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Internal Audit Report 2018/2019

Unscheduled Care Discharge Process (incl. interaction with IJBs)

March 2019

Final

NHS Grampian

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Contents

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	Acute Director (Nursing and Midwifery)
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	Chief Officer, Aberdeenshire Health & Social Care Partnership
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	Chief Officer, Moray Health & Social Care Partnership

This report has been prepared by PwC in accordance with our engagement contract dated 1 August 2017.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is aligned to the Public Sector Internal Auditing Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

1. Executive summary

Report classification	*Trend*	**Total number of findings**				
			Critical	High	Medium	Low	Advisory
Low Risk	N/A – No prior year reviews for comparison	Control design	-	-	-	-	-
		Operating effectiveness	-	-	2	-	-
		Total	**-**	**-**	**2**	**-**	**-**

Summary of findings

The scope of this audit review was to assess the discharge process in NHS Grampian following the creation of the Integration Joint Boards (IJBs) in Scotland. The review focused specifically on unscheduled care discharges and the process for managing and changing the flow and pathway of patients within and between NHS Grampian and the Moray, Aberdeenshire and Aberdeen City IJBs.

Overall conclusions

The current processes and controls in place are designed with a focus on patient rather than bed management and the provision of excellent patient care. Whilst there are areas for improvement, it is important to note that health and social care integration is relatively new and processes and controls are still being embedded into operations. Furthermore, with increasing demand for health and social care, both primary and acute care sectors are working to develop the necessary efficiencies in ensuring robust unscheduled care discharge processes. This is challenging, particularly with the social care sector, against a backdrop of workforce supply, recruitment and retention challenges with a reducing number in the working age population.

Key findings

In summary we have identified two 'medium' risk findings related to control improvement opportunities resulting in this report being classified as 'low' risk. The findings are:

- NHS Grampian 'Patient Discharge from Hospital Protocol' prepared in September 2016 as a draft document has not been finalised or updated.
- Variances in recording and interpreting Estimated Dates of Discharge (EDDs).

The full details of our findings and the agreed actions can be found in **Section 3** of this report.

Good practice noted

We attended a Monday 12 noon Multi-Disciplinary Team (MDT) meeting in Dr. Gray's hospital on 12 November 2018 in Elgin. It was noted that the multi-disciplinary team (MDT) ran through almost every patient admitted to Dr. Grays and discussed what stage of care they were at and the next stage in their care journey. Clear actions were assigned to individuals to drive forward each patient's care and to help ensure that they are discharged as quickly as possible. Furthermore, specific attention was paid to those patients that were already delayed discharges, for a number of reasons. This meeting involved all necessary individuals from both the acute sector and Moray Health and Social Care Partnership with individuals from social work, occupational therapy, physiotherapy, the Geriatric Consultant from Dr. Grays, hospital operational staff, and senior charge nurses from each ward within Dr Grays were all present.

Whilst Aberdeen Royal Infirmary (ARI) also has site wide MDT meetings we did not attend and observe such a meeting.

Management comments

We are pleased to note that the audit recognises the multi-agency and cross-system participation and as such there are examples of good practice in both Aberdeen Royal Infirmary and Dr Gray's Hospital with their respective Health and Social Care Partnerships.

The EDD process relies upon our systems being embedded, which is a current priority, and we welcome the report highlighting this issue.

General Manager (Acute Sector)

2. Background and scope

Background

The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework for the integration of health and social care services in Scotland. It created a number of new public organisations, known as integration authorities and aims to break down the barriers to joint working between NHS Boards and local authorities. As part of this, the Act requires the integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services.

Improving unscheduled care across Scotland is a key ministerial priority for the Scottish Government.

There are many things which have the potential to cause delay and unnecessarily prolong a patient's stay in hospital. Some of these can be categorised as 'external' (services or resources external to the ward or hospital which may not be available when the patient needs them); however, there may also be internal causes of non-clinical delay, and these can also contribute to poor patient experience. Discharge plans begin on patient admission to acute care. Regardless of the terminology used, a delayed discharge is an interruption of a clear flow through a system of care and support. Such interruptions tend to be symptoms of systems that are not geared to work together. Therefore, discharge performance is a clear performance indicator of the effectiveness of integrated health and social services.

