Deloitte.

University Hospitals Birmingham NHS
NHS Foundation Trust

University Hospitals Birmingham NHS Foundation Trust

Findings and Recommendations from the 2016/17 NHS Quality Report External Assurance Review

Contents

Executive Summary

We have completed our Quality Report testing and are in a position to issue our limited assurance opinion.

Status of our work

- We have completed our review, including validation of the reported indicators and receipt of the final signed Quality Report.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement (NHSI) in their "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17".
- We have signed our unmodified opinion which is included in your 2016/17 Annual Report.

The Care Quality Commission has not inspected the Trust during 2016/17.

	2016/17	2015/16
Length of Quality Report	80 pages	80 pages
Quality Priorities	5	5
Future year Quality Priorities	6	5

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's (NHSI) Foundation Trust Annual Reporting Manual and supporting guidance ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected 18 week referral-to-treatment (RTT) waiting times and Accident and Emergency 4 hour waiting times as the publically reported indicators, based on NHSI's specified order of preference – the alternatives were 62 day cancer waiting times and 28 day emergency readmissions.
  - For 2016/17, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected falls with harm.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the 18 week referral-to-treatment waiting times and Accident and Emergency 4 hour waiting times indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
- Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested: 18 week referral-to-treatment waiting times, Accident and Emergency 4 hour waiting times and falls with harm.

Executive Summary (continued)

Summary of Quality Report and indicator review

Content and consistency review

Review content → Document review → Interviews → Form an opinion

We have completed our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM.

	Overall conclusion
Content Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	G
Consistency Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?	G

Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.

From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017, the indicators in the Quality Report, subject to limited assurance, have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17".

Performance indicator testing (continued)

	18 week RTT	Four hour A&E waits	Falls with harm
Accuracy Is data recorded correctly and is it in line with the methodology.	A ⇔	A ⇩	G
Validity Has the data been produced in compliance with relevant requirements.	A ⇧	A ⇩	G
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	B ⇧	G ⇔	G
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	A ⇔	B ⇔	G
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	B ⇧	G ⇔	B
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	A ⇔	A ⇩	G
Recommendations identified?	Yes	Yes	Yes
Overall conclusion	A ⇔ Unmodified Opinion	A ⇩ Unmodified Opinion	G No opinion required

Key:

- G No significant issues noted
- B Satisfactory – minor issues only
- A Requires improvement
- R Significant improvement required
- ⇧ Improvement to 2015/16 rating
- ⇩ Deterioration to 2015/16 rating
- ⇔ Same as 2015/16 rating

Content and consistency review findings

Content and consistency review findings

The Quality Report meets regulatory requirements

Content of the Quality Report

We have reviewed the content of the 2016/17 Quality Report against the content requirements set out in NHSI's 2016/17 Annual Reporting Manual and supporting guidance (ARM).

We have reviewed the Trust's Quality Report and nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017, the content of the Quality Report is not in accordance with the 2016/17 ARM and supporting guidance.

Consistency of the Quality Report

NHSI require Auditors to undertake a review of the content of the Quality report for consistency with the content of other sources of management information specified by NHSI in its "Detailed Guidance for External Assurance on the Quality Reports".

We reviewed the consistency of the Quality Report against this supporting information required by NHSI and:-

- We did not identify any significant matters specified in the supporting information which are not specified in the Quality Report.
- We did not identify any significant areas of the Quality Report that could not be confirmed back to supporting evidence.

Statement of Directors' Responsibilities

NHSI require NHS FTs to sign a Statement of Directors' Responsibilities in respect of the content of the Quality Report and the mandated indicators. The guidance requires these to be published in the Quality Report.

As part of our work we have reviewed the Trust's Statement of Directors Responsibilities and can confirm it is an un-amended version of the pro forma provided by NHSI.

Stakeholder Engagement

NHSI require Auditors to consider the processes which NHS FTs have undergone to engage with stakeholders.

The Trust has circulated the Quality Report to stakeholders and has received feedback from Birmingham Cross City Clinical Commissioning Group and Healthwatch Birmingham as required by the ARM. Birmingham Health and Social Care Overview and Scrutiny Committee has declined to comment.

Performance and Indicator Testing

18 week referral-to-treatment waiting times

Our testing has identified a number of issues

	Trust reported performance	Target	Overall evaluation
2016/17	92.5%	>92%	A
2015/16	95.0%	>92%	A
2014/15	93.6%	>92%	R

Indicator definition

Definition: "The percentage of patients on an incomplete pathway who have been waiting no more than 18 weeks, as a proportion of the total number of patients on incomplete pathways," reported as the average of each month end position through the year.

