Council of Governors

Date:	7th June 2018
Agenda item:	5
Title:	Report to Governors on the Quality Report 2017/18
Items:	• Enclosed

Deloitte.

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Findings and Recommendations from the 2017/18 NHS Quality Report External Assurance Review

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17 May 2018

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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 still to receive the final signed Quality Report, letter of representation, and gain internal quality clearance for the Quality Report at which point we will issue our final report and opinion to the Governors.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance For Quality Reports for Foundation Trusts 2017/18".
- We anticipate signing an unmodified opinion for inclusion in your 2017/18 Annual Report.

Q3 Governance Risk Rating: Requires Improvement

The Care Quality Commission did not inspected the Trust during the year

	2017/18	2016/17
Length of Quality Report (V1)	67 pages	58 pages
Quality Priorities	4	4
Future year Quality Priorities	4	4

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected 18 Week Referrals to Treatment (RTT) and 4 Hour A&E Waits (A&E) as the publically reported indicators, based on NHS Improvement's specified order of preference – the alternatives were 62 day cancer waiting times and 28 day emergency readmissions.
  - For 2017/18, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected 14 Day Breast Symptomatic.
  - 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 RTT and A&E 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: RTT, A&E and Local Indicator.

Executive Summary (continued)

We have not identified any significant issues from our work.

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 2018 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? (based on V1)	✖
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)?	✓

Performance indicator testing

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of the mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.
From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2017/18".

	18 Week RTT	4 Hour A&E Waits	Local Indicator
Recommendations identified?	✖	✓	✓
Overall Conclusion	G Unmodified Opinion	B Unmodified Opinion	B No opinion required

The six dimensions of data quality:
Accuracy Is data recorded correctly and is it in line with the methodology.
Validity Has the data been produced in compliance with relevant requirements.
Reliability Has data been collected using a stable process in a consistent manner over a period of time.
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.
Completeness Is all relevant information, as specific in the methodology, included in the calculation.

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

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Content and consistency findings

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Content and consistency review findings

The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.

Although our work is based around reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report, based upon the points identified in our NHS Briefing on Quality Accounts.

Key questions	Assessment	Statistics
• Is the length and balance of the content of the report appropriate?	G	Length: 67 Pages (Draft)
• Is there an introduction to the Quality Report that provides context?	G	
• Is there a glossary to the Quality Report?		
• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	G	Patient Safety: 3 Clinical Effectiveness: 4 Patient Experience: 3
• Has the Trust set itself SMART objectives which can be clearly assessed?	G	
• Does the Quality Report clearly present whether there has been improvement on selected priorities?	G	
• Is there appropriate use of graphics to clarify messages?	G	
• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?	B	
• Does the Annual Governance Statement appropriately discuss risks to data quality?	G	
• Is the language used in the Quality Report at an appropriate readability level?	B	

Deloitte view (V1)

Overall, the Quality Account has improved on prior year. Management has reflected comments made last year by stakeholders, as well as implementing our prior year recommendations.

As highlighted in our communication with the Trust, there are a number of areas of the report that require additional information to be included to ensure compliance. We have shared what relevant information is required and will review the final version before providing our opinion.

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Performance and Indicator Testing

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Accident and Emergency 4 hour waiting times

	Trust reported performance	Target	Overall evaluation
2017/18	82.7%	>95%	B
2016/17	83.3%	>95%	A
2015/16	86.9%	>95%	Not tested by Deloitte

