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Oxford Health NHS Foundation Trust

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

Contents

Executive Summary

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

Status of our work

- We have completed our review, including validation of the reported indicators. We have still to receive the final signed Quality Report and letter of Representation, at which point we will issue our final report 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 on Quality Reports for Foundation Trusts 2016/17".
- We anticipate signing an unmodified opinion for inclusion in your 2016/17 Annual Report.

The Care Quality Commission inspected the Trust during the year and rated them "good".

	2016/17	2015/16
Length of Quality Report	57 pages	116 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 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital and admissions to inpatient services had access to crisis resolution home treatment teams as its publically reported indicators – the alternative was minimising delayed transfer of care.
  - For 2016/17, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected the total number of incidents reported.
  - 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 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital and admissions to inpatient services had access to crisis resolution home treatment teams 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.

Executive Summary (continued)

We have not identified any significant issues from our work

Content and consistency review

Review content → Document review → Interviews → Form an opinion

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

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

Performance indicator testing

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

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of three mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.
From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17".

Performance indicator testing (continued)

	7 day follow up	Crisis resolution	Incidents reported
Accuracy Is data recorded correctly and is it in line with the methodology.	G	G	G
Validity Has the data been produced in compliance with relevant requirements.	G	G	G
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	G	G	G
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	B	B	B
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	G	G	G
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	B	G	G
Recommendations identified?	✓	✓	✓
Overall Conclusion	Unmodified Opinion	Unmodified Opinion	No opinion required

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

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?		Length: 57 pages
• Is there an introduction to the Quality Report that provides context?		✓
• 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)?		Patient Safety: 1 Clinical Effectiveness: 1 Patient Experience: 1 All: 1
• Has the Trust set itself SMART objectives which can be clearly assessed?		✓
• Does the Quality Report clearly present whether there has been improvement on selected priorities?		✓
• Is there appropriate use of graphics to clarify messages?		✓
• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?		✓
• Does the Annual Governance Statement appropriately discuss risks to data quality?		✓

Deloitte view

Overall, the Quality Account is a clear account of the performance of the Trust in the year.

Particular areas of good practice are:

- Having just four priorities has allowed the Trust to focus their efforts to achieve success in these areas. We would not recommend any further reductions in the number of overall priorities.
- A report of significantly reduced length to previous years which makes the document more accessible to the Trust's stakeholders. We have completed our content check and are satisfied that the required elements remain included.

Care programme approach 7 day follow up

	Trust reported performance	Target	Overall evaluation
2016/17	95.4%	95%	G
2015/16	95.8%	95%	G
2014/15	96.6%	95%	[Not selected]

