Deloitte.

University Hospitals Birmingham NHS Foundation Trust

Findings and Recommendations from the 2015/16 NHS Quality Report External Assurance Review

19 May 2016

the Distinctive audit

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 Monitor in their "Detailed Guidance for External Assurance on Quality Reports 2015/16".
- We have signed our unmodified opinion which is included in your 2015/16 Annual Report.

CQC Governance Risk Rating: **Under review**

The Care Quality Commission inspected the Trust during the year and did not find any significant issues.

	2015/16	2014/15
Length of Quality Report	80 pages	82 pages
Quality Priorities	5	5
Future year Quality Priorities	5	5

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in Monitor's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in Monitor'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 waiting times and Accident and Emergency 4 hour waiting times as the publically reported indicators, based on Monitor's specified order of preference – the alternatives were 62 day cancer waiting times and 28 day emergency readmissions.
  - For 2015/16, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust selected Grade 2 Hospital-acquired pressure ulcers.
  - 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 Grade 2 Hospital-acquired pressure ulcers.

Executive summary (continued)

We have not identified any significant issues from our work for the A&E four hour waits and Grade 2 Pressure Ulcers indicators. We have identified some areas for improvement with the 18 week RTT indicator which are detailed later in this report. Overall, we will be issuing an unmodified audit opinion on the two national indicators.

Content and consistency review

We have completed our content and consistency review. From our work to date, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016 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

Monitor requires Auditors to undertake detailed data testing on a sample basis of three mandated indicators. We perform our testing against the six dimensions of data quality that Monitor 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 2016, 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 Guidance for External Assurance on Quality Reports 2015/16".

We anticipate issuing an unmodified opinion for inclusion in the Trust's Quality Report. However, we have observed errors from our sample testing of the RTT incomplete pathways indicator. The errors identified are summarised overleaf and described in more detail on pages 9-15.

Executive summary (continued)

We have not identified any significant issues from our work for the A&E four hour waits and Grade 2 Pressure Ulcers indicators. We have identified some areas for improvement with the 18 week RTT indicator which are detailed later in this report. Overall, we will be issuing an unmodified audit opinion on the two national indicators.

Performance indicator testing (continued)

	18 week RTT	Four hour A&E waits	Grade 2 Pressure Ulcers
Accuracy Is data recorded correctly and is it in line with the methodology.	A	G	G
Validity Has the data been produced in compliance with relevant requirements.	R	B	G
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	A	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.	A	G	G
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	A	B	G
Recommendations identified?	Yes	Yes	No
Overall conclusion	A Unmodified opinion	B Unmodified opinion	G No opinion required

G No issues noted

B Satisfactory – minor issues only

A Requires improvement

R Significant improvement required

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

We anticipate issuing an unmodified opinion with respect to the two mandated indicators, 18 weeks RTT and A&E four hour waits.

We have observed a volume of errors with respect to the 18 week RTT indicator which has given rise to a range of recommendations. The errors identified include incorrect recording of clock start and clock stop episodes (11 clock start and 7 clock stop errors from a sample of 60).

Furthermore, our sample testing has identified that the Trust has incorrectly reported 3 records as breaches, 1 of which was a result of the incorrect recording of a clock stop episode. The correct reporting of these records would have improved the Trust's performance against this indicator.

The volume of errors have given rise to an overall amber rating for this indicator.

However, the Trust is reporting achievement against the 92% target. Given the volume of breach errors identified and that the correct reporting of these breach errors would have improved Trust performance against this target, we have issued an unmodified opinion for inclusion in the Trust's Quality Report. Our findings are detailed further on pages 9-15.

Content and consistency review findings

the Distinctive audit

Content and consistency review findings

The Quality Report meets regulatory requirements.

Content of the Quality Report

We have reviewed the content of the 2015/16 Quality Report against the content requirements set out in Monitor's 2015/16 Annual Reporting Manual (ARM).

We have reviewed the latest draft version of the Trust's Quality Report and nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016, the content of the Quality Report is not in accordance with the 2015/16 ARM.

Consistency of the Quality Report

Monitor 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 Monitor 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 Monitor 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

Monitor 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 final Statement of Directors Responsibilities and can confirm it is an un-amended version of the pro forma provided by Monitor.

Stakeholder Engagement

Monitor 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 Healthwatch Birmingham and Birmingham CrossCity Clinical Commissioning Group, as required by the ARM. Birmingham Health and Social Care Overview and Scrutiny Committee has declined to offer any feedback.

Performance indicator testing

the Distinctive audit

18 week referral-to-treatment waiting times

Our testing has identified a number of issues

	Trust reported performance	Target	Overall evaluation
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.