In the Performance Report to the NHS Grampian Board Meeting held on 6 December 2018 it was noted that during September 2018, patients spent 4,023 days in hospital due to delays in discharge in Grampian. The figure for September 2017 was 3,408 so 2018 has seen in increase in delayed discharges of approximately 18%.

Across Scotland patients spent 45,470 days in hospital during September 2018 due to delayed discharges. The national figures for September 2017 was 42,110 so 2018 has seen an increase of delayed discharges of approximately 8%.

Multi-disciplinary Team Planning

Within NHSG a multi-disciplinary team (MDT) aims to meet within twelve hours of a patient being admitted to either Aberdeen Royal Infirmary (ARI) or Dr. Grays hospital in Elgin. The MDT is comprised of a number of health professionals from both the acute sector and the individual Health and Social Care Partnerships. The MDT is made up of professionals or disciplines such as the on-shift consultant, senior charge nurse, staff nurse, social care, occupational therapy and physiotherapy. The MDT will discuss the patient's required treatment, specific pharmacy requirements, possible ongoing, external, care at home or in a community care setting. The MDT will identify each dependent task and will agree when each needs to start and finish to ensure that the patient can be discharged without delay.

Setting and Reviewing an Estimated Date of Discharge (EDD) and Discharge Planning

At the MDT meeting to discuss a patient's treatment and possible ongoing care an estimated date of discharge (EDD) will also be set for that patient. Every patient when entering either ARI or Dr. Grays should be given an EDD. An EDD is the date when the MDT believes the patient can be safely discharged from the acute hospital setting. This may be to home or another place of care. EDDs are input into the electronic patient management system (Trakcare), the data from which feeds through to an individual Wardview system that can be viewed by staff nurses and senior charge nurses. The EDD should be updated regularly and should reflect the ongoing

progress of the patient care journey.

EDDs are fundamental to discharge planning and within NHSG are reviewed daily during ward rounds and at the site-wide system and flow huddles held at 9am, 12 noon and 4pm at both ARI and Dr. Grays. The daily ward rounds are fundamental to daily dynamic discharging. Ward staff will meet to discuss each patient in the ward to agree and prioritise the day's tasks – including any patient who can be discharged before 12 noon or in the evening. Daily dynamic discharging and planning help hospital operational staff plan the bed capacity for the day at each site.

Measurement Framework

NHSG conducts Day of Care Surveys with two surveys completed each year. The surveys are conducted at both acute hospitals within NHSG. These surveys are carried out between 9am and 10:30am across all acute sector wards on the same day. The surveys do not include intensive care, medical and surgical high dependency and coronary care beds. The surveys will review those patients who are found to be appropriately in hospital and those who are not, the age profile of patients, wards with patients not appropriate to be in hospital, NHSG length of stay and will also review the main reasons for patients not being discharged – for example, those patients who are waiting for community beds.

On top of these surveys, there are Delayed Discharge Updates which analyses the delayed discharge performance within each Health and Social Care Partnership. These are specified, formal, six monthly updates on delayed discharge performance which are prepared for each IJB.

Delayed Discharge Performance Reporting and Action Plans

Each individual IJB will report delayed discharge census (number of patients delayed at a specific point in time during the month) and bed days lost each month using government criteria. The information is reported to the Information Services Division of the NHS National Services Scotland. Standard delays and complex delays are reported differently by the IJBs.

The IJBs have actions plans which are put in place to improve delayed discharge performance. These include details of performance and data reporting, discharge pathways and processes, plans to deal with complex delays, services and other resources required to support discharges. The Delayed Discharge Performance and Improvement Programme (the six monthly updates) are linked to each Health and Social Care Partnership strategic risk register. The updates explain plans to mitigate the risks identified in the risk registers.

Scope and limitations of scope

This review therefore concentrated on the five key sub-processes which together help ensure effective discharging. These were:

- **Multi-disciplinary (MDT) team planning.**
- **Setting and reviewing an Estimated Date of Discharge (EDD).**
- **Discharge planning.**
- **Measurement framework for measuring and reporting on patient discharge flow.**

- **Delayed discharge performance reporting and action plans.**

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Further details of the scope, key sub-processes and related control objectives are included in the agreed Terms of Reference set out in **Appendix 2** of this report.