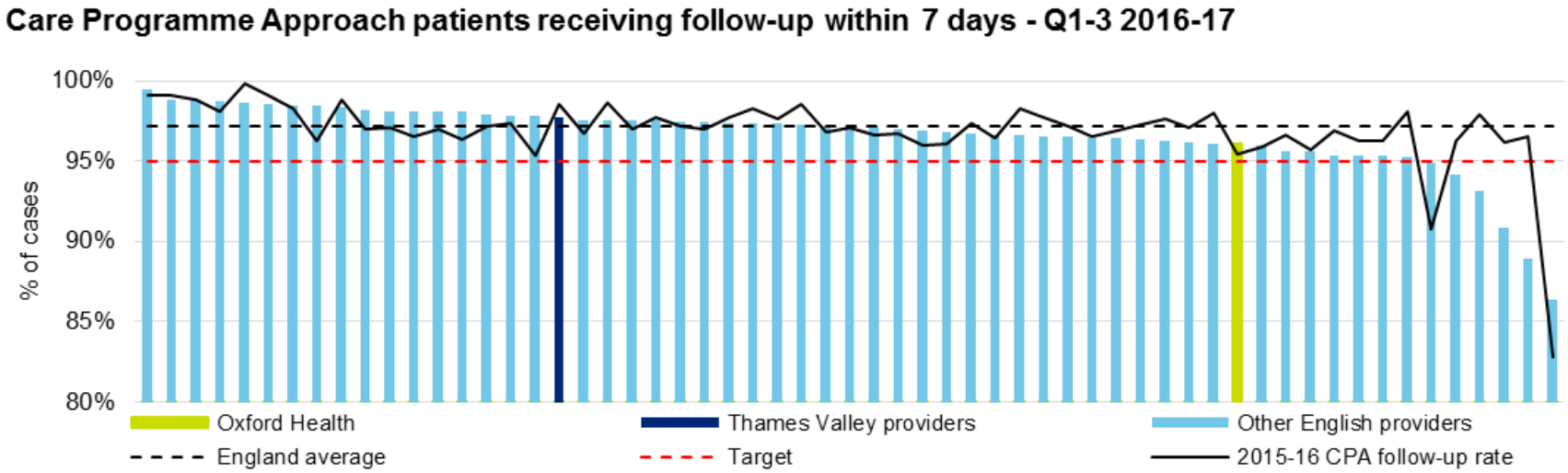
Indicator definition and process

Definition: "The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period."

Patients who are discharged from a mental health in-patient episode on a Care Programme Approach should receive a follow-up contact within seven days of the discharge. Relevant discharges include patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care. All avenues must be exploited to ensure that the patients are followed up within seven days of discharge.

National context

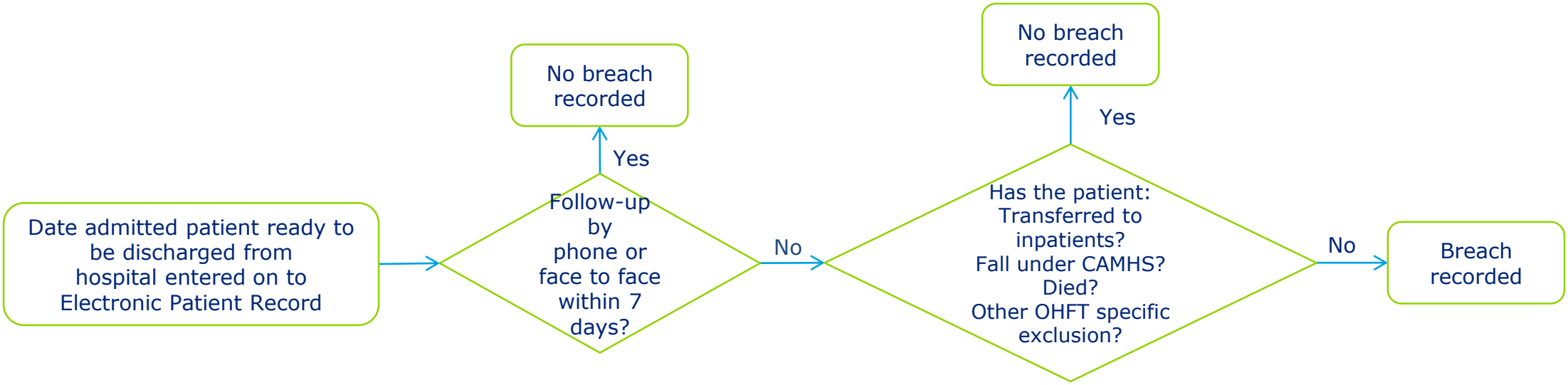
The chart below shows how the Trust compares to other organisations nationally for 2016/17, the latest national data available.



Source: Deloitte analysis of Health and Social Care Information Centre data

Care programme approach 7 day (continued)

Process flow



Care programme approach 7 day follow up (continued)

Approach

- We met with the Trust's leads to understand the process from discharge of a service user to the overall performance 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 2016 to 31 March 2017 including in our sample service users who had and had not been followed up within 7 days.
- We agreed our sample of 24 to the underlying information held within Carenotes.