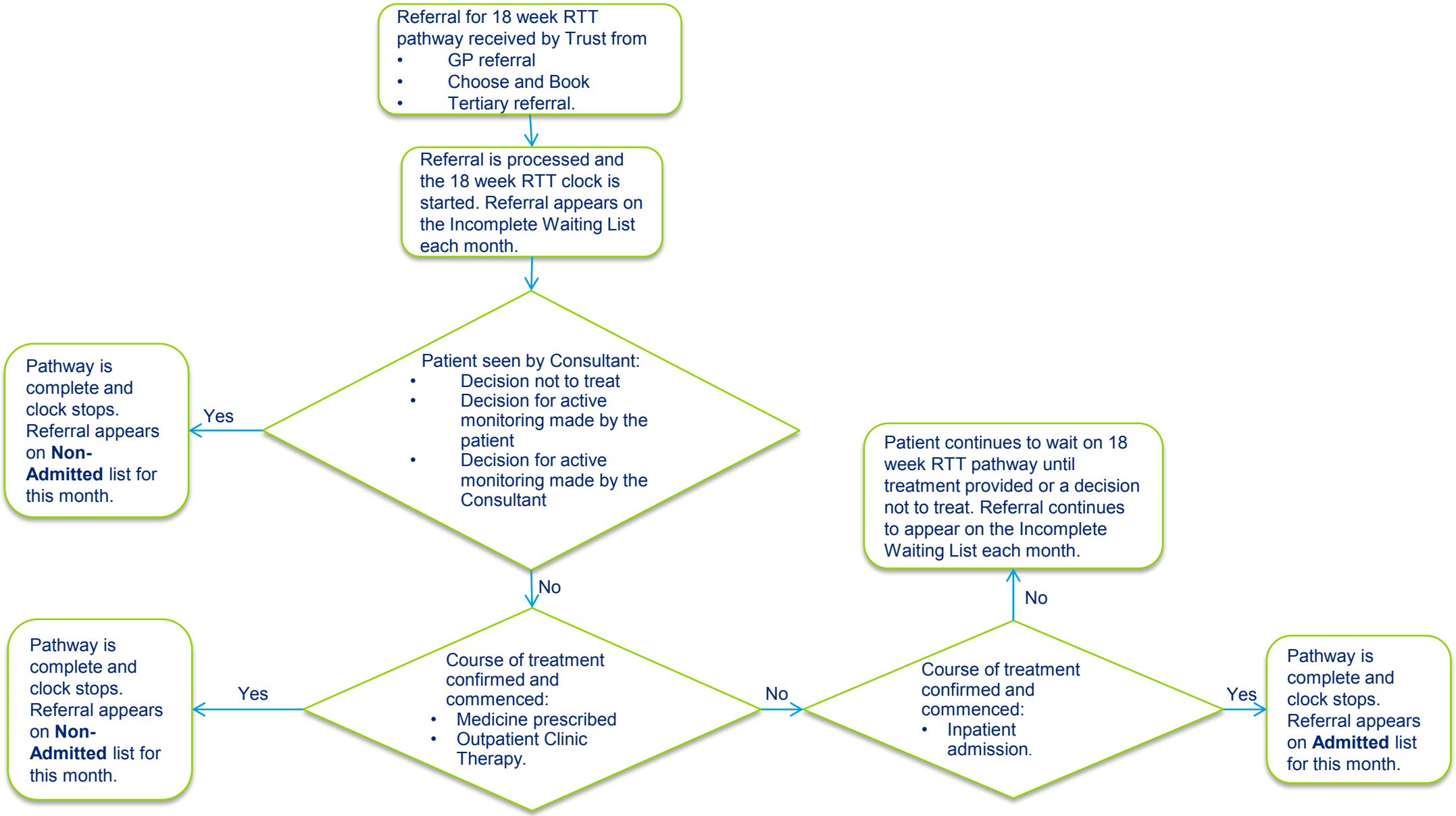
The national performance standard for the incomplete Referral-To-Treatment (RTT) metric (92%) was introduced in 2012. This metric is about improving patients' experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

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 from 1 April 2015 to 31 March 2016, 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 60 to supporting documentation including patient case notes as provided by the Trust.
- 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

Process flow



18 week referral-to-treatment waiting times

Findings

Interviews

- Findings:
  - The Informatics team compiles monthly reports providing a snapshot of all incomplete pathways from the Patient Administration System (PAS). The monthly reports present the combined incomplete waiting list position for internal and external stakeholders.
  - The data around the indicator whilst input by various Trust staff, is monitored by the Informatics team. The information is primarily extracted from the Trust's PAS system – Lorenzo. The Trust is moving to implementing a new system – Oceano. The new PAS system will include a sense check to ensure new referrals are inputted correctly and recorded as a linked referral where appropriate. It will also display the patient's current pathway and only allow the next relevant 18 week status options to be selected which will reduce validation. There has been a delay in implementing the new PAS system and in the interim the extra resource within the Informatics team has been used to train medical staff on how to record patient pathways correctly.
  - 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 ERHA 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.
  - Validation is undertaken by the Central Informatics team and focusses on investigating administration errors, other incorrect start dates and confirming patient treatment.

