

University Hospitals Birmingham NHS
Foundation Trust
Findings and Recommendations from the 2014/15
NHS Quality Report External Assurance Review

26th May 2015



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This report sets out the findings from our work on the 2014/15 Quality Accounts.

We would like to take this opportunity to thank the management team for their assistance and co-operation during the course of our review.



Executive Summary

Executive Summary

We have completed our review of the Trust's Quality Report and testing of performance indicators

Status of our work

- We have received the final Quality Report from the Trust and we will issue our final report to the Trust's Governors.
- 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 2014/15".
- We will be signing a modified opinion for inclusion in your 2014/15 Annual Report.

Summary of Quality Priorities:

	2014/15	2013/14
Length of Quality Report	81 pages	76 pages
Quality Priorities	5	6
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 is required this year to have 18 week referral-to-treatment (RTT) waiting times as a publicly reported indicator, and has also selected 28 day emergency readmissions – the alternative was 62 day cancer wait.
 - For 2014/15, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected observations and pain assessments.
 - 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 28 day readmissions 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, 28 day emergency readmissions and observations and pain assessments.

Executive Summary (continued)

Summary of Quality Report and Indicator review

Content and consistency review



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 2015, 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 two mandated indicators and a further locally selected indicator. We perform our testing against the six dimensions of data quality that Monitor specifies in its guidance.

Our opinion on the 18 week RTT indicator will be qualified, as our testing indicated a number of issues in capturing data required in line with the six dimensions of data quality as set out in the “Detailed Guidance for External Assurance on Quality Reports 2014/15”.

	18 week RTT	28 day re-admissions	Observations and pain
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	G	B
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	G	G
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance?	R	G	G
Completeness Is all relevant information, as specified in the methodology, included in the calculation?	A	G	G
Recommendations identified?	Y	N	Y
Overall conclusion	R Modified opinion	G Unmodified opinion	G No opinion required

G No issues noted

B Satisfactory – minor issues only

A Requires improvement

R Significant improvement required

Content and consistency findings

Content and consistency review findings

The Quality Report meets regulatory requirements

Content of the Quality Report

We reviewed the content of the 2014/15 Quality Report against the content requirements set out in Monitor's 2014/15 Annual Reporting Manual (ARM).

Based on our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015, the content of the Quality Report is not in accordance with the 2014/15 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 review, we reviewed the Trust's "Statement of Directors Responsibilities" to confirm whether 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. Feedback has been received from Healthwatch Birmingham and Birmingham Cross City CCG as required by the ARM.

Performance indicator testing

18 week referral-to-treatment waiting times

18 week RTT incomplete pathways overview

	Trust reported performance	Target	Overall evaluation of work
2014/15	93.6%	>92%	R

G No issues noted

B Satisfactory – minor issues only

A Requires improvement

R Significant improvement required

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 NHS Constitution gives patients a legal right to start NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate to do so. This right is about improving patients’ experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

There are three 18 week Referral-To-Treatment (RTT) metrics:

- Admitted: The pathway ends (first definitive treatment) with the patient being admitted e.g. for surgery;
- Non-admitted: The pathway ends (first definitive treatment) with the patient not being admitted e.g. an outpatient attendance OR no treatment required; and
- Incomplete: The pathway has not ended and the patient is still waiting for treatment.

Our work has focused on the **incomplete 18 week RTT metric**.

The national performance standard for the incomplete RTT metric (92%) was introduced in 2012.

For the first time, this year Monitor has specified that the 18 week RTT incomplete metric should be subject to substantive testing as part of the Quality Report external assurance process for all acute FTs.

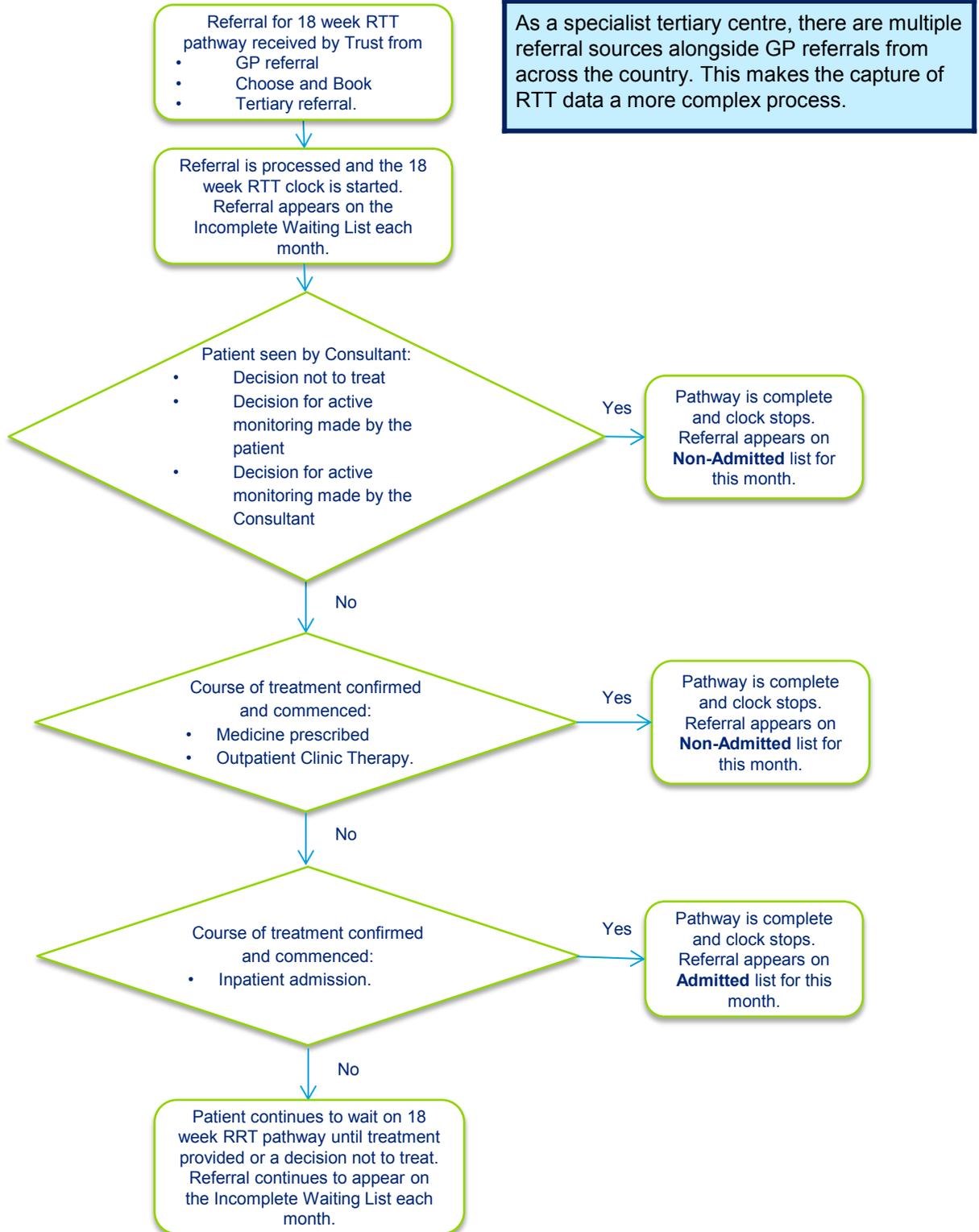
Deloitte View:

The 18 week RTT incomplete pathway indicator 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 is particularly the case for 18 week RTT, which was selected due to issues identified at a number of trusts and following Public Accounts Committee concerns. In particular, the National Audit Office reported in 2014 on waiting times, and found across a sample of trusts only 43% of patient records tested were correct and fully supported by available documentation, with 26% having at least one error. This has been borne out in our work across the sector this year, where we have a range of issues. The results at the Trust, while indicating a need for significant improvement in process and practices, are therefore not out of line with a national picture of weaknesses in 18 week RTT data.

18 week referral-to-treatment waiting times

18 week RTT incomplete pathways overview

Indicator process



18 week referral-to-treatment waiting times

18 week RTT incomplete pathways overview

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. 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. Risk areas were identified to be within certain specialties, namely General Surgery, Urology and Neurosurgery.
- We selected a sample of 40 from 1 April 2014 to 31 March 2015, following patient records through until treatment. We focussed our sample on the specialties identified as risk areas above.
- We agreed our sample of 40 to supporting documentation including patient case notes as provided by the Trust.

Findings

Interviews

- Findings:
 - The Informatics team compiles monthly reports providing a snapshot of all incomplete pathways from the Patient Administration System (PAS). Monthly reports present the amalgamated 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 operates the OPTIMS electronic clinic management system. This system collects 18 week clinical outcomes and automatically enters them on to the PAS system.
 - 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.
 - Following completion of validation by the Informatics team, the month end performance is calculated and submitted for reporting purposes.
 - Clinical staff are responsible for recording a RTT outcome following an appointment.
 - The Trust has designed a safety feature whereby an automatic clock starts is initiated where a clinician adds a patient to a waiting list.

Furthermore, the Trust has a process whereby automatic clock stops are initiated where:

- (i) a pathway has been dormant for three months;
- (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. Whilst the pathway still remains within the PAS system, the consequence of the automated stop is the removal of the pathway from the tracking tools and dashboards used by the Trust to monitor 18 weeks performance.

18 week referral-to-treatment waiting times

18 week RTT incomplete pathways overview

Interviews (continued)

- Findings (continued):

- The Trust does not use the category of 'unknown clock starts'. The Trust assumes all patients referred from other NHS trusts are not on active 18 week pathways upon receipt of referral, unless informed otherwise.

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 MDT;
- For consideration of a second clinical opinion;
- Post-first definitive treatment; or
- Awaiting first definitive treatment.

Where patients are awaiting first definitive treatment, and the Trust has not been notified as such, the Trust will implement a clock start when a decision to treat is made. According to national RTT guidance if a patient is referred from one provider to another as part of one RTT pathway, the RTT clock continues to run until they are treated by the receiving provider. However, this is dependent on the referring trust providing appropriate clock start details, often in the form of a Inter Provider Transfer (IPT) form. 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.

The Trust has confirmed that referrals from other NHS organisations are not always accompanied by the appropriate information or IPT form. In such instances, the Trust documents the clock start as the date at which the referral has been received. **Recommendation 1: Unknown clock start dates**

Deloitte View:

As a specialist tertiary provider across multiple specialties, the Trust is required to manage patients referred from multiple sources and organisations. This requires the Trust to capture various information for RTT purposes, which in turn creates added complexity and challenges in managing RTT data and performance. This is a theme of our findings across many tertiary sector providers.

In response, the Trust, have established a number of systems and processes in light of patient safety to support the capture of data and reporting of RTT incomplete pathway performance. This is to ensure all patients are captured for monitoring purposes before validating whether they are applicable for RTT purposes.

The automatic start and stop clock system has been developed by the Trust to ensure that when a patient is identified by a clinician to be 'added to a waiting list' a clock start is initiated. This is a positive patient safety feature to ensure that any incomplete data entry by clinical, administration or other operational staff does not result in a patient being missed for RTT purposes.