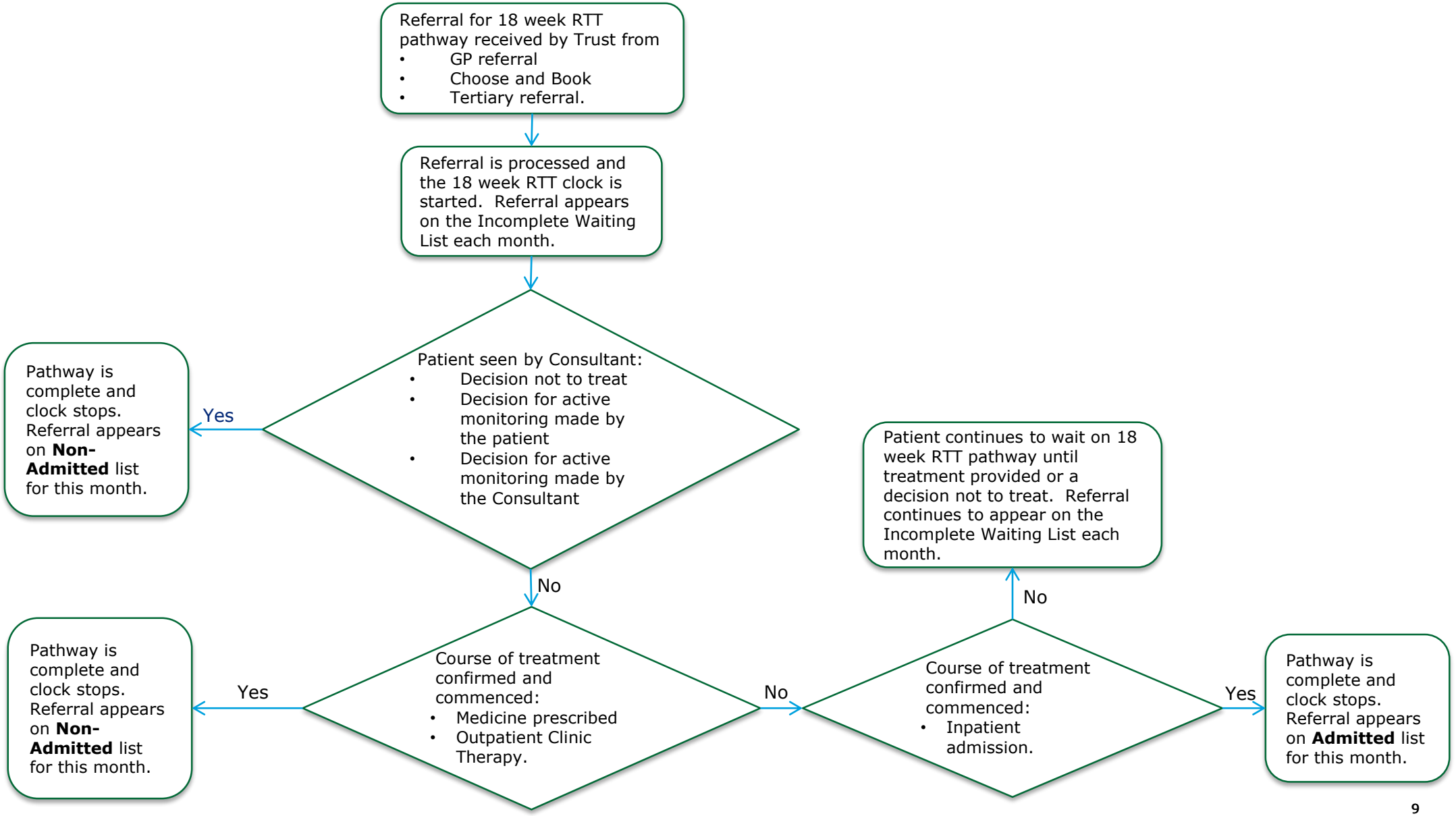
The national performance standard for the incomplete Referral-To-Treatment (RTT) metric (92%) was introduced in 2012. This metric is about improving patients' experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

Approach

- We met with the Trust's Lead for the 18 week RTT metric to understand the process from patient referral to the result being included in the Quality Report. The interview focused on understanding the processes involved, key systems and reporting arrangements.
- We selected a sample of 40 records from 1 April 2016 to 31 March 2017, following patient records through until treatment.
- We agreed our sample of 40 records to supporting documentation including patient case notes as provided by the Trust.
- Six recommendations were made last year in relation to this indicator. Details on the Trust's progress against these recommendations can be found later in the report on pages 24 – 26.
- Our approach to testing was split into two phases:
    1) We undertook testing of the clock start and stop dates and the validity of these events to assess whether these were recorded in line with national RTT guidance. As part of this, we also considered any validations undertaken by the Trust and its impact upon the clock start and stop dates.
    2) We have also reviewed the RTT incomplete tracking lists to assess whether, upon continuation or completion, patients appear on the appropriate lists.

18 week referral-to-treatment waiting times (continued)

Process flow



18 week referral-to-treatment waiting times (continued)

Findings

Interviews

- Findings:
  - The data around the indicator is input by various Trust staff, and monitored by the Operational Performance team. The information is primarily extracted from the Trust's PAS system, Lorenzo. The Operational Performance team compiles monthly reports providing a snapshot of all incomplete pathways from Lorenzo. The monthly reports present the combined incomplete waiting list position for internal and external stakeholders.
  - The Trust is moving to implementing a new system – Oceano, which should be in place from July 2017. To prepare for the implementation of the new system, the Performance Team have been testing the data and parallel reporting has been undertaken, and PAS training has been amended to include the recording of RTT pathways.
  - There has been a delay in implementing the new PAS system and in the interim the extra resource within the Operational Performance team has been used to train medical staff on how to record patient pathways correctly on the current and new systems.
  - The Trust operates the OPTIMS electronic clinic management system. This system collects 18 week clinical outcomes and automatically enters them on to the PAS system. Clinical and administrative staff are responsible for recording a RTT outcome following an appointment.
  - The Trust also uses the electronic referral handling system which captures and scans all GP referrals upon receipt. All referrals are entered onto the PAS system and tracked thereafter. 18 week pathway referrals are processed by the Central Booking Team, excluding direct referrals to consultants and cancer pathways.
  - The Trust does not use the category of 'unknown clock starts'. Unless the Trust is informed otherwise (through inter provider transfer form, other referral information or clinical care records), the Trust will deem that the first definitive treatment has been undertaken prior to referral to UHB. The Trust has taken the decision based on the volume of referrals received from other Trusts and the potential risk in not tracking these patients appropriately if a start date is not received.
  - As a national tertiary provider with a number of regional and supra-regional specialities, the Trust receives a large number of external referrals. These referrals are received for the following reasons:
    - For discussion at Multi Disciplinary Team meetings;
    - For consideration of a second clinical opinion;
    - Post-first definitive treatment; or
    - Awaiting first definitive treatment.
  - National RTT guidance does not set out what receiving trusts should do if the referring trust does not provide key information such as clock start date. As such, the Trust has now documented its local process in its Patient Access Policy: the Trust will implement a clock start when a decision to treat is made where the Trust has not been informed that the patient is awaiting first definitive treatment.