3. Detailed current year findings

3.01 NHSG Patient Discharge from Hospital Protocol – operating effectiveness

Finding

NHSG has a draft 'Patient Discharge from Hospital Protocol' which is dated September 2016. The protocol is to be followed when a patient's needs indicate that they will require support from community health and social care services on discharge into the community. The aim is to provide a consistent co-ordinated approach with multi-disciplinary, multi-agency input while maintaining a patient's interests as central to the discharge planning process.

The protocol states that it is a 'working document and as services and practices develop, it will be reviewed to improve or add to ways of working and to accommodate new service developments'.

The protocol was drafted during the early days following the creation of the Health and Social Care Partnerships and Integration Joint Boards in April 2016. The protocol should be reviewed and updated as necessary to reflect any changes in responsibilities or processes that have arisen as the partnering arrangements have evolved and matured.

Implications

- Risk of ineffective discharge planning or sub-optimal co-ordination between NHS Grampian and the Health and Social Care Partnerships.

Action plan

Finding rating	*Agreed actions*	*Responsible person / title*
Medium	• Management will update and publish an approved Patient Discharge from Hospital Protocol. • Management will ensure the protocol is reviewed on a regular basis and updated as necessary to reflect legislative and regulatory changes, Scottish Government or NHS Scotland guidance and changes in partnering arrangements with the Health and Social Care Partnerships.	General Manager – Acute Sector *Target date:* 30 April 2019 *Reference number:* Unscheduled Care Discharges 3.01 – 18/19

3.02 *Recording, updating and interpreting Estimated Dates of Discharge (EDDs) – operating effectiveness*

Finding

NHS Grampian follows the Scottish Government's 'Daily Dynamic Discharge Approach' aimed at improving the timeliness and quality of patient care by planning and synchronising the day's activities. Under daily dynamic discharging every patient admitted to an acute sector hospital should be given an estimated date of discharge (EDD) as part of the overall discharge planning process. An estimated date of discharge (EDD) is the date when the Multi-Disciplinary Team (MDT) believes the patient can be safely discharged from the acute hospital setting. This may be to home or another place of care. An EDD should be set when the MDT meets within 12 hours of patient admission to an acute setting. It combines a clinical process to estimate and document a date of predicted medical fitness, followed by a MDT view which takes into account primary care requirements, and should be changed to reflect the most recent view of a patient's recovery rate. Through audit interviews and through attending the MDT cross-system huddle of all patients in Dr Grays, it was found that some patients in both ARI and Dr Gray's had no EDD recorded in Trakcare (the electronic patient management system). We observed whilst attending an MDT meeting in Dr Gray's that the senior staff nurse from the ward in which the identified patient was then given an action to go back after the meeting and record an EDD for that patient.

This then led to a discussion with the consultant and with social work staff as to what an EDD actually represents. For the consultant, the EDD represented the date on which the patient was medically fit to leave the hospital. For others, the EDD represented the most-likely, actual, date that the patient will leave the hospital - for example, when transitional issues have been sorted (namely, a community hospital bed, or care package at home). It was stated in the MDT meeting that there was a discrepancy as to what definition for an EDD should be used.

The definition of an EDD (as per NHS Scotland and the Daily Dynamic Discharging Approach Guidance document) combines a medical assessment to assess the likely date that a patient will be ready to leave an acute hospital and a more holistic view of when a patient is able to move from an acute setting to further primary care (complex discharges) which is dependent on the MDT meetings. During discussions with key individuals it was understood that NHSG and Health and Social Care Partnership staff interpret the definition of an EDD differently.