The potential impact of this feature is that an inappropriate clock start is initiated where a patient is incorrectly recorded as needing to be 'added to the waiting list'. If such records are not validated, there is a risk that the incomplete pathway list includes erroneous records which are subsequently included in the monthly performance submission. This has been evidenced through our sample testing.

With respect to the approach to unknown clock start dates upon receipt of referrals from other NHS trusts, the Trust has taken a reasonable approach in the absence of clear national guidance detailing what action should be taken where this information is not provided.

18 week referral-to-treatment waiting times

18 week RTT incomplete pathways overview

Testing Approach

- 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 validation undertaken by the Trust and its impact upon the clock start and stop dates.
 - 2) We have also reviewed the RTT tracking lists (including the incomplete, and the two completed lists for admitted and non-admitted pathways) to assess whether, upon continuation or completion, patients appear on all appropriate RTT tracking lists.

Testing

- Findings:
 - The following errors were identified within the sample testing:
 - Clock start and validity testing:
 - *Inappropriate clock starts: 9 (22.5%)*
 - *Incorrect clock starts: 4 (10%)*
 - Clock stop and validity testing:
 - *Incorrect clock stops: 7 (17.5%)*
 - *Validity of clock stops: 1 (2.5%)*
 - 18 week breach testing:
 - *Non breaches incorrectly reported as breaches: 11 (27.5%)*
 - *Breaches incorrectly reported as non breaches: 1 (2.5%)*
 - 18 week incomplete / completed RTT lists:
 - *Patient did not appear on completed RTT list upon completion of pathway: 2 (5.0%)*
 - During testing we observed a record where a patient had been referred to Neurosurgery without having a MRI scan in place. Patients are required to have a recent MRI scan enclosed as part of their referral. However, the Trust has indicated there is a local agreement in place where the Trust will undertake the MRI scan as part of this referral, rather than discharging the patient back to their GP. As part of this agreement the Trust updates the clock start to the date the MRI scan results are available. In this instance the local agreement was not followed. **Recommendation 2: Formalise local agreements**
 - Our observations during testing identified that there is a significant reliance on the validation team. In particular, the team is required to run a range of validation processes and checks on month end information prior to submission. The validation checks are completed up until the monthly Trust performance exceeds 92%, with the focus being on achieving performance in excess of 94%. The Trust validation team has confirmed that due to the number of records on the incomplete pathways list at each month end, it is not possible for these to all be checked prior to submission of performance information.

Our experience of good practice across other NHS trusts has identified that whilst it is common for trusts to have internal validation teams, there is a greater emphasis on accurate data entry, training and feedback to operational staff. **Recommendation 3: Staff training – data entry**
 - The sample selected identified 11 records where the Trust had recorded inappropriate breaches and therefore potentially understated compliance against the target. There was also an instance of 1 record where a breach had not been reported. These are described further on page 14.

18 week referral-to-treatment waiting times

18 week RTT incomplete pathways overview

- Findings (continued):
 - The use of the automated stop controls has the impact of capturing and stopping pathways where either:
 - The clock has been inappropriately started and the pathway should be nullified in line with national guidance;
 - There is an earlier activity in the pathway which should have stopped the clock; or
 - The pathway is not yet completed and the automated controls has closed the pathway before an appropriate activity to stop the clock.

Where pathways have been closed early by the automated controls, the pathway is no longer monitored and tracked by the tools and dashboards used by the Trust to monitor 18 weeks performance. Evidence of these outcomes was found during our testing and is identified on page 13. [Recommendation 4: Investigate automated clock starts and stops](#)

- Issues:
 - 13 errors were identified when testing clock starts and their validity.
 - 9 errors relate to patients who were assigned onto the 18 week pathway inappropriately and not in line with national guidance.
5 of these 9 errors were the result of outcomes being recorded incorrectly by Trust staff which subsequently led to pathways being identified as 18 week pathways. In most cases, these were the incorrect use of clock stop outcomes. [Recommendation 3: Staff training – data entry](#)
4 errors were identified relating to the automated clock start controls. During our testing we found these records should not have been assigned a clock start date. [Recommendation 4: Investigate automated clock starts and stops](#)
 - 4 errors were identified where an incorrect date was used for the clock start. Our testing identified that 3 of these records should have been assigned earlier clock start dates than those recorded by the Trust. [Recommendation 3: Staff training – data entry](#)
 - 8 errors were identified in relation to clock stop and validity testing.
 - 7 of the clocks were stopped incorrectly.
1 of these errors relates to an inappropriate clock start where the pathway was incorrectly recorded as an 18 week pathway. This record was validated by the Trust. However, an earlier stop date was recorded upon validation rather than the pathway being nullified. [Recommendation 5: Staff training – validation](#)
5 of these errors relate to records where our sample testing identified earlier clock stops should have been recorded. 1 of these was reported as a breach by the Trust. Our testing identified that this should not have been reported as a breach. [Recommendation 3: Staff training – data entry](#)
1 of these errors relates to a record where our sample testing identified a later clock stop date which should have been recorded. This is as a result of the automated clock stop controls following 3 months of dormant activity. [Recommendation 4: Investigate automated clock starts and stops](#)
 - 1 clock stop validity error was identified where an inappropriate outcome was recorded as a clock stop which was not in line with national guidance. In this instance a diagnostic appointment was recorded as a clock stop. [Recommendation 3: Staff training – data entry](#)

