Monitor

Making the health sector work for patients

Results of quality reports assurance 2014/15

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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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Summary

Each year, the auditors of NHS foundation trusts provide assurance on trusts' quality reports. These reports, published as part of a trust's annual report, give an overview of the quality of services provided during the year. The quality report includes performance against a number of defined national indicators. The main part of the assurance work involves the auditors examining two indicators in detail and concluding whether the trust has fairly stated them. Local auditors report publicly on their overall conclusion, and report privately to the trust and Monitor on their detailed findings and recommendations.

We should be clear that auditors are giving a view on data quality rather than service quality. This is still important: high-quality data supports reporting, and reported performance helps patients understand the quality of services they receive.

This document collates the findings of local quality report assurance – including the detailed auditor reports – for the first time. Its purpose is to allow foundation trusts to compare their performance and issues to those of other trusts. Individual foundation trusts will have received detailed recommendations for improvement as part of their auditors' report. This document allows foundation trusts to compare these findings to the sector's aggregate results. The findings will also be of interest to NHS trusts, although their data was not part of the assurance work.

We refresh the indicators subject to assurance every year. In 2014/15 auditors looked at the 18-week referral to treatment target (RTT) at acute trusts for the first time. There was wide variety in what they found. This document explores reasons for the auditor concluding that trusts had not 'fairly stated' indicators. This happened mainly with the RTT indicator, so these findings form the main part of this document.

Issues with this indicator most commonly arose from human error. This is understandable given the large number of outpatient contacts and the complexity of adhering to the RTT standard's requirements, while dealing with the wide variety of other pressures hospitals face. While we recognise the inherent challenges, high quality data is important here to allow hospitals and patients to understand and improve their performance and the service patients receive. The individual recommendations should help trusts focus on what is important for them.

The other main themes leading to indicator issues are system design matters, data review, consistent implementation of policies and the availability and retention of supporting information.

While the key recommendations will vary between trusts and are known to individual foundation trusts, we have grouped the main themes and summarised the recommendations. These are divided into those applying at a service level and at board level. Local external assurance for 2015/16 will review progress against important local recommendations.

Further action is being taken nationally and regionally. This includes refreshed guidance from NHS England on indicators including RTT, standard measures for data validation, a new RTT monitoring tool, the work of Intensive Support Teams and tighter processes around suspending and resuming reporting.

From 1 April NHS Improvement will bring together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

1. Introduction

Background to quality reports

Patients want to know they are receiving the very best quality of care. This is at the core of what we do – our duty is to protect and promote the interests of patients. To achieve this, we require all NHS foundation trusts to produce reports on the quality of care (as part of their annual reports). Quality reports help trusts to improve public accountability for the quality of care they provide.

Foundation trusts must also publish quality accounts each year, as required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended[1] ('the quality accounts regulations').

The quality report incorporates all the requirements of the quality account regulations as well as Monitor's additional reporting requirements. These requirements are part of our requirements to foundation trusts as to the information to be included in their annual reports[2].

External assurance of quality reports

We require trusts to obtain external assurance on their quality reports from auditors, as specified in paragraph 7.87 of the *NHS foundation trust annual reporting manual 2014/15*.

Auditors produce short-form, limited assurance opinions on quality reports, which are published as part of trusts' annual reports. The auditor will say whether:

1. anything leads them to believe the quality report has not been prepared as required by the *NHS foundation trust annual reporting manual 2014/15* or is not consistent with the other information sources in Section 2.1 of the *Detailed guidance for external assurance on quality reports 2014/15*

2. the specified indicators have not been prepared fairly in all material respects.

This document uses the term 'opinion' to refer to this limited assurance opinion and focuses on this second part of the auditor's work.

Auditors also produce long-form reports, which are presented to the trust governors and board of directors. These provide more detail on the findings and should make recommendations for improvement concerning the content of the quality report, and the mandated indicators. Auditors also report on a locally selected indicator as part

[1] SI 2010/279; as amended by the NHS (Quality Accounts) Amendments Regulations 2011 (SI 2011/269 and the NHS (Quality Accounts) Amendments Regulations 2012 (SI 2012/3081)
[2] See paragraph 26 of Schedule 7 to the National Health Service Act 2006.

of their long-form report which is outside the scope of this publication. These long-form reports are not made public.

Purpose of this report

This report uses the private long-form reports to assess common themes arising from auditors' work. It draws on the key issues auditors have identified and highlights recommendations to help prevent problems. Our intention is to share the learning from the sector with trusts and their auditors. We are not planning direct follow-up work based on this report. Foundation trusts should continue to use their own private long-form report with its specific recommendations for their trust.