Implications

- Delays to patient discharge arise as the EDD is used to initiate referrals to community health-care providers and social care agencies (normally at least 48 hours prior to discharge)

Action plan

Finding rating	*Recommended action*	*Responsible person / title*
Medium	• Management will provide clear guidance to ensure every patient receives an EDD when admitted to hospital, and guidance for staff in order to set accurate EDDs and to ensure consistency in setting an EDD in full compliance with the Daily Dynamic Discharge Approach.	Acute Director (Nursing & Midwifery) *Target date:* 31 August 2019 *Reference number:*

Unscheduled Care Discharge 3.02 – 18/19

Appendix 1. Basis of our classifications

Individual finding ratings

Finding rating	*Assessment rationale*
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences**;** or • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences**;** or • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Report classifications

The report classification is determined by allocating points to each of the findings included in the report

Findings rating	Points
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	Points
Low risk	6 points or less
Medium risk	7– 15 points
High risk	16– 39 points
Critical risk	40 points and over

Appendix 2. Terms of Reference

Background and audit objectives

Improving unscheduled care across Scotland is a key ministerial priority for Scottish Government. Through the National Unscheduled Care – 6 Essential Actions Improvement Programme the Government aims to improve the timeliness and quality of patient care from arrival to discharge from the hospital and back into the community and aiming to ensure that 95% of patients attending A&E anywhere in Scotland are seen, treated and discharged or admitted with four hours.

The Six Essential actions are:

1) Clinically-focussed and hospital management
2) Realignment of hospital capacity and patient flow
3) Patient rather than bed management – operational performance
4) Medical and surgical processes arranged to take patients from A&E through the acute system
5) Seven-day services targeted to increase weekend and earlier-in-the-day discharges
6) Ensuring patients are cared for in their own homes or a homely setting.
7)

This review will focus on the 'Patient rather than Bed Management – Operational Performance' action.

There are many things which have the potential to cause delay and unnecessarily prolong a patient's stay in hospital, some of which can be categorised as 'external' (services or resources external to the ward or hospital which may not be available when the patient needs then). However, there are also be internal causes of non-clinical delay, and these can also contribute to poor patient experience.
We will review the discharge process considering practices following the creation of the Integration Joint Boards. The review will focus specifically on unscheduled care discharges and the process for managing and changing the flow and pathway of patients within and between services and sectors.

Scope

The sub-processes and related control objectives included in this review are:

Sub-Process	Objectives
Multi-disciplinary team planning	• A multi-disciplinary team gets together within 12 hours of a patient's admission and develops an understanding of the component parts of a patient's discharge plan – what treatment is required, with what – and for how long. • The team also considers other things that need to be done in parallel with the clinical treatment, in order for each patient to be discharged safely onto the next appropriate area of care • There is effective identification of the dependent tasks and agreement on when they each need to start (and finish) to ensure the patient can be discharged without delay.
Setting and reviewing an Estimated Date of Discharge (EDD)	• There is a clinical process to estimate and document an EDD (i.e., when the patient no longer needs medical treatment in hospital. • There is a communication process to document an EDD based on a holistic/multi-disciplinary approach. • The EDD is subject to on-going review and changed to reflect the most recent view of a patient's recovery rate.

Discharge Planning	• Discharge plans are formulated and to record and communicate the tasks that require timely completion for an on-target discharge. • Discharge plans identify external factors such as; communication with family or home support, identification of transport needs, and identification of support needs. • Discharge plans identify internal factors such as the timing of making diagnostic decisions, fulfilment of pharmacy requests and production of discharge letters.
Measurement Framework	• Systems and procedures are in place for measuring and reporting on the performance of the patient admission to discharge flow. • There is an agreed range of performance metrics e.g., average length of stay, number of discharges per day and time, delay (number of patients and number of days), number of discharges pre-noon number of discharges in the evening and number of discharges Saturday and Sunday = Mid-week
Delayed Discharge Performance Reporting and Action Plans	• Discharge performance is reported by NHSG and the IJBs on a regular basis using Government set discharge delay categorisations. • Action plans are formulated and tracked by NHSG and the IJBs that document current initiatives and future plans for improving delayed discharge performance. • Action plans are suitably linked to strategic and operational risk registers so there is a clear view of the risks being mitigated by action plan initiatives.

Appendix 3. Limitations and responsibilities

Limitations inherent to the internal auditor's work

We have undertaken the review of the medicines homecare service, subject to the limitations outlined below.

Internal control

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness is not relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
- the degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

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 work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected.

Accordingly, our examinations as internal auditors should not be relied upon solely to disclose fraud, defalcations or other irregularities which may exist.