18 week referral-to-treatment waiting times

18 week RTT incomplete pathways overview

- Issues (continued):
 - There were 10 records whereby dormant activity enacted the automated stop controls.
 - In 4 of these instances our sample testing identified earlier clock stops which should have been applied. As such, the automated stop controls were inappropriate. Correct coding of these earlier clock stops would have eradicated this issue. **Recommendation 3: Staff training – data entry**
 - In 1 of these instances our sample testing identified a later clock stop. As such, the automated stop controls were inappropriate. As a result, the patient's pathway remained incomplete and was no longer recorded on an appropriate RTT list. **Recommendation 4: Investigate automated clock starts and stops**
 - In 2 of these instances our sample testing identified inappropriate clock starts which were entered by staff. These were not appropriate RTT activity and should have been nullified in line with national guidance. As such, the automated stop controls were inappropriate. Correct coding of these inappropriate clock starts would have negated this issue. **Recommendation 3: Staff training – data entry**
 - In 3 of these instances our sample testing identified records which had inappropriate automated clock starts and clock stops. These records do not relate to appropriate RTT activity. As such, the automated controls were inappropriate and the incomplete waiting list was inflated. These records are unlikely to be identified by the Trust's validation processes as they are initiated and removed within 12 weeks. The Trust's validation processes focus on pathways approaching 18 weeks. **Recommendation 4: Investigated automated clock starts and stops**
 - There are 12 errors identified with regard to the correct recording of breaches and non breaches.
 - 11 of the errors identified indicate that the Trust has incorrectly recorded a breach of the indicator.
 - 5 of these relate to records where there is an inappropriate clock start date, which has later been validated by the Trust. However, for the reporting period to which they relate to the Trust has reported the records as breaches. Our sample testing has identified that these should not have been categorised as 18 week pathway records for the period identified. **Recommendation 3: Staff training – data entry**
 - 1 of the errors identified relates to a record that should not have been recorded as an 18 week pathway. As such, an inappropriate start date and an inappropriate stop date was recorded which resulted in the Trust reporting a breach for this record. **Recommendation 3: Staff training - data entry**
 - 4 of the errors relate to records where there is either an incorrect clock stop date, which has later been validated by the Trust, or the clock continued running until a later validation. However, for the reporting period to which they relate, the Trust has reported these cases as a breach. **Recommendation 3: Staff training – data entry**
 - 1 of the errors relates to a record where an incorrect stop date was recorded which was generated by the automated stop control. Our testing identified an activity which should have informed an earlier clock stop. This was not picked up by Trust processes due to activity being coded incorrectly. This resulted in the Trust reporting a breach incorrectly. **Recommendation 3: Staff training – data entry**
 - Our testing identified 1 record which should have been recorded as a breach. In this instance, an automated clock start was initiated upon a decision to treat. However, this was closed after the pathway was dormant for 3 months. During testing we identified a later appropriate clock stop that was assigned to a different pathway ID. This was not identified as part of the Trust's validation processes. **Recommendation 4: Investigate automated clock starts and stops**

18 week referral-to-treatment waiting times

18 week RTT incomplete pathways overview

- Issues (continued):
 - 2 errors were identified in relation to the incomplete and complete 18 week RTT list.
 - The 2 errors identified relate to records whereby upon completion of the pathway the patients did not appropriately transfer from the incomplete list to the complete RTT lists.
Recommendation 6: Sample audit

Recalculation

- Findings: The Trust has achieved performance of 93.6% against a nationally set target of 92%, which reconciles with the performance figure included in the Trust's final Quality Report.
- Issues: Not applicable

Deloitte View:

A number of issues and errors have been identified following our interviews with Trust staff and sample data testing. The findings observed have resulted in concluding a Modified opinion with respect to the 18 week RTT incomplete pathways indicator.

The testing undertaken identified 11 records that were incorrectly reported as breaches, and a further 1 record incorrectly reported as a non breach. These 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 errors where invalid clock starts have been commenced, either through the automated start process or by inappropriate reasons entered manually which were not consistent with patient records. Our testing has also identified instances whereby inappropriate clock stops have been entered manually or the automatic stop control has been initiated, resulting in errors or more appropriate stop clock periods not being identified. 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. The automatic clock start control acts as a positive safety feature in instances where RTT outcomes are not documented. Subsequently, a blue rating has been assigned 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. In some instances, this may result in inappropriate recording of breaches / non breaches which are not identified and corrected as soon as possible. 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. This has resulted in a red rating for 'relevance'.

The sample testing identified two records whereby they did not appear on the appropriate completed RTT list following an appropriate clock stop date being recorded. This has resulted in an amber rating for 'completeness'.