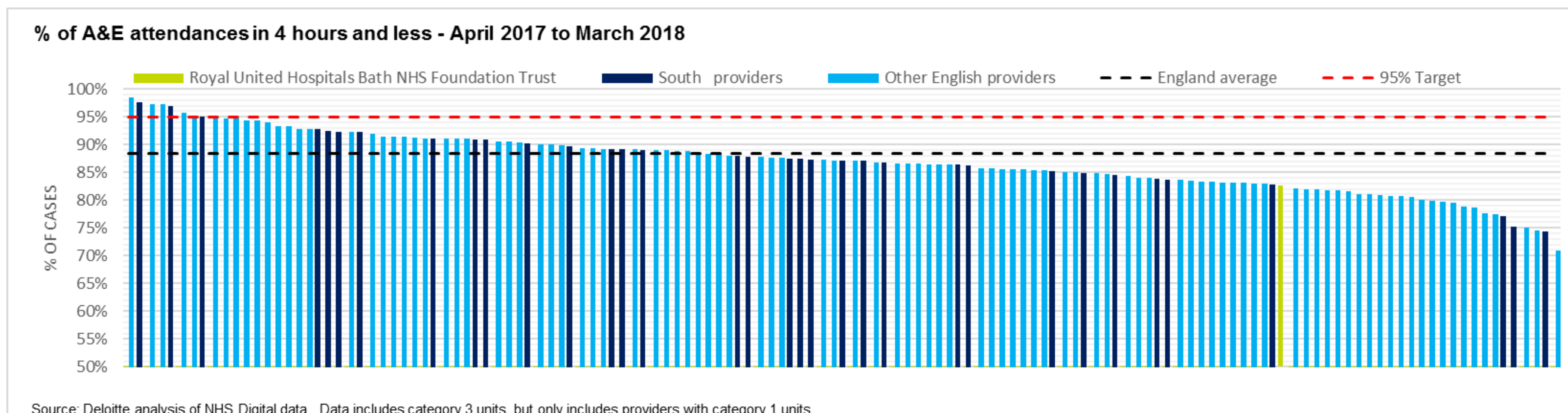
Indicator definition

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.

National context

The chart below shows how the Trust compares to other organisations nationally for 2017/18, the latest national data available.



National context of data quality

NHS Improvement mandated the 4 hour wait times indicator for testing for the first time in 2016/17. Nationally, 28 Foundation Trusts received a qualified report (just under 30% of FTs with any A&E activity). NHSI has not published an overview of findings but common issues relate to system constraints in data recording, retention of audit trails, and record keeping around changes to initial recording.

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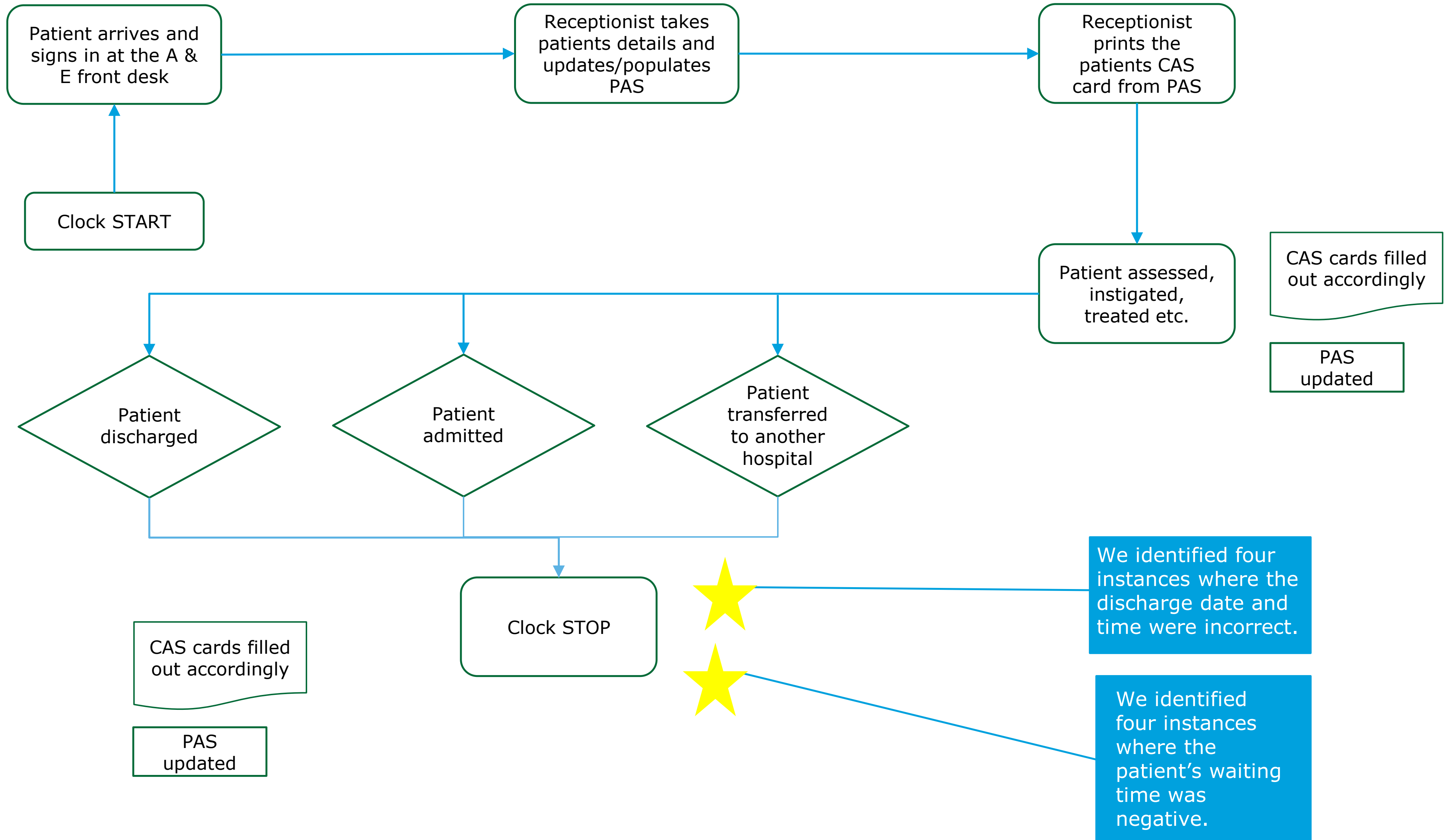
Accident and Emergency 4 hour waiting times (continued)