Findings

- In our testing of 24 samples from the calculation, it was noted in seven instances that the date of follow up was earlier than that recorded per Carenotes. For samples with follow up within the seven days, this has no impact on the calculation. For samples where a breach was initially identified, but patient notes recorded follow up within the seven day period, these samples were appropriately recorded as being valid follow ups. This is consistent with our finding from 2015/16. Although there are no issues identified in the calculation, we recommend stressing the importance to users of Carenotes to record appointments with patients in a timely manner, thus avoiding the requirement for later validation.
- Our completeness testing identified three patients whose case was not included in the data set for the indicator. Two of these patients were valid exclusions so do not have any impact on the reported result (though we note that all other patients with exclusions are included in the report and then excluded appropriately). One patient was missing from the data set who should have been included. The case was a breach but made no difference to the Q1 reported result. The target was still met.
- We noted that in addition to the allowable exclusions per DoH guidance, patients discharged from the eating disorder facility at Cotswold House are not included within the calculation if the CCG contracting the care is outside Oxford and Buckinghamshire. This is consistent with previous years' treatment. Appropriate disclosure is made within the draft quality accounts.

Deloitte View:

The findings from our testing did not have a pervasive impact on the reported indicator which we consider compliant with the guidelines.

Access to crisis resolution home treatment team

	Trust reported performance	Target	Overall evaluation
2016/17	100%	95%	G
2015/16	100%	95%	Not selected
2014/15	99%	95%	

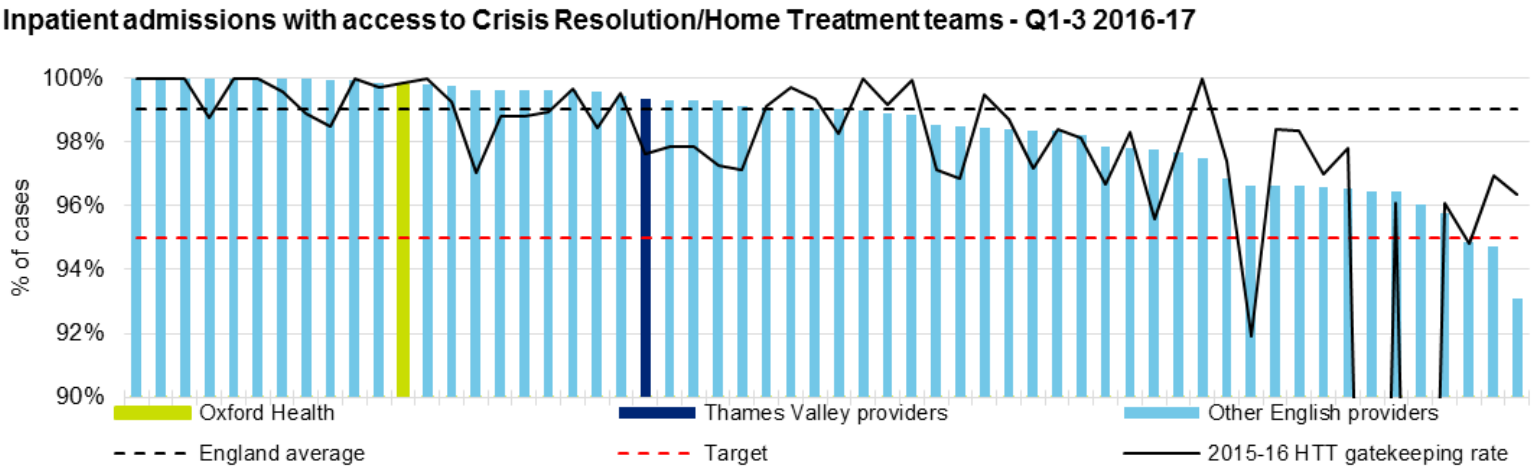
Indicator definition

Definition: "The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams."

Crisis Resolution / Home Treatment Services form part of the drive to ensure inpatient care is used appropriately and only when necessary, with service users being treated in the community setting, where possible. They are to provide a 'gateway' to inpatient care and are deemed to have 'gatekept' an admission if they have assessed the service user before admission and they were involved in the decision making process, which resulted in full admission.