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

28 day emergency re-admissions

Our testing has not identified any significant issues

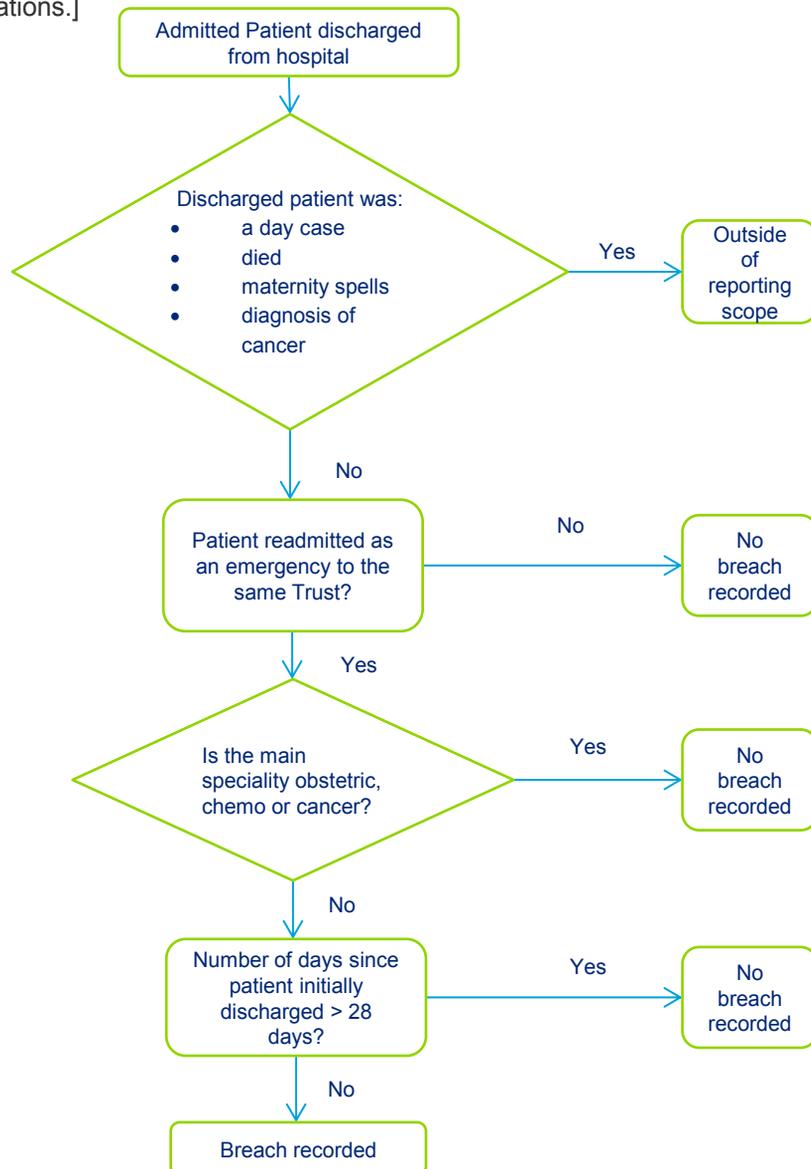
	Trust reported performance	Target	Overall evaluation
2014/15	10.68%	No target	G
2013/14	10.18%	No target	G

G No issues noted
 B Satisfactory – minor issues only
 A Requires improvement
 R Significant improvement required

Indicator definition and process

Definition: “Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust.”

The readmission rate can indicate early complications after discharge and how appropriate the original decision made to discharge was. Some readmissions are to be expected from planned care pathways. [There is a challenge for many trusts in preparing this data due to historic differing demands for 28 day and 30 day reporting by different organisations.]



28 day emergency re-admissions

Our testing has not identified any significant issues

Approach

- We met with the Trust's informatics lead for emergency readmissions to understand the process of a patient being readmitted to the result being included in the Quality Report.
- The interview focused on understanding the processes involved. We discussed with management whether there were any periods during the year or divisions within the Trust representing a greater risk that we should focus sample testing on and no areas were identified.
- We selected a sample of 25 from 1 April 2013 to 31 January 2014 (this was the fullest period of data available at the time that testing took place).
- The sample included those re-admitted both within and outside 28 days and a number of non-emergency admissions. During our work we found no errors.

Findings

Interviews

- Findings:
 - There is an established process in place for data collection, patient data is entered onto Lorenzo by ward clerks. The data from Lorenzo is imported into SQL on a daily basis. Data is extracted from the Trust's system via automated queries and in line with national definitions for the indicator. Inpatient data for the most recent month is uploaded into a SQL table and the automated process is run to identify readmissions. This data is reported to CQMG and included within Quality Accounts quarterly update also.
 - Ward clerk support managers perform a monthly audit of a sample of pathways to assure data quality.
 - All ward clerks must complete 2 days of mandatory induction training on Lorenzo.
- Issues: Not applicable.

Testing

- Findings:
 - No errors were identified within the sample testing undertaken as outlined below:
 - Date of Admission: 0 (0%)
 - Date of Discharge: 0 (0%)
 - Date of Readmission: 0 (0%)
 - Type of Readmission: 0 (0%)
 - Number of Days from Discharge: 0 (0%)
- Issues: Not applicable.

Recalculation

- Findings:
 - Re-calculation of the performance indicator identified 5,349 cases where a patient was re-admitted within 28 days from a total of 50,510 completed episodes, resulting in a rate of 10.68%. This reconciles with the figures reported in the annual quality report.
- Issues: Not applicable

Local indicator: Observations and pain assessments

Our testing has not identified any significant issues

	Trust reported performance	Target	Overall evaluation of our work
2014/15 Observations	71%	No target	G
2014/15 Pain assessments	50%	No target	

G No issues noted
 B Satisfactory – minor issues only
 A Requires improvement
 R Significant improvement required

Indicator definition and process

Definition:

- The percentage of patients who have had a complete set (in a single set to generate a sews score) of observations (includes; Heart Rate, Blood Pressure, Respiratory, O2 SATS, Temperature, AVPU) within 6 hours of admission to ward.
 - Numerator: The number of patients who received a complete set of observations within 6 hours of admission to ward.
 - Denominator: The total number of admitted patients.
- Every pain assessment with a score of 3 requires a timely response of administration of analgesia. Pain relief should be administered within 30 minutes of the assessment, unless pain relief was provided 60 minutes before.
 - Numerator: The number of patients with a pain assessment score of 3 administered analgesia within 30 minutes of the assessment, unless pain relief was provided 60 minutes before.
 - Denominator: The total number of patients with a pain assessment of 3.
- The Trust has not identified a target performance for this indicator for the year ending 2014/15.

Local indicator: Observations and pain assessments

Our testing has not identified any significant issues

Approach

- We met with the Head of Quality Development to understand the process from the patient's admission to a ward through to the reporting of performance against the indicators.
- Walk through of the key systems (PICS) were undertaken to understand how information is captured and reported.
- We selected a sample of 25 records for testing for each indicator. The samples were selected to ensure a spread of cases from across the year. (see Findings section below for further explanation).