Process flow



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Accident and Emergency 4 hour waiting times (continued)

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.
- We evaluated the design and implementation of controls through the process. We discussed with management and used analytical procedures to identify whether there were any representing a greater risk that we should focus sample testing on. We used data analytics to review activity, looking for anomalies, and compare the rate to other organisations we audit.
- We selected a sample of 24 from 1 April 2017 to 31 March 2018, following patient records through until treatment.
- During our work we found four errors and therefore extended our sample by a further 12. We also included the four negative waiting times in our extended sample.
- We agreed our sample of 40 to supporting documentation.

Findings

- We identified four instances where the patient's waiting time had been recorded as a negative figure. - Recommendation 1
- We identified four errors in relation to the discharge date and time. - Recommendation 2

Deloitte View:

Our sample testing identified 4 records where the discharge time was incorrectly recorded. Of the four errors identified, 1 resulted in the incorrect reporting of a breach. This has therefore resulted in an blue rating for 'completeness' due to the impact of the breach and non-breach reporting.

In addition, during our review of the entire dataset for the year, we identified four instances where the discharge time was recorded as taking place prior to the arrival time, due to human error. We have reviewed the entire A&E patient dataset for the year, and have comfort that these four instances are isolated.

18 week Referral to Treatment times

	Trust reported performance	Target	Overall evaluation
2017/18	87.8%	>92%	G
2016/17	90.4%	>92%	A
2015/16	95%	>92%	Not Audited by Deloitte