18 week referral-to-treatment waiting times (continued)

Findings

- Findings (continued):
  - Validation is undertaken by the Operational Performance Team and focusses on investigating administration errors, other incorrect start dates and confirming patient treatment. The Trust validates every pathways over 18 weeks, in addition to using methods of targeted validation, and general maintenance of the pathways.
  - The Trust has a process in place whereby automatic clock stops are initiated where:
    i. A pathway has been dormant for 16 weeks;
    ii. There is no future activity booked against the pathway; and
    iii. The patient is not on a waiting list for treatment.

    All three conditions must be in place for the automated stop to be initiated.
  - Over 700 staff involved in RTT have received mandatory training. The training involves an e-learning package, a half-day taught session and a competence assessment. Staff scores are shared with line managers. To support this, additional RTT guidance has been published on the staff intranet. The competence assessment must be re-taken if the pass mark is not attained. This is in line with best practice.
  - The Training session is amended based on feedback from attendees, and to enforce key messages and findings from audits.
  - The Trust has also developed a pathway compliance toolkit which allows the Operational Performance team to identify the top 10 validation errors each month. This is also built into the training provided.
  - The toolkit allows the Operational Performance team to identify individuals who repeatedly record pathways incorrectly. These individuals will be provided with additional support and training. The informatics team will also identify champions through the toolkit to spread learning throughout the Trust.
  - On request from operational managers and / or the identification of recurrent data quality issues, the Performance Team complete bespoke training sessions for identified individuals.
  - A joint inbox, monitored by the Performance Team, has been set up to provide advice and guidance on specific pathway queries.
  - Additional training has also been provided to clinical staff in the specialty meetings. This focuses on the application of appropriate RTT outcomes after seeing a patient, and the management of cancellations, patient waits and DNAs. These sessions are bespoke to the clinical team involved.
  - Training is now also delivered on induction programmes for Consultants and Senior Managers. This runs every two months.
  - A number of audits have been introduced to review known areas for errors. These are reviewed on a rolling basis.
  - A validation team peer review meeting has been introduced which takes place every two months. A sample of records validated by the team are selected in advance and each member reviews the sample to identify how they would have validated the pathways. This is discussed at the meeting for accuracy and to create a level of consistency within the team.
- Issues: Not applicable.

18 week referral-to-treatment waiting times (continued)

Findings

Testing

- Findings:
  - There were 12 errors identified in total within the sample of 40 records tested as outlined below:
    - Clock start and validity testing: 1 (02.5%)
    - Clock stop and validity testing: 3 (7.5%)
    - 18 week breach testing: 2 (5.0%)
    - 18 week incomplete lists: 7 (17.5%)
  - During testing we identified 1 record where the referral letter had not been stamped to state when it was received. Upon investigation, we reviewed patient case notes to identify if there was evidence of clinical activity preceding the start date recorded by the Trust. We did not observe evidence of activity preceding the start date recorded by the Trust and therefore this has not been reported as an error. **Recommendation 1: Availability of evidence for validation**
- Issues:
  - 1 error was identified in relation to the clock start and validity testing. This error relates to a pathway where the clock was inappropriately started. This error did not impact on the accurate reporting of breaches. **Recommendation 2: Staff training – data entry**
  - 3 errors were identified in relation to the clock stop and validity testing. These errors did not impact on breach reporting.
    - For 1 record validation incorrectly added and removed a clock stop. During testing an appropriate clock stop was identified, however, this was not recorded as a clock stop by the Trust.
    - For 1 record the Trust had incorrectly added a stop during validation of the pathway. **Recommendation 3: Staff training –validation**
    - For 1 record a watchful wait was inappropriately used to stop the clock. **Recommendation 2: Staff training – data entry**
  - 2 errors were identified in relation to the 18 week breach testing. Both errors led the Trust to over report breaches.
    - 1 record was identified where the Trust entered an appropriate clock stop upon validation, however, the validations occurred after the Trust had incorrectly reported a breach.
    - 1 record was identified during testing where the Trust correctly removed a clock start during validation, however, the validation occurred after the Trust had incorrectly reported a breach. **Recommendation 4: Timing of validation**

18 week referral-to-treatment waiting times (continued)

Findings

- Issues (continued)
  - 7 errors were identified in relation to the 18 week incomplete list:
    - 1 error was identified where the patient appeared on the incomplete list for an additional month following an appropriate clock stop. This error will have inflated the denominator the Trust uses for reporting performance achieved which will have negatively impacted on reported performance.
    - 4 records did not appear on all of the monthly incomplete RTT lists for the duration of the patients' 18 week RTT pathway. 3 of these errors were identified where patients did not appear on the incomplete list for months in the middle of their RTT pathway. A further 1 error was found where the patient did not appear on the incomplete list for the month at the beginning of their pathway. These errors will have reduced the denominator the Trust uses for reporting performance achieved which will have positively impacted on reported performance. **Recommendation 5: Review of data extraction processes**
    - The 16 week blue prism rule led to a further 2 errors. This rule means inactive pathways are removed from the incomplete list after 16 weeks of no activity. In these cases, the protocols in place around the 16 week rule had worked correctly to reinstate the reporting of the pathways when future activity had been booked. **Recommendation 6: Focus validation on 16 week rule**

Recalculation

- Findings: The Trust has achieved performance of 92.5% against a nationally set target of 92%, which reconciles with the performance figure included in the Trust's final Quality Report.
- Issues: Not applicable

18 week referral-to-treatment waiting times (continued)

Findings

Deloitte view:

The findings observed have resulted in concluding an unmodified opinion with respect to the 18 week RTT incomplete pathways indicator. The basis for this conclusion is detailed further below.