Findings

Interviews

- Findings:
 - The performance calculations for these indicators are managed by the Informatics team. Upon month end, the team runs a report to identify the number of patients who have had observations completed and the number of patients who have received pain relief following a pain score of 3.
 - Clinical staff are required to undertake patient observations as part of ongoing patient monitoring. Upon admission or following a ward transfer, a set of observations is carried out by an appropriate clinician. The observations are carried out directly on the PICS system. When completing the observations, the clinician also records the time at which the observations are commenced.
 - When completing pain assessments the clinician asks the patient to determine their pain score on a scale of 0-3. The clinician undertaking the assessment records the response directly onto the PICS system. Where a patient states a pain score of 3, the clinician then arranges for pain relief to be administered. In doing so, the clinician also looks to check if the patient has been provided with pain relief up to 60 minutes prior to the pain assessment being undertaken. Pain relief is provided and the information is recorded within the prescribing section of the PICS system.
- Issues: Not applicable

Local indicator: Observations and pain assessments

Our testing has not identified any significant issues

Testing

- We requested a data extract from the Trust detailing all ward admissions from 1st April 2014 to 31st March 2015.
- We selected a sample of 25 records for each of the indicators. The samples were selected to ensure a spread of cases from across the year. The first sample was biased to include a number of cases where pain relief had not been administered within the timeframe. The second sample included patients where a complete set of observations had and had not been completed within the 6 hour timeframe.
- Findings:
 - There was 1 issue identified within the sample testing undertaken with regard to the observations indicator as outlined below:
 - Spell start: 0 (0%)
 - Observations time: 0 (0%)
 - Pain assessment time: 0 (0%)
 - All required checks completed within timeframe: 1 (4.0%)
 - There were 2 errors identified within the sample testing undertaken with regard to the pain relief indicator as outlined below:
 - Spell start: 0 (0%)
 - Pain assessment time: 0 (0%)
 - Pain score: 0 (0%)
 - Time of drug administration: 1 (4.0%)
 - Breach testing: 1 (4.0%)
- Issues:
 - 1 issue was identified in relation to the observations indicator where the Trust had not recorded an AVPU check as complete and observations were recorded as incomplete. During testing evidence was identified of a completed AVPU check, which had not been picked up by the Trust's systems because it was recorded on PAS 1 minute before the patient was admitted onto the ward. **Recommendation 7: Consider processes to pick up checks before ward admission.**
 - 2 errors was identified in relation to the pain relief indicator. The Trust had not recorded pain relief as administered. During testing we identified the patient had been administered pain relief and the analgesia drugs list was in need of updating. This resulted in a further error in our breach testing. **Recommendation 8: Update the analgesia drugs list.**

Deloitte View:

The identification of two errors with respect to the appropriate analgesia not appearing on the drugs list has given rise to a blue rating for 'validity'.

The overall rating assigned to this indicator is green.

Local indicator: Observations and pain assessments

Our testing has not identified any significant issues

Recalculation

- Findings:
 - Re-calculation of the observations indicator identified 58,008 cases where a patient received a complete set of observations within 6 hours from a total of 81,897 eligible ward admissions, resulting in a rate of 70.8%. This reconciles with the figures reported in the annual quality report.
 - Re-calculation of the pain assessment indicator identified 4,942 cases where a patient received analgesic within 30 minutes after a pain assessment of 3 or 60 minutes prior to the pain assessment, from a total of 9,830 patients with a pain score of 3. This resulted in a rate of 50.2%. This reconciles with the figure reported in the annual quality report.
- Issues: Not applicable

Recommendations

Recommendations for improvement

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

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
<p>18 week referral-to-treatment</p>	<p>1) Unknown clock start dates</p> <p>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.</p>	<p>The refreshed Trust Access Policy includes clear guidance on unknown clock starts. The Policy will be shared with commissioners by the Executive Director of Partnerships.</p> <p>Responsible Officer: Head of Operational Performance, Executive Director of Partnerships</p> <p>Timeline: 31 July 2015</p> <p>Process for updating Council of Governors:</p> <p>A progress report will be provided to the Council of Governors in July 2015 and future meetings as required.</p>	<p>Medium</p>
<p>18 week referral-to-treatment</p>	<p>2) Formalise local agreements</p> <p>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.</p>	<p>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 example given within the audit regarding MRI referrals to neurosurgery will be formally agreed.</p> <p>Responsible Officer: Executive Director of Partnerships</p> <p>Timeline: 31 July 2015</p> <p>Process for updating Council of Governors:</p> <p>A progress report will be provided to the Council of Governors in July 2015 and future meetings as required.</p>	<p>Medium</p>