18 week referral-to-treatment waiting times

Findings

- Findings (continued):
    - 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.
    - A mandatory training session for all staff involved in RTT has been piloted and the roll out commenced on the 1 May 2016. The training involves 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 Trust has also developed a pathway compliance toolkit which allows the informatics team to identify the top 10 validation errors. Feedback from interviews has identified that ongoing training will be focussed on these areas. The toolkit allows the informatics 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.
- Issues:
    - Our experience when reviewing or testing RTT data following the implementation of a new PAS is that there is often an impact on the accuracy of RTT reported performance. **Recommendation 1: Implementation of new PAS system**

Testing

- Findings:
    - There were 26 errors identified in total within the sample testing undertaken as outlined below:
        - Clock start and validity testing: 11 (24.4%)
        - Clock stop testing: 7 (15.6%)
        - Clock stop validity testing: 3 (6.7%)
        - 18 week breach testing: 3 (4.0%)
        - 18 week incomplete lists: 2 (3.3%)
    - During testing we identified 4 records where we were unable to confirm the start date because either the letter was not available on the Trust's system or the letter had not been marked to state when it was received. Upon investigation, we reviewed patient case notes to identify if there was evidence of clinical activity following the period recorded as the start date by the Trust, and not any evidence of clinical activity preceding the start date recorded by the Trust. This was confirmed for the 4 cases in question.

      In addition, there was 1 record where we were unable to confirm the clock stop as the evidence available was unclear as to whether the patient wished to suspend their treatment or decline treatment. Upon investigation, we reviewed patient case notes to identify evidence of any subsequent activity which would have deemed the stop clock recorded by the Trust as inappropriate. We identified evidence of a new referral for this patient by GP to the Trust for the same condition. **Recommendation 2: Availability of evidence for validation**

18 week referral-to-treatment waiting times

Findings

- Findings (continued):
  - During testing we identified 4 records which had duplicate pathways open. 2 of these records were closed through the automated 16 week process. The duplicate pathways would have inflated the denominator which would have meant the Trust understated their performance. **Recommendation 3: Staff training – data entry**
- Issues:
  - 11 errors were identified when testing clock starts and their validity. These errors did not impact on the accurate reporting of breaches.
    - 4 records were incorrectly started as RTT pathways. Attempts to exclude the pathways were made, but were implemented incorrectly and therefore had no impact on the pathways which continued to run. This is a potential training issue on the use of the system. The Trust is addressing this through focussed training programmes that have been set up in response to prior year recommendations. **Recommendation 4: Staff training – validation**
    - A further 2 records were incorrectly started as RTT pathways. These were not identified through validation process as the Trust had validated up to an accepted reported performance level before these records were identified. **Recommendation 3: Staff training – data entry**
    - 1 record was incorrectly started as a new pathway and activity should have been recorded against an existing pathway. **Recommendation 3: Staff training – data entry**
    - 4 errors were identified where an incorrect start date was used. Our testing identified this was due to data entry errors. **Recommendation 3: Staff training – data entry**
  - 7 errors were identified in relation to clock stop testing. 1 of these errors impacted on the accurate reporting of breaches.
    - 3 records were automatically stopped due to the 16 week process due to incorrect application of earlier codes. 2 of these records should have been stopped earlier due to the patient receiving their first definitive treatment. A further record was automatically closed as activity had been recorded against a duplicate pathway. **Recommendation 5: Investigate automated clock stops**
    - 1 record was inappropriately validated to stop the clock. An earlier validation had attempted to correctly exclude the pathway, however this had been implemented incorrectly. Instead of correcting the earlier validation, the outcome code for an appointment was inappropriately changed to a clock stop code. **Recommendation 4: Staff training – validation**
    - 2 errors were found where earlier clock stops had not been identified by the Trust. In one case this led the Trust to incorrectly report a breach of the 18 week indicator. **Recommendation 3: Staff training – data entry**
  - 3 errors were identified in relation to clock stop validity testing.
    - 2 records had incorrectly applied the clock stop codes in relation to whether the patient had received first treatment, was on a watchful wait or had declined treatment. Each code has a different impact on how the pathway may continue and can lead to future issues in the patients pathway. However, this has limited impact on reporting the clock stops. **Recommendation 3: Staff training – data entry**
    - 1 record had incorrectly applied the post first treatment codes for a first definitive treatment instead of a clock stop code. This impacted on reporting as the clock remained open and reportable. **Recommendation 3: Staff training – data entry**
  - 3 errors were identified with regard to the correct recording of breaches and non breaches.
    - 3 records identified that the Trust has incorrectly recorded a breach of the indicator. In all 3 cases, testing identified earlier clock stops. 2 records had been validated correctly to identify the earlier clock stop, however, this was after the breach had already been reported. These errors resulted in the Trust over-reporting their breaches. **Recommendation 3: Staff training – data entry**