All foundation trusts that provided patient services at the year-end had to produce quality reports and obtain external assurance on them. This report studies the 150 foundation trusts holding a provider licence at 31 March 2015.

Quality report indicators

The quality accounts regulations require foundation trusts to report performance against core indicators using data from the Health and Social Care Information Centre. We specify additional indicators to be reported as part of the quality report. These are the indicators which foundation trusts report under the requirements of our *Risk assessment framework*.

Auditors provide a limited assurance report on whether two mandated indicators included in the quality report have been reasonably stated in all material respects.

In 2014/15 foundation trusts' auditors undertook substantive sample testing of the mandated indicators included in the quality report as follows.

Foundation trusts providing acute services

1) Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period*

and one indicator from:

2) maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

3) emergency readmissions within 28 days of discharge from hospital.

*If this indicator for referral to treat was not relevant for the trust, indicators (2) and (3) had to be tested instead. If one of either (2) or (3) was not relevant, the foundation trust chose an alternative indicator for limited assurance.

Foundation trusts focusing on specialist services

Specialist foundation trusts had to follow the same guidance as acute foundation trusts. If indicator (1) was not relevant, indicators (2) and (3) were selected. If either

or both of (2) and (3) were not relevant, the trust selected an additional indicator(s) of its choice. Two indicators had to be subject to the limited assurance report.

Foundation trusts providing mental health services

Two indicators from:

1) 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital
2) minimising delayed transfers of care
3) inpatients with access to crisis resolution home treatment teams.

Ambulance foundation trusts

1) Category A call – emergency response within 8 minutes
2) Category A call – ambulance vehicle arrives within 19 minutes.

Foundation trusts providing community services

Community foundation trusts had to select two relevant indicators in the following order of preference (ie if (1) and (2) were both reportable, they were selected):

1) percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
2) emergency readmissions within 28 days of discharge from hospital
3) maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
4) other indicator(s) included in the quality report.

Foundation trusts providing a mix of services

Foundation trusts providing a mix of services had to follow the guidance for the category of services from which they received most of their income.

2. Summary of results

Our analysis focuses on instances where the auditor identified errors that led them to conclude the trust had not fairly stated the indicator – ie where the auditor 'modified' their opinion. The issues listed may occur at other trusts too, but if the auditor was content they were at a sufficiently low level or did not affect the indicator's accuracy they may have issued a 'clean' opinion, so we have not included them in our analysis.

We have identified issues that affect patient pathways and the resulting indicator calculation in different ways for each trust. As such we are unable to estimate any given issue's impact on the sector or detail the proportion of cases affected at each trust.

Table 1 below summarises auditors' opinions on all foundation trusts' quality reports. As trusts had to select two mandated indicators to be subject to external assurance, each trust is counted twice in the table.

Qualified/modified opinions

Accounting firms do this work under the International Standard on Assurance Engagements (ISAE) 3000. This standard gives guidance on forms of modified limited assurance opinions, such as 'qualified', 'adverse conclusion' and a 'disclaimer of conclusion'. The last term technically means that a conclusion has not been issued.

For our analysis we consider that distinguishing between these forms of non-standard reporting is not important, so we use the term 'qualified' to refer to all modified opinions. Similarly, for ease of understanding in Table 1, we refer to unmodified limited assurance opinions as 'clean'.

Table 1: Summary of results by indicators

Indicator	Clean opinion	Qualified opinion	Total number of trusts
Mandated indicators for acute services			
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	44	61	105
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	65	5	70
Emergency readmissions within 28 days of discharge from hospital	29	-	29
Mandated indicators for mental health services			
100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital	34	-	34
Minimising delayed transfers of care	16	1	17
Inpatients with access to crisis resolution home treatment teams	27	1	28
Mandated indicators for ambulance services			
Category A call – emergency response within 8 minutes	5	-	5
Category A call – ambulance vehicle arrives within 19 minutes	5	-	5
Other indicators[3]			
Other – Maximum waiting time of 31 days from urgent GP referral to first treatment for all cancers	2	-	2
Other – Patient safety incidents reported where harm is 'severe harm' or 'death'	2	-	2
Other – reduction of injuries sustained due to physical intervention	1	-	1
Other – Percentage patients indicating improvement pre and post-CORE form assessment	1	-	1
Other – Percentage patients indicating improvement Time 1 and 2 GBM form min 2 targets	1	-	1
TOTAL	**232**	**68**	**300**

[3] 'Other' indicators arise where foundation trusts need to choose an additional indicator as the primary indicators were not relevant. For more details see Section 1.