National context

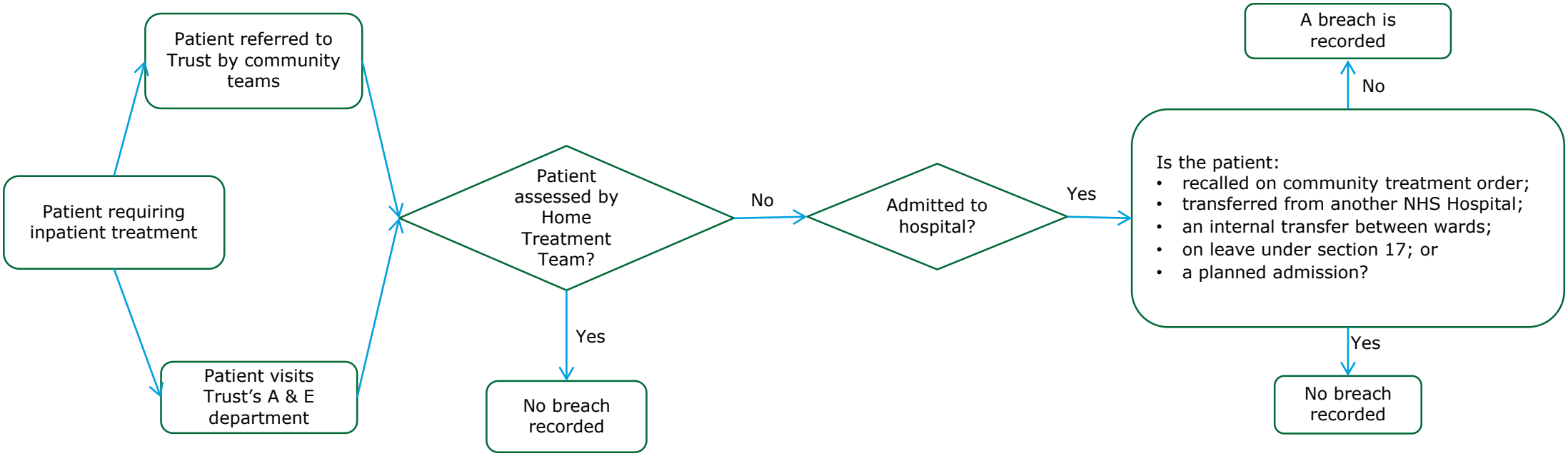
The chart below shows how the Trust compares to other organisations nationally for 2016/17, the latest national data available.



Source: Deloitte analysis of Health and Social Care Information Centre data

Access to crisis resolution home treatment team (continued)

Process flow



Approach

- We met with the Trust's leads to understand the process from identifying that a service user should have access to the crisis resolution team to the overall performance being included in the Quality Report. There were no recommendations from the prior year requiring follow up.
- 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 2016 to 31 March 2017 including both service users assessed by the Home Treatment Team and those who were not assessed. We agreed our sample of 24 to the underlying information held within Carenotes.

Findings

- We note that it is possible for delayed data entry to cause errors in the initial data set both in terms of validity (if an entry is not recorded at the date a report is run) and of timeliness (by data being provided after an event). However, management have implemented a "refreshing process" each month to ensure that any late entries can be captured and the data set can be updated. Whilst ideally, all data would be entered in a timely fashion, the refresh process was found to mitigate the risk of misstatement.

Deloitte View:

The indicator has been found to be reported in line with the guidance. No issues with data quality were identified.