Overview

Our sample testing has identified a range of errors – 4 of which relate to the accurate recording of clock starts and stops. The clock start and stop errors identified did not impact on the accurate reporting of breaches. These errors have led to an amber rating for 'validity'.

Our sample testing identified 2 records which were incorrectly validated by the Trust. This has led a blue rating for 'reliability'.

During our testing we identified 2 records which should not have been identified as RTT pathways, however, they were included within RTT reporting. We observed evidence of validation to remove the pathway from the RTT incomplete list for 1 of the records. This has led to a blue rating for 'relevance'.

Further, our work has identified 2 records whereby the Trust has incorrectly reported breaches, which have subsequently been found not to be breaches during our testing. These pathways were later validated by the Trust, however, the validation occurred after the breaches had been reported. This has impacted the reported performance in that the Trust has overstated the number of breaches for these records, which in turn will have reduced the percentage compliance when reporting against the RTT incomplete pathways indicator. The accurate reporting of these breaches for the records concerned will have improved the Trust's performance against the 92% target for the months in which they were incorrectly reported. Our work also identified 7 errors in relation to the incomplete list. These errors did not impact on breach reporting, however, they would have impacted on the denominator used to calculate the performance indicator. The above errors have led to a amber ratings for 'accuracy', 'completeness' and 'timeliness'.

As a result of these findings, we have given this indicator an overall rating of amber.

Accident and Emergency 4 hour wait times

Our testing has identified a number of issues

	Trust reported performance	Target	Overall evaluation
2016/17	81.8%	>95%	A
2015/16	91.9%	>95%	B

Indicator definition

Definition: "Percentage of patients who spent 4 hours or less in A & E."

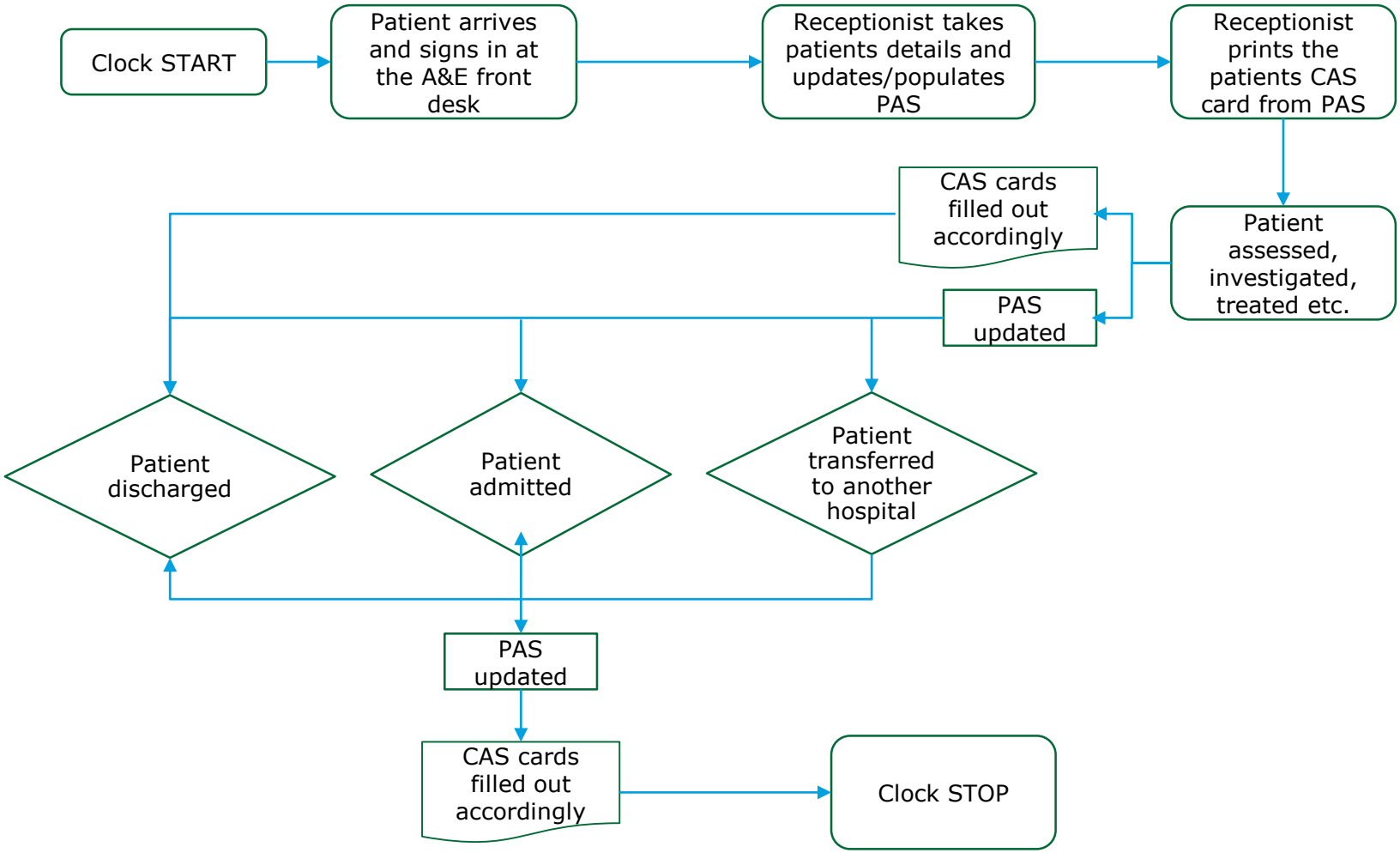
Longer lengths of stay in the emergency department are associated with poorer health outcomes and patient experience as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen, and financial effects. It is critical that patients receive the care they need in a timely fashion, so that patients who require admission are placed in a bed as soon as possible, patients who need to be transferred to other healthcare providers receive transport with minimal delays, and patients who are fit to go home are discharged safely and rapidly.