3. Eighteen-week referral-to-treat indicator findings

The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible.

This right is protected by law, and applies to the NHS in England. Patients can expect that the time from the referral date to the treatment date should not exceed 18 weeks. The referral-to-treat (RTT) standard is for 92% of patients to be seen within 18 weeks of their referral being received.

The RTT indicator was relevant for external assurance at 105 (69%) foundation trusts. Of these, only 41% received clean opinions, as shown in Figure 1.

Figure 1: RTT assurance findings

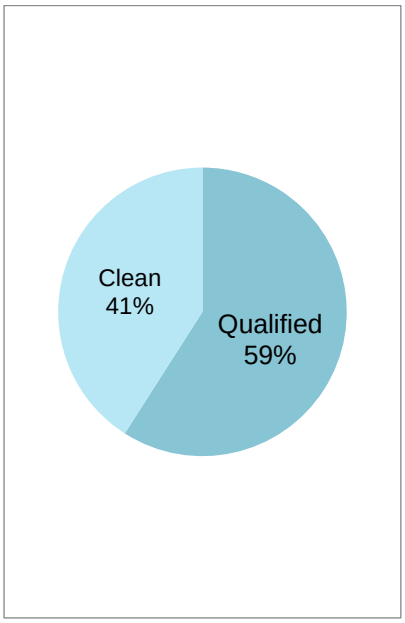
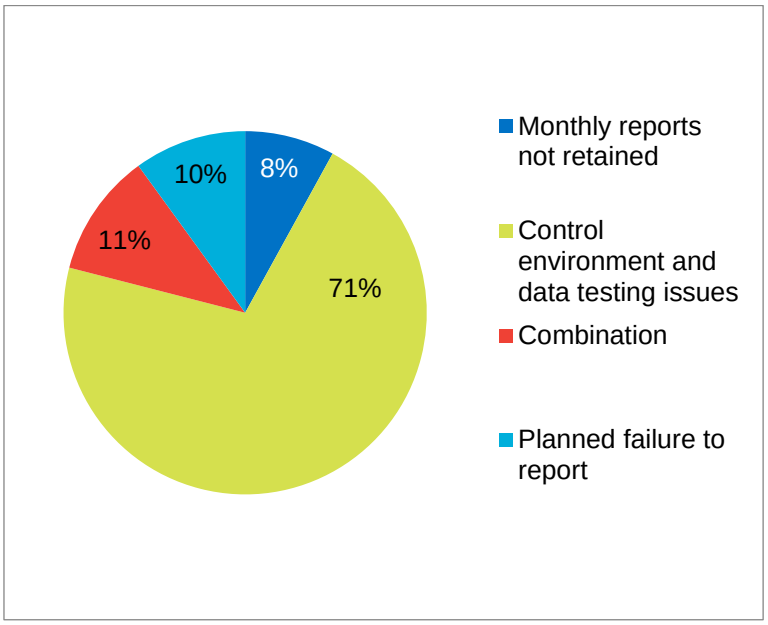


Figure 2: RTT qualified opinion reasons



Of those that received a qualified opinion, 8% were due to the trust not retaining the RTT reports on monthly performance during the year, as can be seen in Figure 2. In these instances the trust's system was unable to recreate old reports, preventing the auditors from accurately testing the reported RTT figures. In a few cases, implementing a new system mid-year caused this.

Most (71%) qualified opinions were due to control environment and data-testing issues, which this section explores further.

Another 11% were due to a combination of the two reasons above: the trust could provide some monthly reports (but not all) for testing, which meant the auditor could not report, but also there were control environment or data issues in what was available. In some cases these reports were not as at month end, but a few days later.

