment appointment.

Consultants, or a nominated deputy, are responsible for the overall care of a patient while in hospital and bear the responsibility for discharging the patient. At the earliest appropriate opportunity the outcome of the admission and an anticipated date for
### Area for Further Development

Discharge (EDD) should be identified.

Through discussion, it was reported that identifying an EDD is often delayed until the patient is nearing discharge.

It was also noted that an early warning system is not in place to identify those patients where an assessment notice has been submitted and are due to be discharged within 48 hours and a needs assessment has not been completed by Social Workers.

### Agreed Actions

The joint protocol will be revised and re-launched.

### Management Response

- The delivery of SAFER via the local delivery plans.
- The governance structure is via the SAFER working groups that report to the acute board in York and Acute and planned care board in Scarborough.
- We have also recently included SAFER on the Operational Performance Assurance Meetings agenda.
- The ‘Why not home, why not today?’ Task Force has been set up following a workshop to discuss the joint delayed transfers of care protocol. The task force will develop a project plan, charter and timeline and will cross reference with the contents of this report. This group will report progress to the Complex Discharge Steering Group on a monthly basis and will include progress against the action plan.
- Updated guidance is due to be published later in the year on coding and counting delayed patients which will need to be included.

### Responsible Officer

Gillian Younger, Project Manager Out of Hospital Care.

### Review Date

30 April 2019
### Section 4: Action Plan - Areas for Development

<table>
<thead>
<tr>
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<tr>
<td><strong>3. Continuing Healthcare Funding</strong></td>
<td>The joint protocol will be revised and relaunched.</td>
<td>The revised protocol will be published in April 2019.</td>
<td>Gillian Younger, Project Manager Out of Hospital Care.</td>
<td>30 April 2019</td>
</tr>
</tbody>
</table>

Clinical Commissioning Groups (CCGs) perform an assessment of eligibility for Continuing Healthcare (CHC) funding upon a patient’s discharge from hospital. From review of the protocol, there was no evidence to confirm that an agreement had been reached between the Trust and the CCG in relation to the timescales for completing such assessments to prevent unnecessary delay.

The joint protocol will be revised and relaunched.

The ‘Why not home, why not today?’ Task Force has been set up following a workshop to discuss the joint delayed transfers of care protocol. The task force will develop a project plan, charter and timeline and will cross reference with the contents of this report. This group will report progress to the Complex Discharge Steering Group on a monthly basis and will include progress against the action plan.

Updated guidance is due to be published later in the year on coding and counting delayed patients which will need to be included.

The revised protocol will be published in April 2019.

| **4. Governance Arrangements** | The joint protocol will be revised and relaunched. | The ‘Why not home, why not today?’ Task Force has been set up following a workshop to discuss the joint delayed transfers of care protocol. The task force will develop a project plan, charter | Gillian Younger, Project Manager Out of Hospital Care. | 30 April 2019 |

The following points were noted in relation to the current governance arrangements in place to oversee the DTOC process:

- Although DMs have the responsibility for the provision of
### Section 4: Action Plan - Areas for Development

<table>
<thead>
<tr>
<th>Area for Further Development</th>
<th>Agreed Actions</th>
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</table>
| support and advice to the Multidisciplinary Team (MDT) regarding DTOC, there is no DM representation at the weekly Sitrep meetings.  
- Patient level detail is not communicated at the Strategic Sitrep meeting.  
- Staff reported that they are not assured a robust MDT escalation process is in place to discuss those patients who are delayed for more than seven days. | and timeline and will cross reference with the contents of this report. This group will report progress to the Complex Discharge Steering Group on a monthly basis and will include progress against the action plan.  
Updated guidance is due to be published later in the year on coding and counting delayed patients which will need to be included.  
The revised protocol will be published in April 2019. | Gillian Younger, Project Manager Out of Hospital Care. | 30 April 2019 |

### 5. Key Performance Indicators (KPI)

There are a number of KPI’s listed within the protocol. The Discharge Liaison Team has the responsibility for collating the Trust data for the KPI’s.

It was reported that no monitoring was being undertaken against these KPI’s.

The lack of monitoring and oversight of these KPI’s may suggest they are not considered to be a robust means of monitoring performance.

The joint protocol will be revised and relaunched.

The ‘Why not home, why not today?’ Task Force has been set up following a workshop to discuss the joint delayed transfers of care protocol. The task force will develop a project plan, charter and timeline and will cross reference with the contents of this report. This group will report progress to the Complex Discharge Steering Group on a monthly basis and will include progress against the action plan.

Updated guidance is due to be published later in the year on coding and counting delayed patients which will need to be included.
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<tr>
<td></td>
<td></td>
<td>coding and counting delayed patients which will need to be included.</td>
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<td></td>
<td></td>
<td>The revised protocol will be published in April 2019.</td>
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Appendix 1 – Key to Internal Audit Advisory Reports

Introduction

Audit Yorkshire uses an inclusive risk-based approach to building its Internal Audit plans, with senior management identifying areas of risk or concerns which may then be included. Whilst this approach identifies current weaknesses and leads to activities which improve control it almost invariably leads to an audit report giving an opinion of "limited assurance".