Approach

- We met with the Trust's Lead for the A&E 4 hour waiting time metric to understand the process from patient referral to the result being included in the Quality Report.
- The interview focused on understanding the processes involved. We discussed with management and used analytical procedures to identify whether there were any periods during the year or divisions within the Trust representing a greater risk that we should focus sample testing on.
- Two recommendations were made last year in relation to this indicator. Details on the Trust's progress against these recommendations can be found later in the report on pages 24 – 26.
- We selected a sample of 25 from 1 April 2016 to 31 March 2017, following patient records through until treatment. During our initial testing stage, we observed a range of errors. We subsequently extended our sample by a further 20 records to test if these errors were as prominent as initially observed during the initial testing stage.
- We agreed our sample of 45 to supporting documentation including patient case notes as provided by the Trust.

Accident and Emergency 4 hour wait times (continued)

Process flow



Accident and Emergency 4 hour wait times (continued)

Findings

Interviews

- Findings:
  - The Trust uses the Oceano system within A&E to input data in real time. Oceano is also the data source for the monthly return.
  - On arrival at A&E patients queue at the reception and are arrived on the system by the administrative team once they are seen at the desk, irrespective of their arrival route. The clock will start when the patient is registered.
  - Casualty (CAS) cards are printed when patients are booked in, and at each stage of their attendance this is manually updated with the activity and time. This information is also entered onto Oceano. However, due to the frantic nature of the A&E department clinical activity might be recorded on Oceano retrospectively.
  - All A&E staff and receptionists are able to record activity in Oceano. However, access rights to amend this information are limited to certain personnel.
  - The Performance Team are responsible for validating 4 hour breaches. They report to the Head of Service Improvement and sit within the Delivery Directorate with accountability to the Executive Director of Delivery. As such, the team is completely separate from the any of the operational divisions.
  - All pathways that are reported on Oceano as having breached the 4 hour target are validated on a daily basis, except for weekends. Validation will include:
    - Making an adjustment for ambulance handover time as set out in the national definitions document;
    - Making an adjustment for mental health patients referred to the Rapid Assessment, Interface and Discharge (RAID) team in less than 4 hours and only where the patient has not received any ongoing medical treatment in the department; and
    - Reconciling any conflicting information between the Oceano clinical system and the CAS card.
  - A&E clinical staff maintain a paper list of pathways that have breached the 4 hour target. This ensures local ownership of issues and provides an additional source of information for the Performance Team when they are validating breaches.
  - The final judgement regarding whether or not a pathway has breached sits with the Head of Service Improvement and the Performance team who all have a good working knowledge of the national rules. To further strengthen the validation process there is an additional step to obtain a clinical review of any pathways with inconclusive evidence of a clock stop.
  - Amendments are made to Oceano by the Performance team following daily validation to ensure there is an accurate and rules-compliant record of all pathways that breached the 4 hour target. An audit trail of all changes made to pathways on Oceano is readily available on the patients' records, and is kept and circulated daily to the wider A&E team including consultant staff.
  - All amendments are currently made to the departure time (the clock stop), including amendments made as part of the ambulance handover time. This was a historical decision taken when Oceano was implemented, which avoided the need to completely delete and re-enter all activity and contact times on the patient record in order to amend the arrival time. The Trust are in the process of assessing the impact of amending the arrival time instead of departure time to determine whether the current process should be amended.

Accident and Emergency 4 hour wait times (continued)

Findings

- Findings (continued):
  - Two types of audits have been introduced. The first assesses data quality sampling 100 records for arrival and departure times, and 'time seen by Doctor'. The second audits the validations made by the Validation Team. The Validation Team undertake a peer review one day per month.
- Issues: Not applicable.

Testing

- Findings:
  - There were 8 errors identified within the sample testing undertaken as outlined below:
    - Admission date and time testing: 0 (0.0%)
    - Discharge date and time testing: 4 (8.9%)
    - Discharge reason testing: 0 (0.0%)
    - Breach testing: 4 (8.9%)
  - During our testing we saw the PAS system documents the time at which the patient departs A&E. Our testing identified that the CAS cards do not consistently specify the time of departure. However, in these instances, we were able to observe that clinical activity on the CAS card took place before the time of departure recorded on the PAS system.
  - 1 record was identified where clinical activity was recorded as being carried out before the recorded admission time. This record relates to a patient who arrived by ambulance. The time of this earlier activity could have been recorded incorrectly. Alternatively, this earlier activity could have been entered onto the CAS card retrospectively and could indicate the patient was seen by a clinician earlier than the admission time recorded in Oceano. If this were the case the earlier time should have been recorded as the admission time meaning the patient would have breached the 4 hour target. As this pathway was not validated at the time of occurrence, there is limited evidence we can use to conclude on its accuracy. **Recommendation 7: Retrospective entries**
- Issues:
  - 4 errors were identified where on inspection of the CAS cards clinical activity was found to be carried out after the recorded departure time on Oceano. The later activity identified that the departure times were later than the times recorded in Oceano. All 4 errors impacted on the accurate reporting of non-breaches. **Recommendation 7: Retrospective entries**

Accident and Emergency 4 hour wait times (continued)

Findings

Recalculation

- Findings: The Trust has achieved performance of 81.8% against a nationally set target of 95%, which reconciles with the performance figure included in the Trust's final Quality Report.
- Issues: Not applicable.