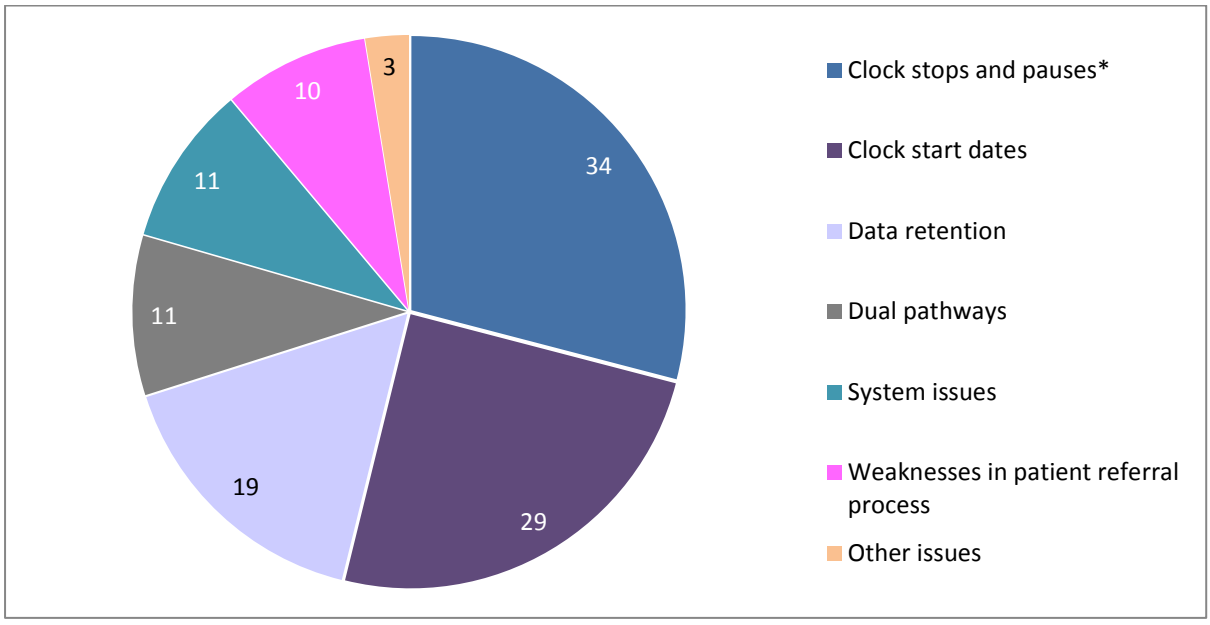
The remaining 10% of trusts that received a qualified opinion for the indicator were subject to a planned failure to report during the year. This means that the trust exempted itself from reporting for part or all of the year due to known issues affecting its ability to report. The board may decide to do this if it believes the underlying data contain fundamental errors that render them inaccurate. The board must be able to fully support its decision. Once the trust restores reliable reporting, the period of non-reporting will end. In these cases the trust received a qualified limited assurance report for the indicator, as detailed audit testing would have been of little value given the known significant issues.

Control environment and data-testing issues

We identified nine distinct categories as causes of these issues. The rest of this section discusses only the 58% of relevant trusts that received a qualified opinion for this indicator.

Figure 3 shows the number of trusts whose auditors identified various control environment or data-testing issues. Trusts may be included within multiple categories, depending on how many issues were identified.

Figure 3: Number of trusts with specific causes



*Clock pauses were not taken into account when preparing the indicator for looking at all patients on an incomplete pathway, but did form part of other RTT indicators that applied in 2014/15 and were therefore an important part of a trust's RTT processes.

Clock stops and pauses

Guidance on clock pauses changed from 1 October 2015. Reporting patient clock pauses in data returns nationally is no longer possible. However, clock pauses may still be applied locally.

A clock pause may occur for only one reason: the patient chooses to wait longer. This is also known as a 'social pause'.

A clock stop is very different and may occur when treatment begins. However, not all patient pathways result in treatment as reasons vary for non-treatment resulting in a clock stop. These are explained in the RTT guidance (see Appendix A).

The most frequent issue auditors identified arose from human error, where clock pauses and clock stop dates were not actioned appropriately. This was identified in 67% of cases where the auditor issued a qualified opinion for this indicator. Clock pauses should never have been (and still should not be) applied to the incomplete pathways indicator. Clock pauses only applied to the now defunct adjusted indicator for completed pathways.

Reasons for issues identified with clock stops and inappropriately used clock pauses included:

- Poor quality date stamps used on paper records. Date stamps are used to mark significant points in time on the patient's pathway, such as receipt of referral, clock pause dates and clock end dates. In some instances these could not be read, no stamps were present at all or multiple date stamps were present and it was not clear which was correct.

- In numerous cases, RTT pathway pause rules were inconstantly applied and in others clock stops did not comply with national guidance. For instance, in one case a wait for diagnostic tests was incorrectly categorised as 'active monitoring', resulting in premature closure of the pathway. Another example would be if the original RTT clock was stopped when the patient was admitted as an emergency but they did not have the elective procedure they were waiting for.

- Evidence suggested that clock stops should have been implemented for some 'open cases'. This resulted in worse performance reported than actually occurred.

The overall effect is that wrong dates are entered into the system, leading to inaccurate breach numbers reported.

Trusts should ensure that clinical and administrative staff are trained in the importance of accuracy in system data inputs and timely data entry. Where staff are

uncertain of pause and stop clock rules, they should check the RTT FAQs[4] or RTT guidance,[5] or ask internally for clarification.