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	<p>3) Staff training – Data entry</p> <p>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.</p>	<p>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.</p> <p>In addition the new Patient Administration System, scheduled for implementation at the end of 2015, will recognise the patient's current pathway and only display relevant status options linked to the current status. This is expected to reduce validation burden.</p> <p>Responsible Officer: Chief Operating Officer</p> <p>Timeline: Completion of RTT refresher training by 30 June 2015, Implementation of PAS from December 2015</p> <p>Process for updating Council of Governors:</p> <p>A progress report will be provided to the Council of Governors in July 2015 and future meetings as required.</p>	High
18 week referral-to-treatment	<p>4) Investigate automated clock starts and stops</p> <p>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.</p>	<p>A weekly report will be available within the RTT dashboard which will allow analysis of automated clock starts and stops in each specialty down to patient level. The validation team will sample audit automated clock starts and stops, reporting to the Director of Performance. Oversight will be provided via the existing weekly RTT Assurance Meeting.</p> <p>Responsible Officer: Head of Operational Performance</p> <p>Timeline: 31 July 2015</p> <p>Process for updating Council of Governors:</p> <p>A progress report will be provided to the Council of Governors in July 2015 and future meetings as required.</p>	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	<p>5) Staff training – validation</p> <p>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.</p>	<p>Specific, tailored training will be provided to the validation team in addition to the 18 week RTT refresher training that has already commenced. The scheduled RTT audits will indicate any ongoing training needs for this group of staff.</p> <p>Responsible Officer: Head of Operational Performance</p> <p>Timeline: 30 June 2015</p> <p>Process for updating Council of Governors:</p> <p>A progress report will be provided to the Council of Governors in July 2015 and future meetings as required.</p>	High
18 week referral-to-treatment	<p>6) Sample audit</p> <p>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.</p>	<p>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.</p> <p>Responsible Officer: Head of Operational Performance</p> <p>Timeline: Audit of 800 pathways in December each year. Smaller sample audit each July.</p> <p>Process for updating Council of Governors:</p> <p>A progress report will be provided to the Council of Governors in July 2015 and future meetings as required.</p>	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)
Pain and observations	<p>7) Consider processes to pick up checks before admission</p> <p>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.</p>	<p>The Trust will review the methodology with the Informatics team, the Executive Medical Director and Executive Chief Nurse to decide if it can and should be changed.</p> <p>Responsible Officer: Head of Quality Development</p> <p>Timeline: 31 July 2015</p> <p>Process for updating Council of Governors:</p> <p>A progress report will be provided to the Council of Governors in July 2015 and future meetings as required.</p>	Low
Pain and observations	<p>8) Update the analgesia drugs list</p> <p>The Trust should updated the analgesia drug list to include all pain relief.</p>	<p>The Trust have 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.</p> <p>Responsible Officer: Head of Quality Development</p> <p>Timeline: Completed 30 April 2015</p> <p>Process for updating Council of Governors:</p> <p>A progress report will be provided to the Council of Governors in July 2015 and future meetings as required.</p>	Medium

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Deloitte Recommendation	Current year status
CT turnaround times	<p>Indicator definitions</p> <p>The Trust should consider whether in light of operational delivery at weekends and in the interests of simplifying calculation, the indicator should be redefined as 7 days rather than 5 working days.</p> <p>Responsible Officer: Paul Brettle/ Jessica Richardson</p> <p>Timeline: June 2014</p>	<p>Complete:</p> <p>The methodology for this indicator and the indicator title have been changed from 5 working days to 7 days to reflect how the Imaging service is now delivered.</p>
CT turnaround times	<p>Identification of cases for exclusion from performance calculation</p> <p>The Trust should consider introducing additional filters/criteria into the data extraction methodology that would help ensure that cases allocated to an incorrect folder would be identified.</p> <p>Responsible Officer: Paul Brettle/ Jessica Richardson</p> <p>Timeline: June 2014</p>	<p>Complete:</p> <p>During indicator testing it was identified that one Imaging (CT) report included within the dataset was an imported one. Imported reports should not be included as they relate to exams performed elsewhere and are generally imported just to complete the full patient history.</p> <p>Imported studies were already excluded based on the room type where the scans took place. An additional exclusion has now been applied to ensure any imported scans are also excluded based on the referrer field too.</p>

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 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

26 May 2015

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 our engagement letter dated 12 February 2014, only on the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Appendix

Data Quality

For evaluating the findings from our testing

Indicator definition and process

The volume and importance of non-financial performance information across the NHS has grown significantly in recent years. Performance reporting has emerged as a key tool used both internally and externally. Managers use information to monitor performance, regulators use it to gauge risk, commissioners use it to ensure their priorities are met, and governors, patients and the public use it to gain more information about their trust and to hold them to account.

Whilst the availability and use of non-financial performance information has developed quickly, the control frameworks used to produce and control such information has not been subject to the same level of rigour as that of financial information. On average a trust will receive information on 61 performance indicators on a monthly basis, but very few will be subject to independent review. This can result in a potential assurance gap.

In the table below we have prepared a summary of key considerations that each trust should be able to answer regarding their performance information. It can be used as an assurance tool to gauge the risk around accuracy and completeness of performance information.

Area	Overview	Key considerations
System	The accuracy of an indicator is influenced by the level of automated vs manual controls. In general, an automated system requiring minimal manual adjustment has a lower risk of error. However, this assumes that the system controls are operating as they are intended.	<ul style="list-style-type: none"> Is the indicator generated from one system or the interaction of different systems? How often are system controls reviewed to ensure they are appropriate and meet indicator definitions? How quickly is data produced after the event? Does data require manual adjustment prior to being reported as a performance indicator?
Governance	Accuracy and completeness of indicators are influenced by the 'tone at the top'. Good performance would mean clarity of responsibility for performance metrics, clear processes and procedures in place for each metric which are regularly updated, and quick and comprehensive action where concerns have been raised.	<ul style="list-style-type: none"> Who is responsible for the quality and completeness of performance information at Board level? If different individuals are responsible for different indicators, is it clear who is responsible for each? Are there documented procedures and processes for each indicator and is this regularly updated? If data quality concerns have been raised have they been addressed quickly and comprehensively?
Inputs	Some performance indicators rely on a wide variety of sources to produce the end metric. In general, the greater the number of separate sources of information, and the higher the volume of data, the greater the likelihood of error.	<ul style="list-style-type: none"> What is the volume of inputs of each indicator on a daily / weekly / monthly basis? How many different sources of data are there, and how do you know they all apply consistently? methodology in collecting and reporting the data? What checks are in place to ensure the consistency and completeness of input data?
Complexity and skill	Some indicators require specific skills to identify, analyse and report performance. Some indicators have complex rules, which requires specialist consideration. If the complexity of these rules is not understood and applied correctly, there is a risk that indicators contain errors or are reporting incomplete information.	<ul style="list-style-type: none"> If performance indicators have specific rules, is there regular training to ensure that all individuals involved understand these rules and apply them correctly? Does the Trust have its own assurance systems in place to test compliance with such rules? Has the Trust got the appropriate skill and level of resources to identify, analyse and report performance for complex indicators? If national guidance is not clear, does the Trust have local guidance regarding process and procedures and is this shared with appropriate individuals?