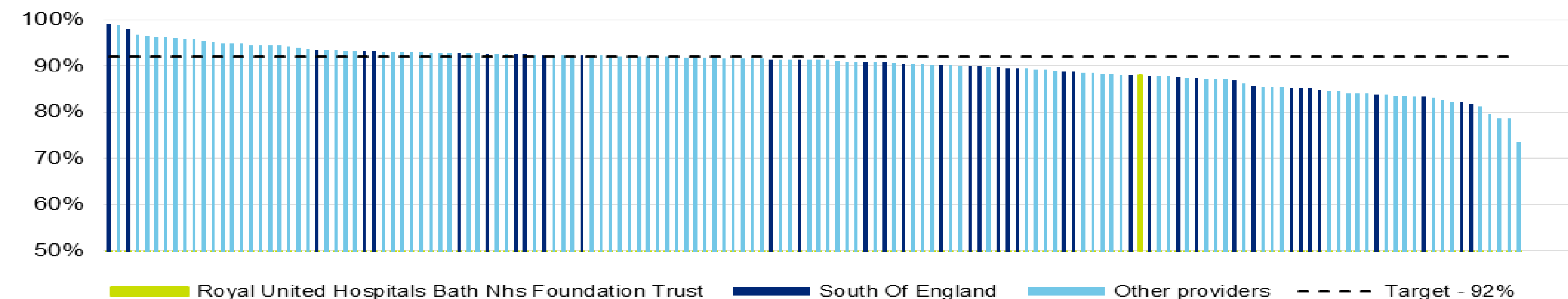
Indicator definition

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.

National context of performance

The chart below shows how the Trust compares to other organisations nationally for the first nine months of 2017/18, the latest national data available.



Source: Deloitte analysis of NHS Digital data

National context of data quality

NHS Improvement mandated the 18 week RTT indicator for testing for the first time in 2015/16. Nationally, only 41% of trusts subject to testing received a clean opinion. NHS Improvement have reviewed auditor reporting on this metric, and noted that of the qualifications, 71% were due to control environment and data testing issues, 10% due to a planned failure to report the metric, 8% as monthly reports were not retained, and 11% due to a combination of issues. Themes identified among the specific causes included clock stops and pauses, clock start dates, data retention, duplicated pathways for the same patient, system issues, and weaknesses in patient referral processes.

The indicator continued to be mandated for 2016/17, with many trusts experiencing continued issues. Although there was some improvement where trusts had opportunities for "quick wins" or addressing data retention type issues, there were still 52 qualifications of Foundation Trust quality reports in 2016/17 compared to 61 in 2015/16.

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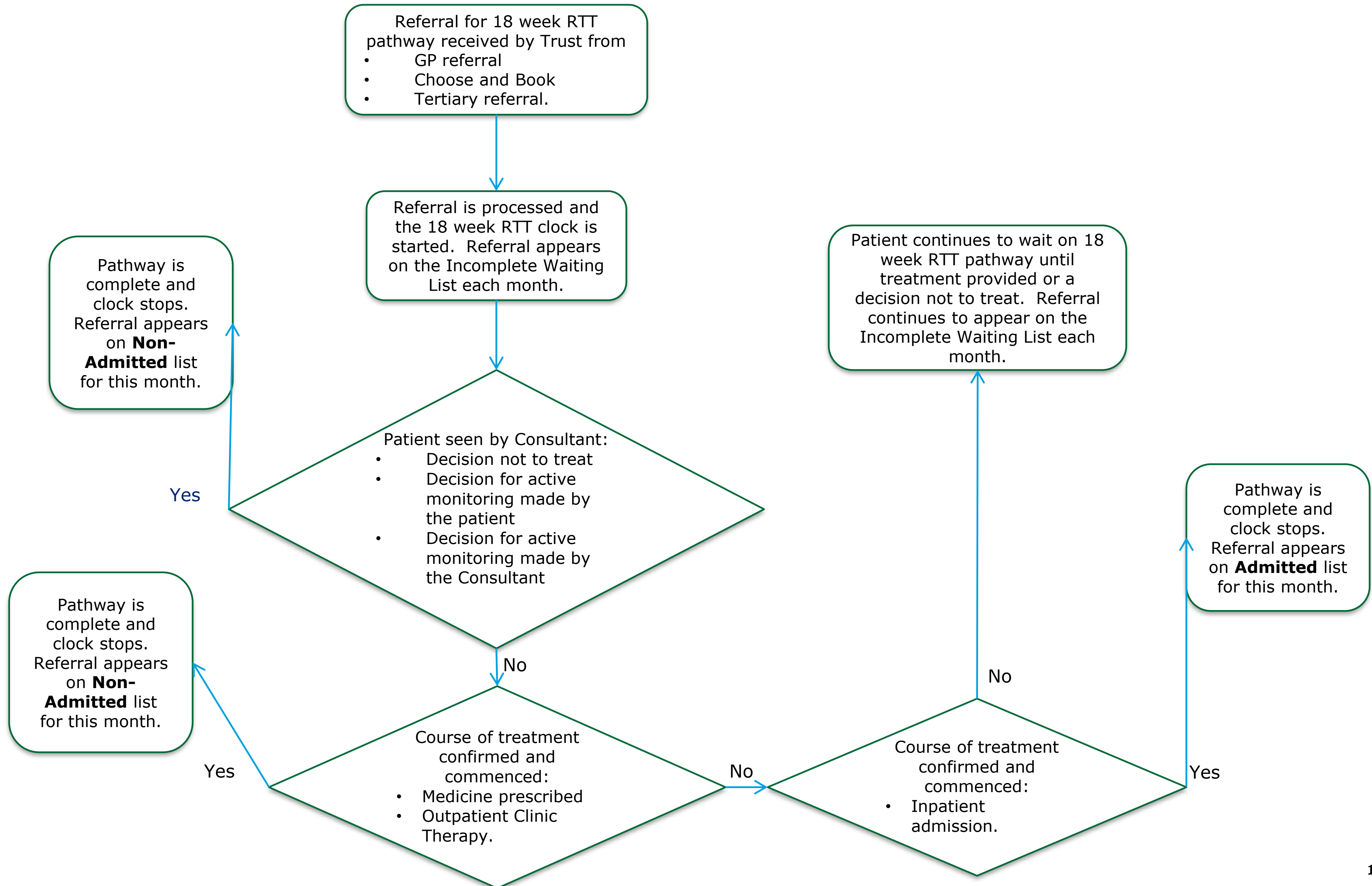
18 week Referral to Treatment times