Date stamps that provide a reliable result should be used. Staff should be vigilant in ensuring date stamps are legible and accurate.

As well as prevention techniques, detection tools should be in place. Validation checks should ensure errors are identified promptly. This could be on a spot-check basis instead of checking every patient's files. Regular internal audits could help spot errors.

Clock start dates

The guidance on referral-to-treatment waiting times states that:

"A waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referral, refers to a consultant-led service… [or] an interface… which may result in an onward referral to a consultant-led service…A waiting time clock also starts upon self-referral by a patient."[6]

When a patient is initially referred for treatment at a consultant-led service, the clock start should begin on the day the referral is received – for example, a GP referring a patient to hospital, or a doctor referring an admitted patient to another specialty for outpatient care. This date starts the 18-week clock.

Of trusts that received a qualified report, 57% had errors relating to clock start dates; these are often caused by staff recording the incorrect date – for example, using the date of the patient's first hospital appointment instead of the referral date. Incorrect clock starts can also occur if the referral date cannot be clearly determined from patient notes.

Auditors identified various reasons for a clock start error:

- In most instances, staff had incorrectly entered the clock start date into the patient administration system (PAS). Auditors identified this when they compared the dates on the electronic patient record to the patient notes. Errors can occur wherever data is manually entered; in response, auditors recommended trusts should have validation processes in place to check input data regularly.
- The auditors observed multiple examples where the first appointment date – rather than the referral date – was incorrectly classified as the clock start date. This resulted in the trust reporting better performance against the RTT

[4] *Recording and reporting RTT guidance FAQs*.
[5] *Referral to treatment consultant-led waiting times rules suite*: October 2015, p5-7.
[6] *Referral to treatment consultant-led waiting times rules suite*: October 2015, p5.

standard than was actually achieved given the referral date would normally be earlier.

- Auditors found one instance where the clock was incorrectly started when an initial procedure was conducted, rather than when the patient was referred.
- They identified several examples at a few trusts where unexplained changes were made to the clock start initially recorded. This is a concern as it makes it difficult to trace the audit trail relating to the patient's pathway of care and verify the data's integrity.

These errors affect the number of breaches reported by a trust. For example, if the first appointment date is several weeks after the referral date and is wrongly recorded as the clock start date, a patient may wait longer than 18 weeks for treatment, but the system will not record this as a breach.

As human error causes most inaccuracies, trusts should review and improve guidance and staff training to ensure employees entering data are aware of the guidelines on clock start dates. Trusts need to regularly remind staff of the rules and ensure new staff are aware and trained accordingly. In addition, trusts should implement robust validation to check the system data against patient records and detect outstanding errors.

Data retention

One of the most frequent causes of error, identified by auditors at 37% of trusts, was a trust's inability to provide supporting patient records as evidence of either the referral or treatment date. This makes it impossible to validate the data recorded on the PAS.

Reasons for this issue included:

- Staff had discarded referral letters and supporting documentation or these were missing from medical records; most trusts in this category had instances of this.
- In several instances clinical outcome forms were not kept. It is possible to use accompanying documentation to find out when a patient's treatment began, but this is less likely to be accurate, affecting the validity of the clock stop dates.
- There were several examples of trusts conducting insufficient validation checks for non-breaches (ie pathways which do not appear to have exceeded the 18-week standard). Trusts can check the RTT waiting list, reviewing a sample of pathways against patient notes to identify breaches and non-breaches. These checks should be often enough for the board to feel confident about the accuracy of reporting. In practice this is often twice a year.

These checks help ensure trusts are accurately reporting their performance. Incorrectly including cases classified as non-breaches would inflate the reported performance for the indicator.

- In one trust paper records had not been scanned into the PAS or could not be found in the system using the search function, so staff were unable to link them to patient records.
- Several trusts changed pathway start and stop dates without retaining evidence to explain changes on the PAS.

It is good practice for trusts to conduct spot checks twice a year of data entered into the PAS against patient records. These checks should cover breaches and non-breaches. Trusts should regularly remind staff that it is important to keep referral and treatment paperwork for a full audit trail. They must ensure paper records are not destroyed unless electronic scans have been uploaded to the PAS.