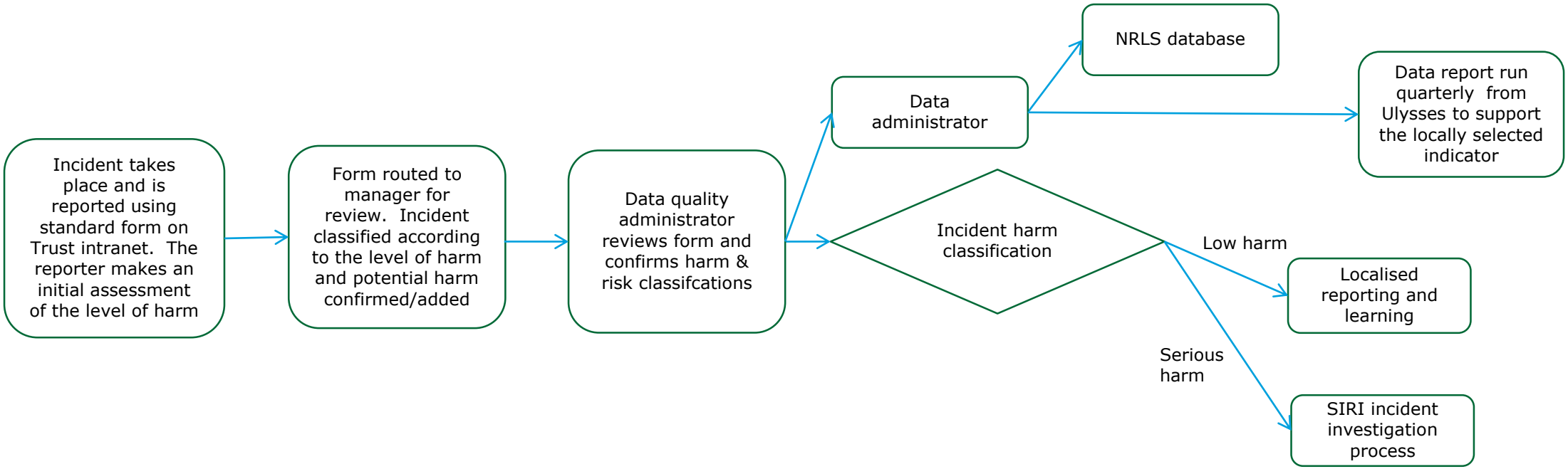
Number of incidents reported

	Trust reported performance
2016/17	13,492
2015/16	Not published
2014/15	Not published

Indicator definition and process

Every incident that occurs is obligatorily reported on the online incident reporting function on the Trust's intranet portal. This is a trust wide indicator for all types of cause groups. For this purpose, an incident is defined as an instance of something happening; an event or occurrence:
The event could be a near miss and could have occurred to patients, staff, visitors or be an event the affects the ability of the trust to provide a safe service such as a broken item of equipment in use, dangerous floor, inadequate staffing or delays in delivery of goods or services. It is important that patient safety incidents that could have or did harm a patient receiving NHS funded care are reported so they can be learnt from and any necessary action can be taken to prevent similar incidents from occurring in the future.

Process flow



Local Indicator (continued)

Approach

- We met with the Trust's leads to understand the process from an incident occurring to it being included in the Quality Report. There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 24 from 1 April 2016 to 31 March 2017. During our work we found no errors in the date reported or in the classification given. We selected a further 12 incidents classified as having caused severe harm or death and reviewed the Ulysses report to gain assurance that the classification was appropriate.
- We have reviewed board minutes and considered our wide knowledge of the Trust and have not become aware of any incidents not included in the listing which would indicate that the population was not complete.