18 week referral-to-treatment waiting times

Findings

- Issues (continued):
    - 2 errors was identified in relation to the incomplete 18 week RTT list.
        - 2 records did not appear on all of the monthly incomplete RTT lists for the duration of the patients' 18 week RTT pathway. In both cases a post first definitive treatment code was added to the pathway which resulted in the pathway not appearing on the RTT incomplete list for that month. For the months concerned, this would have reduced the denominator the Trust uses for reporting performance against the indicator and also had a potential minor impact on the percentage performance achieved. We observed these as an isolated incident from our sample of 60 due to an incorrect stop code being applied. For these months, the reported performance was in excess of the 92% target (August 2015 – 97% and May 2016 = 93%). **Recommendation 6: Sample audit**

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 – 18 of which relate to the accurate recording of clock starts and stops. Further, our work has identified 3 records whereby the Trust has incorrectly reported breaches, which have subsequently been found not to be breaches during our testing. 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. Of the clock start and stop errors identified, only 1 of these stop clock errors subsequently led to the Trust incorrectly reporting a breach.

In line with practices across many NHS Trusts and Foundation Trusts, the Trust has a validation process in place prior to the submission of RTT performance data. During our review, we have observed that the Trust is particularly reliant on this process to support the accurate reporting of breaches and non breaches – particularly because of the volume of patients recorded as being on a RTT pathway, the volume of referrals accepted from other organisations and also because of the complexity of the patient care pathways as a specialist tertiary centre.

Depending on the reporting timescales and validation resources available, the Trust concentrates its process on validating records to a point at which performance is between the 92% - 95% rate in order to meet the national target of 92%. The Trust has reported performance in excess of the 92% for each of the reporting months in 2015/16.

Our observations of the validation process and feedback from key Trust leads have identified that the Trust has considered the level of additional resource and work required to validate every record prior to submitting monthly performance information. The Trust as taken a decision not to validate every record due to the performance already being in excess of 92% target, and any additional resource or capacity would only impact level of performance achieved. This has been observed during our sample testing where we identified evidence of 3 records which were reported as breaches, which were found not to be breaches under the RTT guidance.

The Trust has included a statement within the final version of the Quality Report which describes the basis for validation and the methodology in place further. We have reviewed the accuracy of this statement in line with the processes observed and results of our sample testing and will be issuing an unmodified opinion.

18 week referral-to-treatment waiting times

Deloitte View (continued):

Impact on RAG rating

The testing undertaken identified 3 records that were incorrectly reported as breaches. Two were later validated by the Trust, however this took place following initial reporting of the results. As such, this has resulted in an amber rating in relation to 'accuracy'.

Our sample testing has identified a high volume of errors including, records which were started inappropriately and not in line with the national guidance. Our testing has also identified instances whereby inappropriate clock stops have been entered, resulting in errors or more appropriate stop clock periods not being identified. The automated clock stop function in place at the Trust has played a role in this. There were also a number of data quality errors identified in relation to clock starts and stops. In addition, there were a number of records we were unable to validate as the evidence was either not available, or was not available to view on the Trust's systems. These have resulted in a red rating with respect to 'validity'.

The Trust currently has established systems in place and although is proposing a change to a new PAS system, this is yet to be implemented. However, testing identified a number of records which were incorrectly validated, or were validated and did not result in the required impact i.e. they did not nullify the pathways. This has resulted in an amber rating with respect to 'reliability'.

The Trust has processes to ensure that information is captured as close to the event as possible, either through manual data entry or automated processes. However, due to the volume of pathways on the incomplete list, it is not possible for each of these to be validated prior to reporting. The Trust has arrangements in place to validate records in excess of 92% performance – up until 95% is achieved. This has resulted in an amber rating for 'timeliness'.

The sample testing identified records which should not have been identified as appropriate RTT pathways however were included on the incomplete pathways list. In most cases, we observed evidence of an attempt to validate these records. This has resulted in an amber rating for 'relevance'.

The sample testing identified 2 records which did not appear on the appropriate incomplete RTT list. This has resulted in an amber rating for 'completeness'.

The overall rating assigned to this indicator is amber, due to the errors and issues observed during our testing process.