System issues

Electronic system issues were identified at 22% of trusts, leading to qualified opinions. The specific reasons varied from trust to trust and include:

- The pathway's diagnostic elements are not always included in the full incomplete RTT waiting list. If these are not included, they should be visible in a local patient tracking list.
- Patient notes correctly agree with the system input but the patient appears on the wrong system report. This led to incorrect reporting.
- Patients appear on the incomplete pathways listing for the month, despite the pathway end date being before the end of the month. This occurs when the system has not been updated to state that the procedure has occurred, and is a common data quality issue.
- Records are amended after the monthly report has been run, but the report is not rerun to include these retrospective changes.
- The system incorrectly calculates the number of days waiting.
- Trusts that changed systems during the year had not always completed data migration.
- In one instance, the system incorrectly excluded dental pathways from the RTT indicator compilation.
- In one instance, the system correctly showed a patient as a breach in month 1; then in month 2 showed the patient as a non-breach in error; then in month 3 correctly returned the patient to the breach listing.

In all these cases, pathways were not identified correctly as breach/non-breaches, leading to inaccurate reporting.

Individual system issues can be more challenging to foresee and prevent. To make them less likely and promptly detect any that have occurred, trusts should carry out systems control testing alongside validation exercises. Control testing should generally be done twice a year.

Duplicate pathways

Among trusts that received a qualified report, 22% had duplicate pathways due to human error. Effectively, new pathways were created for patients who already had open and valid pathways. For example, in one a follow-up postoperative appointment was added as a new pathway.

The number of incomplete/complete pathways included in the reported RTT figures was therefore wrong. This is because one of the two pathways remained open in error, distorting the figures.

Staff should be reminded to check for existing pathways before creating new ones in the system. Again, trusts should carry out validation exercises to detect where this has occurred, and checks could also form part of internal audits.

Weaknesses in patient referral process

National RTT guidance requires that when a patient is referred from one provider to another the pathway should continue. However, this depends on the referring trust providing the correct clock start dates. In 20% of trusts that received a qualified opinion, auditors identified weaknesses in recording data for patients transferred from or to other providers.

In four cases errors occurred because the referral forms from the referring NHS organisation did not include the clock start dates, leading to the trust recording the referral date from the original trust as the clock start for a new pathway. This is more likely in tertiary specialist providers that manage patients referred from multiple external organisations, as information on the patient pathway must be captured from several sources. To mitigate this, trusts should have clear policies for confirming referral and treatment dates with other providers and ensure outgoing referrals include relevant referral and treatment dates. National guidance says it is mandatory for all organisations to use the Inter-Provider Transfer Administrative Minimum Data Set (IPTAMDS) for patients moving between organisations, to ensure key information, such as clock starts, transfers with them.[7] These processes should be

[7] *Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care*, p33.

clearly documented in the patient access policy, and staff and commissioners regularly told about them.

Other reasons reported by auditors included:

- missed or unclear communications from other providers
- one receiving trust's policy of not requesting the clock start date where it was omitted in the referring trust's initial paperwork.

Internal standard operating procedures should enable issues with referrals to be escalated in the receiving organisation and if needed, addressed at a higher level with the referring trust.

Other issues

One trust issued treatment letters when treatment was completed instead of when it began. This introduced errors in the clock start and stop dates as the length of treatment changed. Although the external assurance reports do not specify how patients were informed, this could have taken place on the phone, explaining why the treatment plan was not issued at the start.

This is not good practice and should be avoided to ensure that patients are aware of their treatment plan ahead of treatment, and that the data collected are accurate.

User access controls were out of date at one trust. This meant that staff could make erroneous amendments and change dates when they should not have access rights. This led to unquantified errors identified in the data.

Trusts should regularly review user access authorisation controls to prevent such issues. Internal audit could also review this control.

One trust's system recorded negative waiting times. Managers could not explain why, so the audit report offers little explanation of whether this was human error or a system problem. The implication is that the RTT calculation was distorted.

Without identifying a cause it is difficult to recommend how to prevent this. To prevent system issues, trusts should regularly carry out controls testing. To mitigate human error, they should give staff more systems training. To detect any outlying data such as negative waiting times, trusts should carry out monthly high level data reviews and data validation checks.

4. Other acute trust indicator findings

Auditors for acute providers reported on two other mandated indicators:

- emergency readmissions within 28 days of discharge from hospital
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Emergency readmissions

All acute (and specialist) trusts whose auditors reported on emergency readmissions within 28 days of discharge received clean opinions for this indicator. Some emergency readmissions may be potentially avoidable and the result of poor treatment in hospital or poor rehabilitation and support services when a person is discharged home following treatment. This indicator seeks to highlight the extent of readmissions. The clean opinion indicates that trusts' procedures to record and validate this indicator are materially sufficient.

62-day cancer waiting time

Auditors from 70 trusts reported on the 62-day waiting time for cancer treatment; 93% provided clean opinions.