Process flow



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18 week referral to treatment times

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.
- We evaluated the design and implementation of controls through the process. 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.
- We selected a sample of 24 from 1 April 2017 to 31 March 2018, following patient records through until treatment.
- We agreed our sample of 24 to supporting documentation.

Findings

- We did not identify any issues which would have resulted in us offering recommendations.
- The Trust has achieved performance of 87.8% against a nationally set target of 92%, which reconciles with the performance figure included in the Trust's final Quality Report.

Deloitte View:

The 18 Week RTT pathway underlying data has improved based on the results of our testing, comparing to the prior year where a number of recommendations had been raised.

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14 day breast symptomatic waiting times

	Trust reported performance	Target	Overall evaluation
2017/18	90.5%	93%	B
2016/17	[]	[]	Not Audited By Deloitte
2015/16	[]	[]	Not Audited By Deloitte

Indicator definition

Definition: "Percentage of patients seen within two weeks of an urgent GP symptomatic referral."

Numerator: Patients urgently referred with breast symptomatic by their GP (GMP, GDP or Optometrist) who were first seen within 14 calendar days within the given month/quarter.

Denominator: All patients urgently referred with breast symptomatic by their GP (GMP, GDP or Optometrist) who were first seen within the given month/quarter.

The guidance stipulates:

- The starting point for this period is the receipt of the referral for an appointment in the appropriate breast clinic. Referrals are received either direct from the GP or via Choose and Book.
- That the clock should be stopped when the patient is seen by the first time by a consultant or in a diagnostic clinic.
- If a patient chooses an appointment outside of the two week period or declines an appointment within two weeks they should not be excluded from reporting. The operational standard has been set to take into account patients who may choose not to be seen within two weeks.
- If a patient DNAs an appointment, which would have been recorded as their date first seen if they had attended, the start date now becomes the date they were due to be first seen.

There are two types of referrals – Breast and other. Breast referrals are sent to the breast unit, by GPs via email or fax (majority of 2 week referrals are via fax). The referral is logged on the 'I system', and an appointment is booked for the referee.

Other referrals are sent via email or fax (majority of 2 week referrals are via fax) to the Outpatient appointment centre, where they are printed off, and date stamped. The referral is placed onto the RUHB PAS system (Millenium).

The Trust has software which overnight extracts all patients who are booked under 2 week waits from the data warehouse, and pulls them into the a report. This software calculates the 2 week waits & breaches automatically.

From this information, an email is sent daily to specialty managers listing the breaches for review and action. The Breast Unit team also validates all 14+ day breaches.