Accident and Emergency 4 hour waiting times

Our testing has identified minor issues

	Trust reported performance	Target	Overall evaluation
2015/16	91.9%	>95%	B

Indicator definition

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

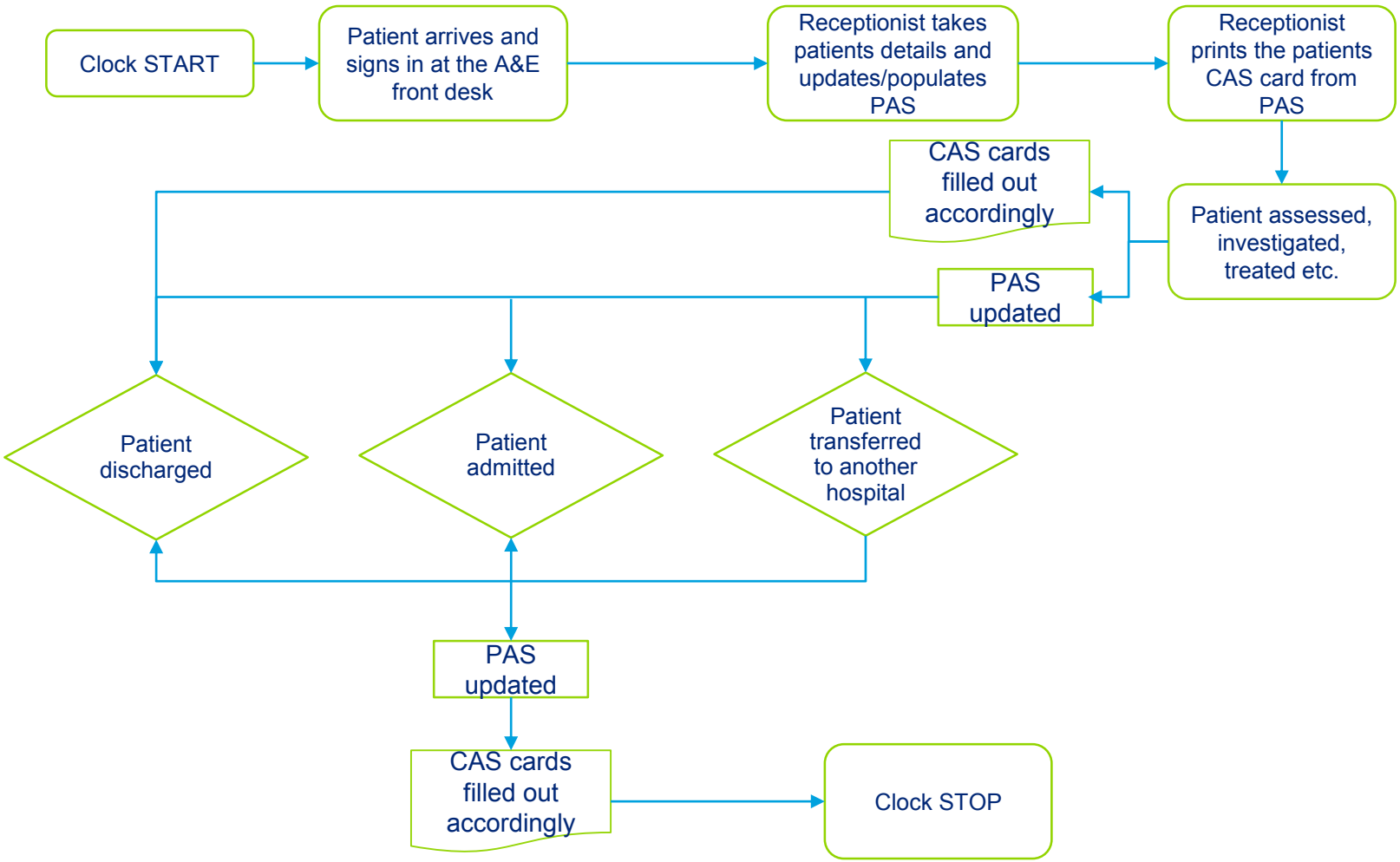
Longer lengths of stay in the emergency department are associated with poorer health outcomes and patient experience as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen, and financial effects. It is critical that patients receive the care they need 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.
- There were no previous recommendations for this indicator as the A & E waiting time target is being tested nationally as part of external assurance of Quality Accounts for the first time this year.
- We selected a sample of 25 from 1 April 2015 to 31 March 2016, following patient records through until treatment.
- We agreed our sample of 25 to supporting documentation including patient case notes as provided by the Trust.

Accident and Emergency 4 hour waiting times

Process flow



Accident and Emergency 4 hour waiting times

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 an additional step was incorporated in January 2016 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.
- Issues: Not applicable.