There was clear overlap on the themes that led to qualified opinions.

One key reason was human error and inconsistencies in start dates, such as:

- In multiple instances, the clock start date recorded in the system did not correspond with the clock start date detailed in the patient notes.
- The preoperative assessment date and the actual operation date were used inconsistently as the date of treatment for surgical cases. In practice the preoperative date would not be the same as the operation date. This could lead to the clock being stopped too early.
- In one instance the GP referral was faxed to the wrong department at the trust. It was forwarded to the appropriate department, but the referral date was incorrectly entered into the system as the date the appropriate department received the referral, when it should have been the date that the trust originally received the referral. This led to an actual breach being reported as a non-breach.

These issues could be avoided by more staff training and reiterating the importance of maintaining accurate records. Trusts could give all staff a document outlining a protocol to follow when they are unsure what action to take. Trusts should also ensure that GPs know where to send referrals.

System errors and weaknesses in system designs were another important theme:

- Many trusts made limited validation checks on data entry. Adding extra controls to the data input, such as reviews or spot checks, could improve the accuracy of the data in the system.
- Weaknesses were identified in the system design for reporting, which meant a trust was unable to rerun the 62-day cancer waiting list to agree to the reported figures. This could be resolved by keeping on file reports used to determine the reported figures.
- In one instance a private patient was included in the report in error, affecting the number of breach patients. This could be either human or system error. Additional controls checks could be carried out on the data to ensure only valid breaches are included.

A lack of record retention was also identified in some cases:

- Referral forms were not scanned into the system and had been destroyed or misplaced, preventing the auditors from checking the accuracy of the clock start dates. This could be mitigated by training staff and implementing checks to ensure all patient notes are filed electronically before destroying the original copy.
- In two instances no treatment date was recorded in the patient notes as the treatment had been verbally communicated to the clinical nurse specialist. The auditors could not confirm that the correct treatment date was recorded on the system. We recognise that when treatment dates need to be communicated quickly, doing so verbally may be the best way. But paperwork should not be dismissed as unnecessary or overlooked.
- In other cases, files were not available for the auditors to test, contributing to the decision to qualify the indicator.
- Overall, improved system controls, data validation and staff training should remedy most issues identified. Trusts could also ensure all paperwork and data entry are checked at the multidisciplinary team stage first and then again at treatment.

5. Mental health trust indicator findings

Trusts providing mental health services were asked to select two mandated indicators from a list of three:

- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital
- minimising delayed transfers of care
- inpatients with access to crisis resolution home treatment teams.

Care Programme Approach seven-day follow-up

Thirty-four foundation trusts reported on the CPA indicator, which measures whether CPA patients were followed up within seven days of discharge. Trusts are responsible for ensuring they follow up patients discharged home, to residential accommodation or non-psychiatric care. All received clean opinions, indicating they have robust procedures for recording and validating their data.

Minimising delayed transfers of care

Seventeen foundation trusts providing mental health services selected the indicator on mental health delayed transfers of care (DTOC) for external assurance. This measures the number of days a non-acute patient's care is delayed after the multidisciplinary team (MDT) has declared them fit to be discharged.

Only one trust received a qualified report. The auditor identified several instances where the discharge dates in the PAS did not match the paper patient records and one instance where a DTOC was recorded without supporting evidence that an MDT made the decision.

Trusts can minimise this type of error by routinely checking that paper records carry correct DTOC start and discharge dates that are entered into electronic patient records.

Inpatients with access to crisis resolution home treatment (CRHT) teams

Twenty-eight foundation trusts reported on the indicator measuring the percentage of patients admitted to inpatient mental health services who had access to CRHT teams. CRHT teams should be available 24 hours, seven days a week for assessment requests, and should be actively involved in all requests for admission to mental health psychiatric inpatient care.[8]

[8] Monitor's *Risk assessment framework (updated August 2015),* p48.

One trust received a qualified report because of an incorrect classification of breaches due to clinicians' errors in data input and the trust's inadequate quality assurance of the data.

The auditors recommended that trusts ensure adequate training for staff and regular internal audits to review the reported data throughout the year.

6. Ambulance trust indicator findings

Ambulance foundation trusts were asked to report on two indicators:

1) Category A call – emergency response within 8 minutes (Category A8)
2) Category A call – ambulance vehicle arrives within 19 minutes (Category A19).

Category A call – emergency response within 8 minutes

Five ambulance foundation trusts reported on this indicator, which is divided into two types of call:

- Red 1 calls are the most time-critical calls, for patients suffering a cardiac arrest or other severe life-threatening conditions
- Red 2 calls are serious but less time-critical and include conditions such as strokes or fits.