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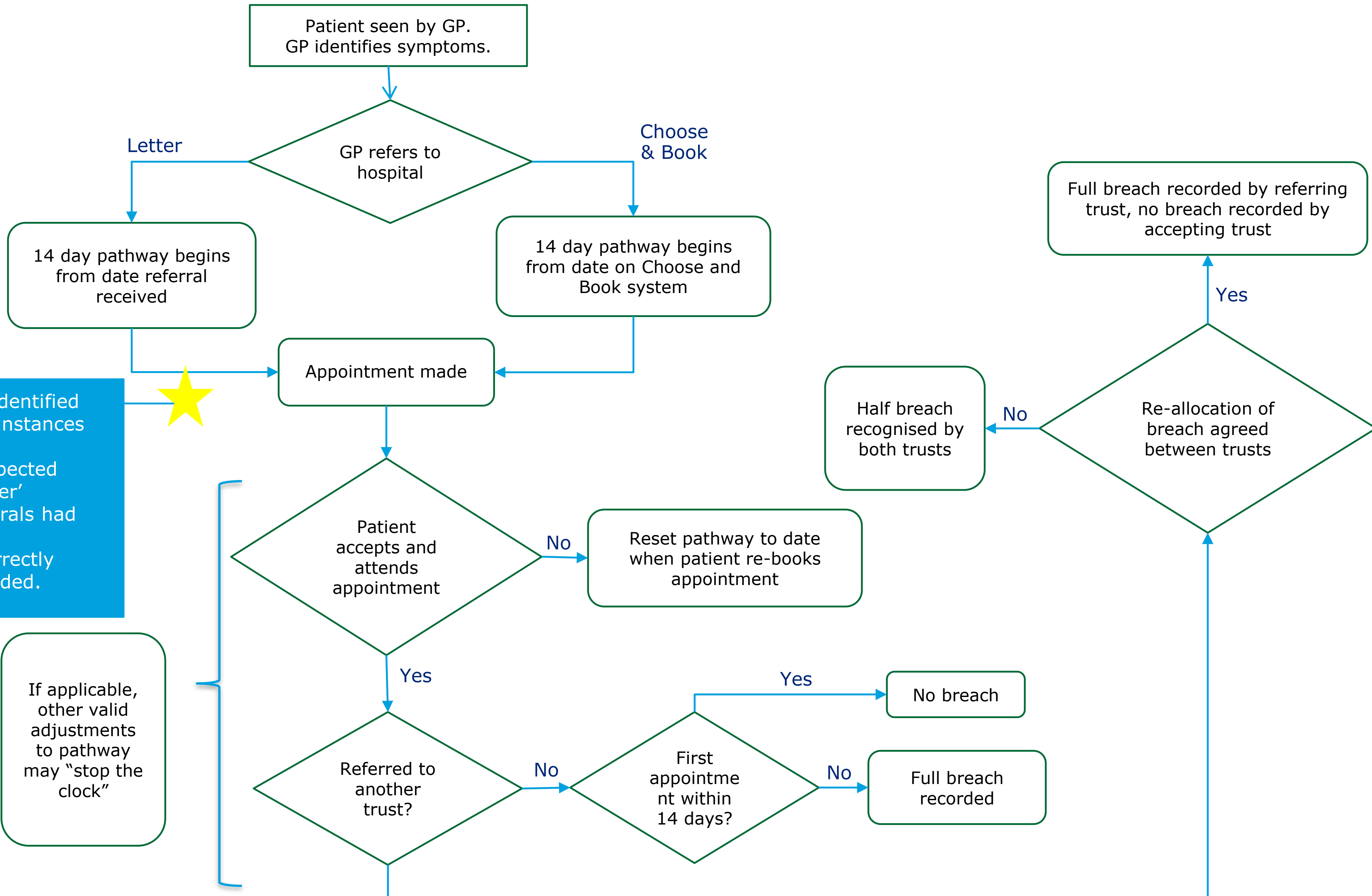
14 day breast symptomatic waiting times (continued)

Process flow



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14 day breast symptomatic waiting times (continued)