Deloitte view:

Our sample testing identified 4 records where clinical activity was found to be carried out after the recorded departure time on Oceano. This errors will have impacted on performance reporting, as all 4 records were incorrectly reported as non-breaches when they should have been reported as breaches. As a result, an amber rating has been assigned with respect to 'validity', 'accuracy', and 'completeness'.

The Trust's process of recording data as a patient moves around the A&E department may result in a delay in the entry of data onto Oceano. This is understandable given the operational environment of the A&E department, with some records therefore entered retrospectively on Oceano and the CAS cards. However, these entries are not clearly marked as retrospective. This has resulted in an blue rating for 'timeliness'.

As a result of these issues, we have given this indicator an overall rating of amber.

Local Indicator: Falls resulting in harm

No errors were identified from our testing

	Trust reported performance	Target	Overall evaluation
2016/17	17.4%	N/A	G

Indicator definition and process

Definition: The number of falls that result in harm as a proportion of the total number of falls in the year. There is no target currently set for this indicator.

Numerator: The number of patient falls that result in harm in the year

Denominator: The total number patient falls in the year

The Trust monitors all falls and categorises them according to the level of harm caused and the severity of the fall.

Level of harm caused:

- No harm
- Near miss
- Patient harmed
- Death.

Severity of the fall:

- Insignificant
- Minor
- Moderate
- Severe
- Catastrophic

Approach

- We met with the Trust's Lead for the Falls resulting in harm metric to understand the process of recording and reporting patient falls, and identifying if the fall resulted in harm.
- This indicator was not tested last year as part of our audit.
- We selected a sample of 25 Datix records from 1 April 2016 to 31 March 2017, including in our sample falls that had not been categorised as resulting in harm.
- We agreed our sample of 25 records to the underlying information held within the Datix system.

Local Indicator: Falls resulting in harm

Our testing has not identified any significant issues

Findings

Interviews

- Findings:
  - The Trust includes managed falls and near misses within their reported figures. Any falls are reported by frontline staff, usually by nurses, via an incident form on the DATIX system. The incident will be reviewed by the Ward Manager to ensure all information is correct and accurately captured.
  - Where any harm has occurred to a patient as a result of a fall, the Ward Manager will review the incident report, complete investigations and review patient notes to provide further commentary for the incident report. The Risk team will also complete a Root Cause Analysis (RCA) to identify the need for any staff training or interventions. The RCAs are all signed off by the Deputy Director for Nursing.
  - The severity of an incident may be upgraded or downgraded based on whether the level of harm appears different to when the fall initially happened. This change is made by the Risk team within Datix. For example, where an incident is initially reported as no-harm, but later diagnostics show some form of injury. The related investigation will be captured in the commentary section on Datix.
  - All incidents are categorised by the Risk team to identify the level of severity – from minor to catastrophic. These categories are aligned with National Reporting and Learning System categories.
  - Falls are generally reported on the same day but the date of reporting could be up to a couple of days after the incident where there is a delay due to clinical reasons - the Trust considers this to be an acceptable reason for short delays.
  - There is an audit trail on the DATIX system which details who has amended particular details and when this amendment was made.
  - Falls data is reported to the Preventing Harm Group (chaired by the Lead Nurse for Quality and Standards), which reports to the Care Quality Group (chaired by the Chief Nurse). Falls data is also included in the Clinical Risk report, presented to the monthly Clinical Quality Monitoring Group (chaired by the Executive Medical Director) and as part of the performance report to Trust Board. A download of the DATIX data also goes to the CCG Contracting meetings on a monthly basis.
- Issues:
  - The difference between a near miss fall and a fall causing no harm is unclear, this is a grey area for the members of staff within the Trust and it was noted that they generally do not have any falls reported as near misses. **Recommendation 8: Provide clear definitions**

Testing

- Findings:
  - There were no errors identified from testing a sample of 25 records as outlined below:
    - Incident date: 0 (0.0%)
    - Fall applicability: 0 (0.0%)
    - Severity recorded: 0 (0.0%)
- Issues: Not applicable.

Local Indicator: Falls resulting in harm

Our testing has not identified any significant issues

Findings

Recalculation

- Findings: The Trust has achieved performance of 17.4%, which is consistent with the performance reported in the Trust's final Quality Report.
- Issues: Not applicable.

Deloitte view:

Discussions with Trust staff during testing identified the difference between a near miss and a fall causing no harm is unclear. This should be clarified to ensure the correct categories are used. This resulted in a blue rating for 'relevance'. The Trust has robust processes in place to identify falls and review these on a regular basis to ensure reporting is accurate we have therefore assigned an overall green rating for this indicator.