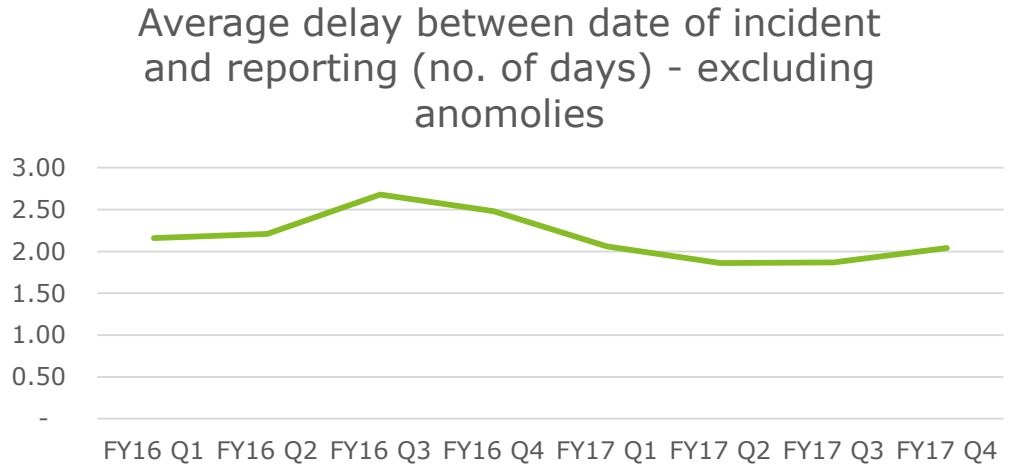
Findings

- The definition of the indicator is "incidents reported" in the year, therefore, by definition the timeliness of the report does not change the validity of the outcome, however, we believe that from management's perspective, this is an important measure of the quality of the data. Therefore we have completed some analysis of the timeliness of reporting as set out below.

Timeliness of incident reporting

- The table below shows the source of delayed reports by Trust department
- The graph excludes a small number of incidents with reporting delays of greater than 365 days as these are considered likely to be data errors as opposed to genuine delays in reporting. For the remaining population, the average delay in reporting is shown.

Department	# incidents reported > 7 days delay	% incidents with > 7 days delay
Oxon Community Eating Disorder Community	11	55%
CMHT North Bucks	12	44%
CMHT South Bucks	17	31%
Pharmacy Kennington	11	28%
DNNE Gosford Hill Medical Centre	12	18%
AMHT Oxon North And West	14	17%
DNSW Wallingford Medical Centre	12	14%
DNN Horse Fair Surgery & Woodlands	12	13%
AMHT Bucks Aylesbury Team	11	13%
AMHT Oxon City And NE	19	10%
DNSE Goring & Woodcote	10	10%
Vaugham Thomas Ward	17	6%
CAMHS Marlborough House	13	3%



Deloitte View:

Based on the limited assurance procedures performed, nothing has come to our attention to cause us to believe that the indicator has not been reasonably stated.

Recommendations for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
7 day follow up	**Completeness testing** We recommend that the Trust investigate the background to a patient being erroneously left out of the data set for the indicator to ensure that no similar omissions occur again. We recommend that the Trust performs its own completeness test on a quarterly basis to satisfy itself that its published data is complete.	Response: as part of the monthly validation process the Performance & Information team identify where contacts have not been recorded to reflect clinical notes detailing follow up. These are shared with clinical services to address as appropriate and areas of concern escalated to Directorates. Please note that there will always remain a cohort of patients where the contact is made by in-patient staff who do not record contacts in the clinical info system. **Process for updating Council of Governors:** Continue to report performance and any exceptions against the national KPI in monthly performance report presented to the trust board.	M
7 day follow up Crisis resolution	**Accurate recording of follow up directly to Carenotes** We recommend communication with staff to stress the importance of recording appointments with patients directly to Carenotes to ensure accurate reports	Response: staff have the ability to enter information to record appointments correctly and have been provided with SOPs. Actions and adherence to this sits with Operations and the Performance & Information support this with the provision of data quality reports. **Process for updating Council of Governors:** Continue to report performance and any exceptions against the national KPI in monthly performance report presented to the trust board.	M