Approach

- We met with the Trust’s lead for 14 day cancer waits to understand the process from an urgent referral to the Trust to the result being included in the Quality Report. There were no recommendations from the last year to follow up.
- We evaluated the design and implementation of controls through the process. We discussed with management and used analytical procedures to focus on pathways which appear to be most at risk of error e.g. patients with manual adjustments and pathways close to the 14 day breach date.
- We selected a sample of 24 from 1 April 2017 to 31 March 2018 including in our sample a mixture of cases in breach and not in breach of the target.
- During our work we found three errors and therefore extended our sample by a further 9. We also included the four negative waiting times in our extended sample.
- We agreed our sample of 30 supporting documentation.

Findings

- We identified two instances where ‘Suspected cancer’ referrals have been incorrectly recorded in the dataset - Recommendation 3
- We identified two instances where the pathway start dates had been incorrectly entered. One instance resulted in breaches when the correct start date was considered. The other instance was not a breach due to the patient ‘DNA’ and the clock was reset - Recommendation 3

Deloitte View:

Our sample testing has identified 2 records which related to ‘Suspected cancer’ instead of ‘Breast symptomatic waiting times’. We have raised a recommendation in relation to the coding of cancer referrals. Our sample was therefore extended by 6 items and as a result we subsequently identified an error with the inputting of the start date which impacted the reporting of a breach. This results in us giving the Trust a amber rating for accuracy of data. We have also raised a recommendation in relation to this.

Appendices

Appendix 1: Recommendation for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
4 Hour A&E	**Extension of Spot Audit** The Trust should ensure through validation checks, any negative waiting times are investigated and suitably corrected to ensure their data is reported accurately.	Any negative waiting times will be picked up on validation reports from Business Intelligence Unit and validated by the A&E Department **Responsible Officer:** Head of BIU / Senior Matron Emergency Directorate **Timeline:** June 2018 **Process for updating Council of Governors:** -	M
4 Hour A&E	**Ensuring Accurate Data Input** The Trust should ensure discharge dates and times are input correctly to ensure the correct reporting of breaches and non-breaches.	The A&E management triumvirate will ensure data quality is kept high on the agenda and that staff understand the importance of dates being entered correctly. **Responsible Officer:** Lead Consultant / Specialty Manager / Senior Matron, Emergency Department and Acute Medicine **Timeline:** June 2018 **Process for updating Council of Governors:** -	M
14 Day Breast Symptomatic	**Incorrect Population** The Trust must ensure that only 'Symptomatic' referrals are included in the data set.	The Trust has an existing process where all Breast referrals are triaged / reviewed and will be upgraded to Breast Cancer pathway (more common) or in some cases moved to the Breast Symptomatic pathway (less common) depending on the detail in the referral. The error identified in the audit will be reviewed and learning identified. **Responsible Officer:** Helen Back, Specialty Manager, Women and Children's Division **Timeline:** July 2018 **Process for updating Council of Governors:** -	M

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Appendix 1: Recommendation for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
14 Day Breast Symptomatic	**Accurate Data Input** The Trust must ensure start dates are correctly recorded onto the system helping to ensure breaches and non-breaches are accurately recorded.	Staff will be reminded of the importance of accuracy in data entry. The move to electronic referrals will reduce the opportunity for error on referral date and this process is underway in the Trust. **Responsible Officer:** Helen Back, Specialty Manager, Women and Children's Division **Timeline:** July 2018 **Process for updating Council of Governors:** -	M

Appendix 2: Update on prior year recommendations

Our prior year recommendations have been addressed.