Accident and Emergency 4 hour waiting times

Findings

Testing

- Findings:
  - o There was 1 error identified within the sample testing undertaken as outlined below:
    - Admission date and time testing: 1 (4.0%)
    - Discharge date and time testing: 0 (0.0%)
    - Discharge reason testing: 0 (0.0%)
    - Breach testing: 0 (0.0%)
  - o 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. As best practice, the Trust should consider recording a note on the CAS card as to when the patient departs A&E. **Recommendation 6: CAS card notes**
- Issues:
  - o One error was identified where clinical activity was found to be carried out before the recorded arrival time on inspection of the CAS card. This is not material to performance and did not impact on the reporting of a non-breach. **Recommendation 7: Spot check audits**

Recalculation

- Findings: The Trust has achieved performance of 91.9% 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:

Sector comparison:
The A&E waiting time target is being tested nationally for the first time this year. Our experience is that indicators tested for the first time typically show a high error rate, as process issues are identified. This has been borne out in our work across the sector this year, where we have identified a significant level of issues.

Our sample testing identified 1 record where activity within the A&E department was recorded as taking place prior to the clock starting. As a result, a blue rating has been assigned with respect to 'validity'.

The Trust 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 due to the nature of the A&E department and the subsequent requirement for retrospective entry. However, we found in a some cases where there was a greater delay in departing the patient from the system following completion of their A&E activity. This has resulted in a blue rating for 'timeliness'.

There is not always clear evidence recorded of when the patient left the department. This has resulted in a blue rating for 'completeness'. Consequently, the overall rating assigned to this indicator is blue.

Local indicator: Grade 2 hospital-acquired pressure ulcers

Our testing has not identified any significant issues

	Trust reported performance	Target	Overall evaluation
2015/16	79	132	G

Indicator definition and process

Definition: Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply (NICE, 2014). They are also known as "bedsores" or "pressure sores" and they tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. Some pressure ulcers also develop due to pressure from a device, such as a urinary catheter.

Reason for testing: The Trust has previously focused on improving performance for Grade 3 and 4 hospital acquired Pressure Ulcers, which has led to a reduction. Therefore, for 2015/16, the Trust has decided to focus on improving performance for Grade 2 pressure ulcers that are hospital acquired, avoidable and non-device related. The Commissioners have set the Trust a target of 132 pressure ulcers that fit this criteria for 2015/16.

Approach

- We met with the Trust's Tissue Viability Lead to understand the process from identifying pressure ulcers, and how the Tissue Viability team check the ulcers, to how pressure ulcers are reported.
- This indicator was not tested last year as part of our audit.
- We selected a sample of 25 from 1 April 2015 to 31 January 2016 including in our sample pressure ulcers both as a result of medical devices and not, and hospital-acquired and community-acquired. We also tested pressure ulcers both downgraded from and regraded to a Grade 2. Due to validations and the Trust's processes, data for February and March wasn't available at the time of testing.
- We agreed our extended sample of 25 cases to the underlying information held within the Datix system.

Findings

Interviews

- Findings:
  - On entering the Trust, all patients have a skin inspection (where it is appropriate to do so). If a pressure ulcer is identified at the time of being admitted, or through later identification by staff, a Datix Incident Report is created. If the report is generated within 72 hours of admission, it is classed as a non-hospital acquired pressure ulcer. If the report is generated post 72 hours from admission, it is classed as a hospital acquired pressure ulcer.
  - The Datix system is reviewed daily by the Tissue Viability team who verify grade 2 or above pressure ulcers. A Tissue Viability Nurse is in place on Saturdays to maintain this target. If, on review, the Tissue Viability team deem the referral not to be a pressure ulcer it will be labelled on the Datix system correctly.
  - All referrals are logged onto a local database (an excel spreadsheet) which also records the final outcome of the review.
  - In addition to the grade 2, 3 and 4 pressure ulcers, reports of grade 1 pressure ulcers are also retained to see if the pressure ulcer deteriorates into a grade 2.

Local indicator: Grade 2 hospital-acquired pressure ulcers

Findings

Interviews (continued)

- Suspected deep tissue injury / ungradable pressure ulcers are recorded and monitored locally. They are monitored every 10-14 days on average, or sooner if staff feel they have deteriorated in the interim. They are then reported through Datix in the usual process once they become gradable.
- A member of the Tissue Viability team will review the local database to see if there are any duplicates. This is a cross-checking process, reviewing the referrals on Datix for the month against what is held on the local database and what has been seen by the Tissue Viability team – a month end data cleanse.
- A full audit trail is kept of the decisions made.
- If staff are unsure whether a wound is a pressure ulcer they will refer it to the Tissue Viability team. The Tissue Viability team will review the suspected pressure ulcer and request the member of staff raise a Datix report if it is confirmed. The Tissue Viability team will log the pressure ulcer onto the local database and chase the member of staff if they do not receive the Datix report.
- Performance is reported internally for both the number of pressure ulcers in total and the number of patients reported having pressure ulcers. This is to ensure patients with more than one pressure ulcer are properly treated. Only the number of patients reported as having pressure ulcers are reported externally to the CCG and in the Quality Report.
- Performance is only reported for grade 2 pressure ulcers that are hospital acquired, avoidable, and not as a result of a medical device. Grade 2 pressure ulcers are reported monthly through Governance. This is then sent to the Commissioners.