Recommendations for improvement

Recommendation for improvement

We have made the following recommendations as a result of our testing

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
18 week referral-to-treatment	**1. Availability of evidence for validation** The Trust should remind staff of the importance of stamping all referrals letters on receipt.	The Trust's 18 week RTT guidance document will be updated to remind staff of the importance of stamping all referrals on receipt. **Responsible Officer:** Head of Operational Performance **Timeline:** By end of June 2017 **Process for updating Council of Governors:** A progress report ill be provided to the Council of Governors in July 2017 and future meetings as required.	**Medium**
18 week referral-to-treatment	**2. Staff training – data entry** Following implementation of the new PAS system, Oceano, the Trust should ensure there is a continued focus on staff training for data entry to support accurate recording of clock starts and stops on the new PAS.	The Oceano PAS system has been specifically designed to ensure 18 week RTT clock starts and stops are captured correctly. Users of the system will be presented with guidance text about when to start and stop a clock and only logical RTT pathway options will be presented for selection in order to reduce the likelihood of errors. For example it will not be possible to record a watchful wait clock stop after a clock has already been stopped for first treatment. The current PAS system does not stop users from selecting illogical pathway codes such as this. The validation process also identifies when users persistently repeat the same type of error and these users are subsequently offered further training. **Responsible Officer:** Head of Operational Performance **Timeline:** The Oceano PAS system is due to go live in July 2017. **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2017 and future meetings as required.	**Medium**
18 week referral-to-treatment	**3. Staff training – data validation** The Trust should consider refreshing staff training for those involved in validation. The Trust should consider if the training needs a specific focus due to the types of errors being made when validating a pathway, and if it needs to be delivered to specific individuals who are making the errors.	A peer review process was introduced for the validation team during Q4 2016/17. On a monthly basis a small sample of validated records are selected and reviewed by the whole team to ensure the 18 week clock rules are being correctly applied. This ensures the rules are applied consistently and identifies where further training or guidance may be required. The validation team also attend the Trust's RTT training programme annually. **Responsible Officer:** Head of Operational Performance **Timeline:** Ongoing **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2017 and future meetings as required.	**Medium**

Recommendation for improvement

We have made the following recommendations as a result of our testing

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
18 week referral-to-treatment	**4. Timing of validation** The Trust should review the focus and timing of validation to avoid incorrectly reporting breaches.	100% of pathways with a waiting time of 18 weeks or over are now validated by the team. This amounts to circa 5,000 pathways per month. There are occasions where there is not enough information available at the time of validation to make a decision whether a clock should stop or continue. When this happens additional information is sought from clinical or operational staff and the clock is left running until an evidence-based decision can be made. This inevitably means the Trust over-reports a small number of breaches. The process will be reviewed to determine whether it can be achieved within a tighter, defined timescale. **Responsible Officer:** Head of Operational Performance **Timeline:** Review process by end of July 2017 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2017 and future meetings as required.	**High**
18 week referral-to-treatment	**5. Review of data extraction processes** The Trust should consider reviewing the data extraction process for the incomplete reports to understand why patients do not always appear on the appropriate incomplete list.	This issue has been investigated and is linked to the 16 week rule. The issue is fully resolved by the implementation of Oceano PAS in July 2017. **Responsible Officer:** Director of Patient Administration **Timeline:** Implementation of Oceano PAS; July 2017 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2017 and future meetings as required.	**Medium**
18 week referral-to-treatment	**6. Focus validation on 16 week rule** The Trust should consider including pathways where the 16 week rule has been applied within their suite of monthly validation reports.	The 16 week rule will no longer be necessary once Oceano PAS is live. All pathways with no future activity will be reviewed and validated as soon as they reach a waiting time of 18 weeks. **Responsible Officer:** Head of Operational Performance **Timeline:** From July 2017 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2017 and future meetings as required.	**High**

Recommendation for improvement

We have made the following recommendations as a result of our testing

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
A&E four hour waits	**7. Retrospective entries** The Trust should consider introducing a process for recording retrospective entries on the CAS card and PAS to specify whether the entry has been entered after the activity occurred. This should apply when the note is recorded a significant period post-activity (e.g. more than 10 minutes).	A methodology for recording a retrospective entry on the CAS card will be agreed and implemented. **Responsible Officer:** Director of Operations, Division C **Timeline:** by end of Q2 2017 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2017 and future meetings as required.	**High**
Falls resulting in harm	**8. Provide clear definitions** The Trust should consider revising their definitions with regard to near miss falls and falls causing no harm as staff members have identified that they are unsure of the difference between the two.	A document will be devised which clearly sets out the circumstances when a fall is deemed to have resulted in 'patient harmed', and when it has resulted in 'no harm' (these are the terms used in the 'severity' field in Datix). This will be used by both the Falls Team and the Risk Team when reviewing incident data relating to Falls. **Responsible Officer:** Lead Nurse for Standards & Head of Clinical Risk & Compliance **Timeline:** draft by the end of Quarter 1 2016/17, final by the end of Quarter 2 2016/17 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2017 and future meetings as required.	**Medium**

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Deloitte Recommendation	Current year status
18 week referral-to-treatment	**1. Implementation of new PAS system** The Trust should ensure appropriate tests are completed to ensure the new PAS system is suitable for RTT reporting purposes. As part of this and in line with good practice, the Trust should undertake extended validation to incorporate all records included in RTT incomplete pathway submissions. This extended validation should cover any handover period between the PAS systems and also for an appropriate period following full implementation. **Responsible Officer:** Neil Grogan, Director of Patient Services, Lorraine Simmonds, Head of Service Improvement **Timeline:** Ongoing, with delivery of new PAS system expected to be May 2017	**Update:** Test scripts for referral-to-treatment (RTT) reporting are already in place within the Patient Administration System (PAS) replacement project. Extended validation of RTT incomplete pathways has started with the development of a pathway monitoring tool. As well as identifying individuals who require RTT training, this will provide timely validation of common pathway errors regardless of whether a breach has occurred. Plans are also in place for the migration of data to the new PAS. RTT migration rules have been determined which include checks to provide assurance that RTT data pre and post-migration is consistent. Go live date for the new Patient Administration System has slipped slightly to July 2017. A KPMG external review has been undertaken with the overall health check evidencing that the project is on track to go live in July. Successful testing is required in order for the trust to make the go/no go decision. **Current Status:** Go-live date is planned for July 2017.
18 week referral-to-treatment	**2. Availability of evidence for validation** The Trust should remind staff of the importance of stamping all referrals letters on receipt and ensuring they are scanned to the Electronic Patient Record. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** 18 week RTT guidance and training programme updated by end of June 2016. Referral management SOP to be implemented by end of August 2016	**Update:** The new 18 week training programme has been amended to include operational guidance on the management of receipt of referral letters (June 2016). The updated 18 week RTT procedure document has been updated to include detailed guidance on the management of referral letters and was signed off in October 2016. **Current Status:** completed October 2016/