Recognising that Internal Audit’s role includes supporting management in improving control and that attention should be legitimately given to such areas of need, the challenge is to:

- agree a constructive approach which recognises the current situation
- encourage remedial control activity
- provide for a formal assurance opinion in that area to be given
- provide for a balanced overall opinion on the organisation’s internal control systems.

The following protocol for a control improvement audit sets out a 2-stage approach which recognises existing risks and/or weaknesses, provides for a supported action plan to improve control, and is then followed up at a later date, with an assurance opinion reported. All of which will form part of the formal Internal Audit plan.

Advisory Services Protocol

Audit Yorkshire has an existing Advisory Services Protocol which is based on best practice guidance and the Public Sector Internal Audit Standards (PSIAS). The protocol uses the term “advisory” rather than the more commonly used “consultancy”.

The Institute of Internal Auditors defines “assurance” and “consulting” (advisory) as follows:

- **Assurance** = an objective examination of evidence for the purpose of providing an independent assessment on the risk management, control and governance processes for the organisation.
- **Consulting** = advisory and client related activities, the nature and scope of which are agreed with the client and which are intended to add value.

The key distinction between the two being that assurance is historic, whereas advisory/consultancy services are future-orientated.
The PSIAS require that internal audit does not assume any managerial responsibility in areas where either assurance or advisory work is undertaken and require reporting of control issues identified via advisory work, but does not explicitly require reporting of advisory work per se.

- Standard 2010.C1 – The chief audit executive should consider accepting proposed consultancy engagements based on the engagement’s potential to improve management of risks, add value and improve the organisation’s operations. Accepted engagements must be included in the plan.
- Standard 2120.C2 – Internal auditors must incorporate knowledge of risks gained from consulting engagements into their evaluation of the organisation’s risk management processes. [By this we interpret that findings from advisory work should contribute to the Head of Internal Audit Opinion where appropriate – this is specifically mentioned within the AY Internal Audit Charter].
- Standard 2130.C1 – Internal auditors must incorporate knowledge of controls gained from consulting engagements into evaluation of the organisation’s control processes.

It should be recognised that the majority of the work undertaken by Internal Audit has shades of assurance and consultancy/advisory.

Internal Audit Managers will ensure that advisory work is undertaken only if:

- it has potential to improve the management of risks
- it adds value to the client organisation
- it improves the likelihood of achievement of an organisational objective.

**Planning & Approval of Control Improvement Audits**

Potential areas of control improvement will be identified as part of the internal audit planning process for inclusion within the Internal Audit Operational Plan which is subject to review by senior management and by the Audit Committee. Any Advisory work, including Control Improvement Audits will be clearly identified in the plan. This approach should ensure that the allocation of internal audit resources between assurance and advisory/improvement work is appropriate for the needs of the individual organisation.
Control improvement audits may be identified as part of the annual planning process or by management on an ad-hoc basis in response to the emerging risks faced by and the needs of individual clients. A standard process is already in place for the agreement and approval of work arising in-year (approval by Finance Directors with subsequent reporting and approval of Audit Committees) and all clients have a small budget within their internal audit plans for “matters arising” or “client directed”.

**Approach and Reporting Arrangements for Control Improvement Audits**

The approach to undertaking a control improvement audit will follow the established process for an assurance audit, which is to identify, evaluate and RAG rate current risks and controls, identifying any findings (gaps) and making recommendations to introduce, develop or improve controls in the specified area (system).

The key difference is that for a control improvement audit an [advisory report](#) will be issued, to the responsible manager, with a copy sent to the Audit Sponsor. This report will, in effect, take a similar form as an assurance report i.e. it will include the results of a professional audit review and will identify areas where controls can be introduced, developed or improved. It will not, however, include an assurance opinion.

At stage one the Audit Committee will be advised that a control improvement audit is underway and, if completed, the system RAG rating and number of actions made to introduce develop or improve control.

The second stage of the process will include a detailed follow up to establish whether agreed actions to improve controls have been undertaken. The timescale for this detailed follow up will be agreed at the outset of the audit and will be set out in the Audit Brief. This will usually take place within the planned year.

An [Assurance Opinion](#) report will be issued to the responsible manager and Audit Sponsor as a result of the follow-up. On completion, details, including an Executive Summary and actions taken will be reported in the Audit Committee’s next periodic report. The results will be considered and taken into account as part of developing the formal, annual Head of Internal Audit opinion on the organisation’s control environment.

Any agreed actions found to be outstanding at the follow up stage will be added to the Recommendations Tracker and followed up and reported as part of the agreed process.
Appendix 1 – Key to Internal Audit Advisory Reports

System RAG Rating

System RAG ratings are assigned on a five-point scale. This aligns with NHSI’s 1-5 scale of risk ratings, but, because some clients prefer it, is also shown on a traffic light scale. These should be regarded as an assessment of the system and controls in their current state, before any of the actions have been implemented.

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<td>Red/Amp</td>
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<td>Amp</td>
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<td>4</td>
<td>Amp/Gre</td>
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INCREASING RISK

Limitations

The findings contained in this report are based on the review work undertaken and are not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.