- Issues: Not applicable.

Testing

- Findings:
  - There was 1 error identified within the sample testing undertaken as outlined below:
    - Date seen: 1 (4.0%)
    - Grade: 0 (0.0%)
    - Hospital / community acquired: 0 (0.0%)
    - Avoidable / unavoidable: 0 (0.0%)
    - Medical device related: 0 (0.0%)
- Issues:
  - Testing identified 1 error where there was no date seen recorded for the pressure ulcer on the Trust's local spreadsheet. The Datix entry had correctly recorded the date first seen. This is due to human error and is not material to performance.

Local indicator: Grade 2 hospital-acquired pressure ulcers

Findings

Recalculation

- Findings: The Trust reported 79 patients with non-device-related, hospital-acquired avoidable grade 2 pressure ulcers, against the agreed target of 132. This has been reconciled to the figures included in the Trust's Quality Report.
- Issues: Not applicable.

Deloitte View:

The Trust has a robust system in place that is able to process Pressure Ulcers and monitor them appropriately. There are systems and processes embedded to ensure all grade 2 pressure ulcers are reported, and the Tissue Viability team is able to validate all skin issues to capture performance accurately. One error was identified from our testing, but this was due to a human error with the Trust's local tracking database, and was not material to performance. We have therefore graded this indicator green overall.

Recommendations for improvement

the Distinctive audit

Recommendations 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) 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.	Test scripts for RTT reporting are already in place within the 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. **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 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2016 and future meetings as required.	**High**
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.	The Trust 18 week RTT guidance document will be updated to provide additional clarity on the management of receipt of referral letters. This will also be highlighted within the 18 week RTT training programme. In addition a Standard Operating Procedure for the management of referrals will be implemented to provide detailed operational guidance. **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. **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2016 and future meetings as required.	**Medium**

Recommendations 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	**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.	The Trust 18 week RTT guidance document and training programme reflect and reference the national clock rules. Activities that stop a clock are described in detail. However, the guidance document and training programme will be enhanced in the future to provide clear instructions on the correct RTT pathway codes required to accurately identify key RTT pathway steps. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** by end June 2016 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2016 and future meetings as required.	**High**
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.	The validation team will undergo enhanced training on the 18 week RTT clock rules. There will be an assessment of competence following the training which will be repeated annually. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** by September 2016 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2016 and future meetings as required.	**High**

Recommendations 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	**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.	A report detailing clocks automatically stopped in the previous month will be reviewed by the validation team as part of the regular validation process. This will ensure automated clock stops are appropriate and in line with the RTT clock rules and reporting requirements. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** From June 2016 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2016 and future meetings as required.	**Medium**
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.	A sample auditing process to assess the accuracy of incomplete pathways is already in place. However, this will be extended in the future to also assess the accuracy of monthly reporting. Each quarter 25 samples will be taken from breaches on the admitted and non-admitted reports to ensure they have been correctly reported on admitted / non-admitted and incomplete reports for all appropriate preceding months. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** From June 2016 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2016 and future meetings as required.	**Medium**

Recommendations for improvement

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

Indicator	Deloitte recommendation	Management response	Priority (H/M/L)
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.	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. **Responsible Officer:** Lorraine Simmonds, Head of Service Improvement **Timeline:** by end June 2016 **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2016 and future meetings as required.	**Low**
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.	Spot check audits on attendances within the 4-hour limit will be introduced from Quarter 1 2016/17. 100 records will be audited each quarter. Findings from the audits will be reported to the Unscheduled Care Steering Group where actions to address any recommendations will be overseen. **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. **Process for updating Council of Governors:** A progress report will be provided to the Council of Governors in July 2016 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) Unknown clock start dates** In the absence of clear national guidance, the Trust has taken a reasonable approach to recording clock starts when receiving referrals with unknown start dates. The Trust should ensure that this approach is documented in the patient access policy and is communicated to commissioners. **Responsible Officer:** Head of Operational Performance, Executive Director of Partnerships **Timeline:** 31 July 2015	**Update:** The Trust's 18 Week RTT Guidance document has been refreshed to reflect changes to the national clock rules that became operational on 1st October 2015. The final guidance was approved at the Chief Operating Officer's Group meeting in January 2016 and published internally in February 2016. It will now be shared with commissioners. Key changes to the national rules have already been communicated to Trust staff via the Chief Operating Officer's Group and the RTT Assurance Group. **Status:** Complete
18 week referral-to-treatment	**2) Formalise local agreements** We acknowledge there are instances where the Trust has agreed exceptions from national guidance in the interest of patient safety and experience. Such exceptions should be documented appropriately, approved by commissioners, and communicated to all staff responsible for data entry and validation. **Responsible Officer:** Executive Director of Partnerships **Timeline:** 31 July 2015	**Update:** The Executive Director of Partnerships has established a process with the host CCG for discussing and approving local arrangements that, in the interests of patient safety and experience, provide detail over and above that in national guidance. The pathway for neurosurgery spinal referrals was formally agreed across the local health economy with commissioners in September 2015. The revised 18 week guidance document now reflects this. **Status:** Complete