These calls are assessed against a threshold of 75%, so ambulances must reach at least 75% of Category A8 calls within 8 minutes.

All ambulance trusts reporting on this indicator received an unqualified opinion.

Category A call – ambulance vehicle arrives within 19 minutes

Five ambulance trusts reported on the Category A response-time indicator for ambulance vehicles arriving within 19 minutes.

This indicator is linked to the Category A8 calls when onward patient transport is required, which should arrive within 19 minutes. An example is an ambulance rapid-response car being dispatched after an A8 call, followed by a decision that the patient needs an ambulance to take them to hospital. The threshold for this indicator is also 75% of calls.

All trusts reporting on this indicator received an unqualified opinion.

7. Recommendations

Service level

- All staff involved in patient care should be trained to ensure patient pathway information is accurate. In relation to RTT, both clinical and clerical staff involved on the patient pathway should be trained. Training should include ensuring that patients' notes are clear and legible; that all staff understand when to start/pause/stop the clock; the importance of time stamps; the importance of recording in a timely manner and ensuring that patient records are kept for data validation.
- Good practice suggests that checks should be made twice a year; these include internal audits, controls testing and high level reviews. Certain validation and common sense checks should be made when data is entered into the system to prevent errors occurring.
- Organisations should apply local data quality checks at least twice a year to an appropriate sample size that covers all specialties and both breach and non-breach waiting times.
- Communication about referrals between trusts should be clear and accurate. This includes ensuring the clock start date is received/provided, pathways are closed when a patient is referred on where appropriate and referrals are sent to the right person in the organisation (ie correct contact details are maintained).
- Trusts should have clear policies ensuring outgoing referrals include the referral and treatment dates, and they should clearly articulate these to all staff. This should be part of standard operating procedures, and staff should be aware of what to do if they receive a referral without the minimum dataset.
- Data migration can cause many issues. Trusts should introduce vigorous testing before and after implementation, adequately and continuously training staff in the new system.

Board level

- Boards have overall responsibility for ensuring that processes for checking data quality and accuracy are robust. They should be sure that the frequency and extent of testing gives them sufficient confidence in their data's validity.
- Referrals between trusts should be undertaken at service level. Boards are responsible for ensuring internal standard operating procedures are implemented for confirming referral and treatment dates with other providers. Where referring organisations fail to provide the minimum dataset, they should ensure these concerns are taken up with the referring trust's board.

- Boards are responsible for ensuring processes are in place to manage data migration effectively, and should seek to mitigate the risks of this process.
- In the absence of national guidance for a specific point of detail, trusts should ensure the approach taken is not unreasonable and is consistently applied internally for every reporting period. Their approach should be in line with internal policy and communications, and demonstrate that the trust is applying local access policies as agreed with providers and commissioners.

Appendix A: Glossary

Admitted clock stop: A pathway that ends in a clock stop for admission (day case or inpatient).

Crisis resolution home treatment (CRHT) team: A crisis resolution home treatment team is a multidisciplinary team of mental health professionals who support service users at home during a mental health crisis. CRHT teams should accept requests for assessment 24 hours a day, seven days a week, and be actively involved in all requests for admission to psychiatric inpatient care.[9]

Clock start: The date when a referral is received into a consultant-led service.

Clock stop: This can only be made to a patient's referral-to-treatment pathway when treatment occurs or a decision not to treat is made.

62 day cancer clock stop: The clock stop occurs when the patient starts active monitoring or palliative care.

Care Programme Approach: A means of assessing, planning, co-ordinating and reviewing services for someone with mental health problems or a range of related complex needs.

Inter-Provider Transfer Administrative Minimum Dataset (IPTAMDS): The minimum data required when responsibility for a patient pathway is transferred between healthcare providers; it enables the receiving provider to report appropriate data for the relevant standard.

Non-admitted clock stop: A pathway that results in a clock stop.

Patient pathway: Usually a patient's journey from first contact with the NHS for an individual condition, through referral, diagnosis and treatment for that condition. For chronic or recurrent conditions, a patient pathway will continue beyond the point at which first definitive treatment starts, as it will include further treatment for the same condition. A person may have multiple referral-to-treatment periods (see below). NHS England often uses the term 'RTT pathway' in published reports, as we do in this document, and this is the same as an 'RTT period'.

Referral-to-treatment (RTT) period: The period of time between a clock start and a clock stop.

[9] Monitor's *Risk assessment framework (updated August 2015)*, p48.

Appendix B: Bibliography

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Monitor

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Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

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