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Deloitte Recommendation	Current year status
18 week referral-to-treatment	**3. Staff training – data entry** We understand the Trust has implemented a new training programme covering the 18 week clock rules in response to recommendations made as a result of last year's audit. As part of this training, the Trust should ensure staff are reminded of the rules and requirements of national RTT guidance particularly focusing on what activity will stop a clock and how it should be recorded to accurately code the stop to accurately inform the identification of key steps of the RTT pathway. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** by end June 2016	**Update:** The 18 week training programme has been enhanced to include guidance on the use of RTT pathway codes. There is a competence test for all delegates. Training commenced in July 2016 and so far we have trained 700 of 800 staff. We are aiming to train all 800 staff on an annual basis. **Current Status:** completed end of June 2016
18 week referral-to-treatment	**4. Staff training – validation** We understand the Trust has implemented a new training programme covering the 18 week clock rules in response to recommendations made as a result of last year's audit. As part of this training, the validation team should be reminded of the rules and requirements of national RTT guidance. As part of this, there should be a focus on identifying appropriate clock starts and clock stops, and how to correctly nullify RTT pathways. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** by September 2016	**Update:** Enhanced training was carried out during Quarter 2. In addition, a regular peer review process has been place since Quarter 3 to ensure validation decisions are calibrated across the whole team correctly. **Current Status:** Action complete as of Quarter 3
18 week referral-to-treatment	**5. Investigate automated clock stops** The Trust should generate a monthly report detailing automated clock stops recorded. These should then be investigated as part of the Trust's ongoing validation arrangements. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** From June 2016	**Update:** A report detailing clocks automatically stopped in the previous month has been incorporated into the new targeted validation process from October 2016 and is ongoing. This ensures automated clock stops are appropriate and in line with the RTT clock rules and reporting requirements. **Current Status:** Action complete (report commenced in October 2016.)

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Deloitte Recommendation	Current year status
18 week referral-to-treatment	**6. Sample audit** In line with best practice, the Trust should consider undertaking sample audits across the RTT incomplete list throughout the year, focusing on appearance on reports as well as the accuracy of the pathway. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** From June 2016	**Update:** The first sample audit for Q1 2016/17 was completed in August 2016 and is now repeated quarterly. Going forward this now forms part of the regular peer review of validation decisions. **Current Status:** Action complete (audits commenced in Q1 2016/17).
Accident and Emergency 4 hour waiting times	**7. CAS Card Notes** The Trust should consider recording a clinical note on the CAS cards for when the patient departs from the A&E department. This is in line with best practice and should be adopted to provide an audit trail for use in validations as well as a clear and consistent departure time that reconciles to that on the PAS system. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** by end June 2016	**Update:** Departure times are recorded by clinical staff on the A&E Clinical IT System (Oceano). This is the source of information for the Trust's monthly A&E return. To require clinical staff to also note departure time on the CAS card would be a duplication and would place unnecessary burden on valuable clinical time. Where departure time is ambiguous there are a number of alternative data sources that can be used for validation purposes; for example PAS, PICS and WMAS transport collection time data. The A&E 4 hour wait validation process guidance will be updated to provide additional detail on when and how to access these additional data sources to ensure departure times are accurately reported. **Current Status:** Completed end of June 2016.
Accident and Emergency 4 hour waiting times	**8. Spot Check Audits** The Trust should consider introducing spot check audits on attendances which are seen within the 4 hour limit. The spot check audits should focus on those patients that have arrived by Ambulance. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement, Steve Cumley, Director of Operations Division C **Timeline:** Q1 audit to be carried out by end of July 16 then ongoing.	**Update:** Spot check audits on attendances within the 4-hour limit have been introduced from Quarter 1 2016/17. 100 records will be audited each quarter. An audit of see and treat attendances was carried out in Q1 2016/17. The Q2 audit focussed on patients who attended by ambulance. The Q3 audit focussed on patients admitted to CDU. The Q4 audit will again focus on patients who arrive by ambulance. **Current Status:** Action complete (audits commenced in Q1 2016/17, findings are presented quarterly at the Unscheduled Care Steering Group meeting).

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Deloitte Recommendation	Current year status
Accident and Emergency 4 hour waiting times	**8. Spot Check Audits** The Trust should consider introducing spot check audits on attendances which are seen within the 4 hour limit. The spot check audits should focus on those patients that have arrived by Ambulance. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement, Steve Cumley, Director of Operations Division C **Timeline:** Q1 audit to be carried out by end of July 16 then ongoing.	**Update:** Spot check audits on attendances within the 4-hour limit have been introduced from Quarter 1 2016/17. 100 records will be audited each quarter. An audit of see and treat attendances was carried out in Q1 2016/17. The Q2 audit focussed on patients who attended by ambulance. The Q3 audit focussed on patients admitted to CDU. The Q4 audit will again focus on patients who arrive by ambulance. **Current Status:** Action complete (audits commenced in Q1 2016/17, findings are presented quarterly at the Unscheduled Care Steering Group meeting).

Responsibility statement

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP
Chartered Accountants

24th May 2017

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, of University Hospitals Birmingham NHS Foundation Trust and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to NHSI for their information in connection with this purpose, but as made clear in our works order dated 16th April 2013, on the basis that we accept no duty, liability or responsibility to NHSI in relation to our Deliverables.

Deloitte.