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** The Trust should remind staff of the rules and requirements of national RTT guidance. As part of this, there should be a focus on ensuring accurate data entry and recording of outcomes which subsequently inform the identification of key steps of the RTT pathway. **Responsible Officer:** Chief Operating Officer **Timeline:** Completion of RTT refresher training by 30 June 2015, Implementation of PAS from December 2015	**Update:** 18 week RTT refresher training was commissioned in response to the audit carried out by the Trust in December 2014. Training for all staff involved in RTT pathways commenced 1st May and comprises a half-day taught session with an assessment of competence at the end. The new Patient Administration System will display the patient`s current pathway and only allow the next relevant 18 week status options to be selected which will reduce validation. It is anticipated that the new PAS system will be implemented by the end of 2016/17; the go-live date will only be agreed once the suppliers have delivered the final software update which will contain a number of requested fixes. The RTT training course is now offered by the PAS training team as a core module within their training portfolio, the course is for new staff and as a refresher course for staff. A new training programme covering the 18 week clock rules and Trust guidance has been internally developed and will be tested in March 2016. This will become a monthly rolling programme of training aimed at administrative and clerical staff. **Status:** Complete
18 week referral-to-treatment	**4) Investigate automated clock starts and stops** The Trust should generate a monthly report detailing automated clock starts and clock stops recorded. These should then be investigated as part of the Trust's ongoing validation arrangements. **Responsible Officer:** Head of Operational Performance **Timeline:** 31 July 2015	**Update:** Informatics have finalised a report to allow weekly sample audits to be undertaken by the validation team. The results will be analysed and shared at the RTT weekly meeting. **Status:** Complete

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Deloitte recommendation	Current year status
18 week referral-to-treatment	**5) Staff training – validation** 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:** Head of Operational Performance **Timeline:** 30 June 2015	**Update:** As per recommendation #3 above, the validation team staff have all attended the RTT refresher training course. A range of audit tools are being explored to ascertain whether these would add value to the validation process. A Business Case, if required, will be produced by the end of May 2016. **Status:** Complete
18 week referral-to-treatment	**6) Sample audit** In line with best practice, the Trust should consider undertaking sample audits across RTT lists. Audits should focus on data quality across the RTT pathways, as well as data completeness to monitor whether patients are being transferred between RTT lists appropriately. **Responsible Officer:** Head of Operational Performance **Timeline:** Audit of 800 pathways in December each year. Smaller sample audit each July.	**Update:** The Trust commenced a programme of scheduled RTT audits in December 2014. A detailed audit of approximately 800 pathways will be carried out annually by the Service Improvement Team. A smaller sample audit will be undertaken mid-way through each year to provide assurance that recommendations have been addressed. A sample audit of 100 pathways was completed in August 2015. The audit focused on clock starts for tertiary referrals. A sample audit undertaken in December 2015 focussed on patients on an inpatient waiting list (IPWL) but not on an active 18 week clock. This has led to further analysis and process review in some specialties. The final findings and recommendations will be presented to the Chief Operating Officer's Group (COOG) in April 2016. **Status:** Complete
Pain and observations	**7) Consider processes to pick up checks before admission** The Trust may wish to consider amending the methodology so that all observations completed as part of the same set are counted even where one observation was done just before the due time. **Responsible Officer:** Head of Quality Development **Timeline:** 31 July 2015	**Update:** The Trust has already acted upon this recommendation. The analgesics drug class in the Prescribing Information and Communication System (PICS) has been revised by the Lead Pharmacist for Electronic Prescribing. The methodology for this indicator has been revised to ensure it always refers to the analgesics drug class in PICS so that the list of analgesic drugs remains up to date. **Status:** Complete

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Deloitte recommendation	Current year status
Pain and observations	**8) Update the analgesia drugs list** The Trust should updated the analgesia drug list to include all pain relief. **Responsible Officer:** Head of Quality Development **Timeline:** Completed 30 April 2015	**Update:** The Trust has decided to keep the observation part of the indicator methodology consistent during 2015/16 to enable performance to be monitored. In December 2015, the Trust replaced the 0-3 pain scale with a new 0-10 pain scale in the Prescribing Communication and Information System (PICS). The two indicators relating to pain assessment and high pain scores have been updated accordingly. **Status:** Complete

Responsibility statement

the Distinctive audit

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 under Monitor's Audit Code 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

19 May 2016

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, 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 Monitor for their information in connection with this purpose, but as made clear in the ConsultancyOne Letter of Appointment dated 12 February 2014, only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.