Data Quality Responsibilities

The new False or Misleading Information offence applies to this year's Quality Accounts.

New legal responsibilities over data quality

From 1 April 2015, health providers are subject to the False or Misleading Information ("FOMI") offence, introduced in response to issues over data quality in the NHS. The FOMI offence applies to:

- specified information which trusts already report regularly to the Health and Social Care Information Centre; and
- the contents of the Quality Accounts.

The FOMI offence is a two stage offence:

- firstly, a NHS or private sector provider organisation is guilty of the offence if it provides information that is false or misleading whether intentionally or through negligence i.e. this is a strict liability offence where intent is not relevant to the offence being committed.
- secondly, if a provider has committed an offence, it is possible that a director or other senior manager or other individual playing such a role may be personally guilty of an equivalent of the FOMI offence as well.

The potential penalties for providers include fines, a requirement to take specific action to remedy failures in data reporting, or to publicise that the offences have been committed and corrected data. For an individual, penalties can be an unlimited fine or up to 2 years in jail.

Providers and individuals are able to make a defence that they reported information having taken "took all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information" – however it is currently unclear what would be interpreted as "reasonable" in this context. In practice, there is likely to be significant discretion exercised in determining whether to mount a prosecution.

Deloitte view

Over the course of the year, we have updated the Trust on the potential implications of the offence and have discussed with management the findings from our Quality Accounts work in the context of the offence. We have recommended additional wording that has been included in the Quality Accounts to make clear the inherent limitations of recording and reporting some metrics, which the Trust has included in order to present reported data in the appropriate context.

The scope of the FOMI offence is wide ranging, and covers many more indicators and data sets than are considered in our Quality Accounts data testing of three indicators, or than Internal Audit are able to cover in their data work each year. In order to be able to demonstrate across all reported metrics that they have taken "all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information", providers are ultimately reliant upon the quality of their systems for data recording and information reporting.

However, accurately reported data is not just a compliance requirement – it is perquisite for creating an insight driven organisation. A lack of accurate, complete and timely data can increase operational and financial risk. Failure to govern and use data effectively can lead to poor patient experiences and reputational damage. Data issues can also undermine a Trust's ability to run an efficient service, as key information that should influence decision making is not available or accurate.

To support boards in considering their use of data, our latest NHS Briefing on Data Quality highlights areas of good practice for Trusts to consider in improving how they govern and use data. Key questions for Trust boards to consider include:

- Is there a risk that your reported data is not accurate or that you are making decisions on unreliable data?
- What sources of assurance has the Board sought around the quality of data? Do you place too much reliance on the mandatory external data governance reviews to assure data quality?
- Is there an opportunity to improve patient outcomes, patient experience, operational efficiency and financial performance of your Trust by using data in a more sophisticated way?
- Has your Trust adequately identified the costs and benefits associated with a data governance effort?
- Does your Trust have in place a system of Data Governance designed to address data quality concerns and enable more effective data usage?
- Is your data governance effort owned at a sufficiently senior level and is the Board aware of data governance issues and concerns?
- Has your Trust set out its analytics and information vision and strategy?
- Is your analytics and information strategy aligned to other Trust strategies?
- Does your Trust have the analytics capacity, capability and technology to exploit its data assets effectively?

Events and Publications

Our events and publications to support the Trust.

Deloitte UK Centre for Health Solutions

The Deloitte Centre for Health Solutions generates insights and thought leadership based on the key trends, challenges and opportunities within the healthcare and life sciences industry. Working closely with other centres in the Deloitte network, including our US centre in Washington, our team of researchers develop ideas, innovations and insights that encourage collaboration across the health value chain, connecting the public and private sectors; health providers and purchasers; and consumers and suppliers.

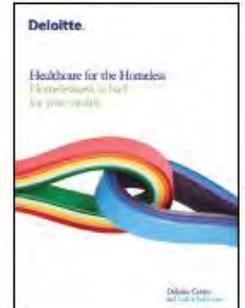
Recent reports include:

- Connected Health;
- Healthcare and Life Science Predictions 2020;
- Better care for frail older people;
- Guideposts Dementia Information Prescription, in partnership with the Guideposts Trust; and
- Working differently to provide early diagnosis.

Upcoming studies include End of Life Care, and the Cost of Compliance

For access to our latest studies and opinion pieces, please sign up to receive our weekly blog at <http://blogs.deloitte.co.uk/health/> or email centreforhealthsolutions@deloitte.co.uk:

Deloitte Centre
for Health Solutions



NHS Briefings and publications for the Trust



We provide the Trust through the year with publications and access to webinars and information on accounting requirements, including our “Stay Tuned Online” accounting update sessions.

We regularly publish NHS Briefings designed to disseminate our insights on topical issues within the NHS in general, and Foundation Trusts in particular. They focus on current issues facing the sector and ask questions to help readers assess if the issue is being appropriately addressed at their Trust.

Briefings have covered a range of topics including Data Quality, The Dalton Review: Implications for providers, Joined up QIPP, Patient Administration Systems, Effective Boards, the Evolving Role of Governors, Narrative Reporting, Quality Accounts requirements, Human Resources, Mergers & Acquisitions in the NHS, Transforming Community Services, and the challenges of Monitor’s Quality Governance framework.



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