Recommendations for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
Incident reporting	**Delays in recording incidents** There are significant delays in reporting incidents in some departments. We recommend the Trust liaise with these teams to understand the reasons behind reporting delays and seek to improve the timeliness of incident data.	Response: the average number of days between incident date and date detected/ reported can be skewed by a few incidents which we only discover long after the fact, a historic allegation of sexual abuse is one example from the previous year. Actions; Add review of date of incident to routine data quality checks for every incident, as some inaccuracies were identified. Lead Charlotte Forder, Information Analyst in the Quality and Risk Team. Timescale from 01/06/17 to add check around date of incident. Review and amend the Serious Incident Policy which includes standards/ internal timelines for reporting all incidents to ensure this is still fit for purpose. Lead Jane Kershaw, Head of Quality Governance. Timescale to revise policy ready for sign off by 30/07/17 Project being led by the operations management team to improve the timeliness managers review and close incidents held in web holding. Lead Liz Williams, Programme Director Learning Disabilities Transition. Timescale –complete review and identify actions by 31/08/17. Revise training package for incident entry and management and re-emphasise the importance of reporting all incidents as soon after they occur or are detected. Lead Paul Butler, Patient Safety Lead . Timescale 30/07/17 **Process for updating Council of Governors:** Report on progress with actions in the quarterly safety report presented to the trust board.	M

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Prior year recommendation	Planned response	Current year status
Seven day follow up	**Accurate recording of follow up directly to Carenotes** We recommend communication with staff to stress the importance of recording appointments with patients directly to Carenotes to ensure accurate reports.	Will be actioned as part of review of Carenotes user training and communications and as part of the wider Carenotes Programme. **Responsible Officer:** MM/RA **Timeline:** on-going **Process for updating Council of Governors:** TBC	We note that this finding has recurred in this year's audit. Management update requested on 5 May 2017, not yet received.
Delayed transfer of care/Seven day follow up	**Improve reliability of Carenotes reports generated** We recommend: • increased validation of reports generated by Carenotes to identify source of the issues and develop action plan to prevent repetition of issues; • increased communication to users of Carenotes to appropriately record movement and activities of patients and other common pitfalls; • further training for users; • prevent multiple episodes to be opened simultaneously; • embed prompts within system as reminders for best practice and prevention of common pitfalls	The Programme Board for the implementation of Carenotes continues to oversee the actions necessary to ensure Carenotes meets the original specifications. Actions are being implemented to address all of the recommendations made but have to be considered as an integral part of improving the overall system. As an interim measure, the processing of bed management data, admissions, discharges and transfers will be carried out by a central team to ensure system data accuracy which in turn will ensure reporting accuracy. **Responsible Officer:** MM **Timeline:** on-going **Process for updating Council of Governors:** TBC	Management update requested on 5 May 2017, not yet received.

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Prior year recommendation	Planned response	Management update
Delayed transfer of care	**Review of calculation prior to reporting to board or monitor** We recommend a review of the working paper required for the calculation of the indicator prior to reporting to board and monitor	Agreed, an arms length review prior to report submission will be implemented. **Responsible Officer:** MM **Timeline:** July 2016 **Process for updating Council of Governors:** TBC	Management update requested on 5 May 2017, not yet received.
Reducing serious incident pressure damage	**Implementation of review** • Present indicator calculation with a clear audit trail to allow for effective review: include additional data to allow reviewer to re-perform calculation.	Agreed, pressure ulcer grade 3 and 4 and serious incident data to be cross checked at least quarterly, prior to reporting and to allow a YTD refresh. **Responsible Officer:** RA **Timeline:** Quarterly testing from Q1, July 2016 **Process for updating Council of Governors:** Updates on objectives in quality account, report formally to governors at least six monthly	Throughout the year a cross check was completed between the Ulysses system and the serious incident database, prior to quarterly reporting. A year end check was also completed for the year based on refreshed data. In 2016/17 we moved to the serious incident database being managed as a module within the Ulysses system, in shadow form initially and moved entirely to the Ulysses module from May 2017. Therefore a cross check between the lists is no longer required as there is only one list held on Ulysses with links between modules.

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" circulated to you on 22 May 2017.

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

Deloitte LLP

Deloitte LLP
Chartered Accountants

Reading
19 May 2017

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, 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 29 March 2017, only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

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