Indicator	Prior year finding	Prior year management response.	Current year status
18 week referral-to-treatment	**1. Inter-Provider Transfers** The Trust should consider reviewing the current policy in place for Inter-Provider Transfers. If it is clear that no treatment has been provided at the originating provider, the clock start details should be chased and recorded as such on the Trust's PAS. Alternatively, the Trust should require all transfers to be accompanied by a completed Inter-Provider Transfer form.	The Trust will review current processes in place for Inter-Provider Transfers and recommend process changes to increase the information available for Inter-Provider transfer patients. **Responsible Officer:** Deputy Divisional Manger, Surgery **Timeline:** September 2017 **Process for updating Council of Governors:** The Council of Governors will be provided an update on the recommendations via the Quarterly Governor Quality Working Group.	We did not identify an issue of this nature during our sample testing.
18 week referral-to-treatment	**2. Staff training – validation** The Trust should consider providing training to the Validation Team on how to correctly stop a clock through an admin event when an outpatient appointment or admission is not the clock stop. The Trust should also consider documenting and communicating a process to the Medical Secretaries and Booking Team to notify the Validation Team when one of these clock stops occurs (for example, the patient phones to decline treatment).	The Validation Team will have refresher training on stopping clocks through an admin event. A review of wider awareness of admin stop processes will be undertaken to consider if the validation team or specialty and booking staff should close these pathways. **Responsible Officer:** Head of Business Intelligence **Timeline:** Validation Team refresher training – June 2017 Review of admin stops – September 2017 **Process for updating Council of Governors:** The Council of Governors will be provided an update on the recommendations via the Quarterly Governor Quality Working Group.	Per discussion with the Head of Business Intelligence: The Validation Team training was completed and the team now apply adhoc stops for the date of the actual admin event rather than e.g. the date of appointment. The Validation Team usually lead on this and other areas such as the Booking Team will note the admin event as "Clock Stop" on the Trust PPM monitoring system and the Validation Team will pick these up and apply the appropriate stop. We did not identify an issue of this nature during our sample testing.

Appendix 2: Update on prior year recommendations

Our prior year recommendations have been addressed.

Indicator	Prior year finding	Deloitte Recommendation	Current year status
18 week referral-to-treatment	**3. Staff training – data entry** The Trust should consider reviewing the training provided to the Booking Team with a particular focus on when an RTT clock should not start and how to close the pathway down correctly if a clock has been started.	The Trust Data Quality Steering Group has recommended a review of RTT training and this recommendation will be included in this review. **Responsible Officer:** Head of Business Intelligence **Timeline:** September 2017 **Process for updating Council of Governors:** The Council of Governors will be provided an update on the recommendations via the Quarterly Governor Quality Working Group.	We did not identify an issue of this nature during our sample testing.
A&E Four Hour waits	**4. Extension of spot check audits** The Trust should extend the current spot check audit to additional activities, including Urgent Care Centre referrals and anomalies in the dataset.	The Trust will extend the current spot checks undertaken by the Emergency Directorate to include the Urgent Care Centre. Business Intelligence Unit validation will add extra tests to find anomalies. **Responsible Officer:** Senior Matron, Emergency Directorate **Timeline:** June 2017 **Process for updating Council of Governors:** The Council of Governors will be provided an update on the recommendations via the Quarterly Governor Quality Working Group.	The Urgent Care Centre was added to validation reports including the daily 4 hour breach validation list. The Urgent Care Centre is now managed by RUH (since May 2018) and will be within routine validation processes, reporting and scrutiny.
Two Week Cancer Waits	**5. Availability of evidence for validation** The Trust should remind staff of the importance of retaining all stamped referral letters within patient notes. In addition, the Trust should consider scanning all referral letters and clinic notes so that they are available on the Electronic Patient Record.	The Trust has a project in place to meet the timeline targets for electronic referrals as set out in the NHS national CQUINs. This will be the main focus on ensuring accurate referral details being held electronically. A paperless outpatient project started in May 2017 following a successful pilot stage. **Responsible Officer:** EPR and Information Governance Manager and Deputy Divisional Manager, Surgery **Timeline:** Project rolling out through specialties in 2017/18 **Process for updating Council of Governors:** The Council of Governors will be provided an update on the recommendations via the Quarterly Governor Quality Working Group.	The Trust is continuing its paperless outpatient project and compliance with the national electronic referrals roll out. This includes cancer services and will result in documentation being retained electronically.

Responsibility statement

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Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties.

What we report

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

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

What we don't report

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

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.
- This report should be read alongside the supplementary "Briefing on audit matters" with this report.

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

Deloitte LLP
Statutory Auditors

Birmingham
17 May 2018

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 2 November 2017, only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

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