2014/15: External assurance on your quality report

Sheffield Teaching Hospitals NHS Foundation Trust

18 May 2015

Contents

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This report is addressed to the Board of Directors and the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust (the Trust) and has been prepared for your use only. We accept no responsibility towards any member of staff acting on their own, or to any third parties.

This engagement is an assurance engagement over the content of the quality report and mandated indicators conducted in accordance with generally accepted assurance standards.

In preparing our report, our primary source has been information made available and representations made to us by management. We do not accept responsibility for such information which remains the responsibility of management. We have satisfied ourselves, so far as possible, that the information presented in our report is consistent with other information which was made available to us in the course of our work in accordance with the terms of our Engagement Letter dated 28 April 2015.

Headlines

Introduction

In February 2015, Monitor released their 'Detailed guidance for external assurance on quality reports 2014/15'. This document provides an overview of the external assurance requirements for the quality report and forms the basis for our approach to reviewing your quality report and performing testing over performance indicators. The output of our work is a 'limited' assurance opinion as well as this report to your Council of Governors on our findings and recommendations for improvements concerning the content of the quality report, the mandated indicators and the locally selected indicator.

Conclusion

You have achieved a **limited assurance** opinion (see Appendix C) as our work has led us to believe that:

- your quality report complies with the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- your quality report is consistent with specified documentation; and
- both of the indicators we have tested have been reasonably stated in all material respects.

Key findings

Our work is now complete, having carried out final checks to ensure you have reflected our comments in the quality report. We have set out the key headlines from our work below.

Content – the content of your quality report complies with the requirements set out in the NHS Foundation Trust Annual Reporting Manual

The content of the quality report was accurately reported in line with the quality report regulations.

See section one for our detailed findings.

Consistency – the content of the quality report is not inconsistent with other information sources specified by Monitor

We reviewed the information sources specified by Monitor and identified that:

- Significant matters in the specified information sources were reflected in the quality report where appropriate;
- Significant assertions in the quality report were supported by the specified information sources.

See section one for our detailed findings.

Mandated Indicator 1: Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

We did not identify any issues that impact on our ability to issue a limited assurance opinion in respect of this indicator.

We have identified minor areas for improvement in relation to this indicator. See section two for our detailed findings and our recommendations are set out in Appendix B.

Mandated Indicator 2: Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We did not identify any issues that impact on our ability to issue a limited assurance opinion in respect of this indicator.

See section two for our detailed findings.

Key Significant issues identified which impact on your opinion | Opportunities to improve | No issues/ minor areas of improvement identified

Report structure and next steps

Local indicator: Data Completeness for Community Services	
We have identified minor areas for improvement in relation to the data completeness for the community services indicators. See section two for our detailed findings and our recommendations are set out in Appendix B.	

Recommendations raised

We have raised four recommendations which are set out in Appendix B, none of which are high priority.

Structure of this report

The remaining sections of this report cover the:

- Section 1 - Detailed findings: Content of the quality report – this section outlines the work we performed, summarises our findings and concludes on whether a limited assurance opinion has been issued; and
- Section 2 - Detailed findings; our review of two selected performance indicators– this summarises our work performed on the two mandated indicators subject to a limited assurance report specified by Monitor and the locally selected indicator. It concludes on whether a limited assurance opinion has been issued for the mandated indicators and whether improvements are needed before you could seek a limited assurance opinion on the locally selected indicator.

Steps to be taken to conclude the 2014/15 quality report assurance process

1) The Trust needs to provide us with its Statement of Directors' Responsibilities in respect of the Quality Report (see Appendix D of this report) and a signed letter of management representation.

2) In line with Monitor's reporting requirements, we will provide a final signed opinion on or shortly after 21 May 2015 along with the finalised version of our report for Governors.

3) The Trust should include our limited assurance opinion on the content of the quality report and the mandated indicators (see Appendix C) in the Annual Report. The Trust needs to submit this to Monitor by 29 May 2015.

Detailed findings – Content of the quality report

Conclusion

We have carried out our final checks to ensure you have reflected our comments in the quality report and reviewed changes made by the Trust after the date of the draft report. We are satisfied that there is sufficient evidence to provide a limited assurance opinion on the content of the quality report and this is planned to be issued on or shortly after 21 May 2015.

We have raised no recommendations relating to this section as all mandated content was sufficiently included and the report was consistent with all other relevant Trust documents.

We have included our opinion in Appendix C to this report.

Work performed and findings

In this section, we report our work on the content of the quality report against two criteria:

1) Content addresses requirements of the quality report regulations

We reviewed the content of the quality report against the requirements set out in the NHS Foundation Trust Annual Reporting Manual. Our findings are set out below:

Issue considered	Findings
Inclusion of all mandated content	All areas of mandated content have been reflected in the report.

2) Consistency of quality report content with specified other information

We were required to review the consistency of the quality report against specified information. Our findings are set out below:

Issues considered	Findings
Are significant matters in the specified information sources reflected in the quality report?	We identified that the Trust reflected its significant matters, relevant to the selected priorities from the specified information sources, in its quality report.
Are significant assertions in the quality report supported by the specified information sources?	Significant assertions in the quality report are supported by the relevant information sources.

We have set out in more detail the scope of this work in Appendix A.

Detailed findings: Our review of selected performance indicators

Introduction

We carried out work on two mandated indicators, chosen by the Trust from a list of three available indicators as specified by Monitor in its guidance:

1. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
2. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

In addition, we carried out work on a locally selected indicator chosen by your Council of Governors. The indicator selected was Data Completeness for Community Services. This indicator is not subject to a limited assurance opinion.

We have set out in more detail the scope of this work in Appendix A.

Conclusion

Our work on the indicators requiring a limited assurance report suggests there is **sufficient evidence to provide a limited assurance opinion** in respect of both of the indicators selected by the Trust. We have included our opinion in Appendix C to this report. Please note that the extent of the procedures performed is reduced for limited assurance. The nature of the procedures may be different and less challenging that those used for reasonable assurance. Therefore, our work was not a reasonable assurance audit of either the performance indicators or the processes used to collate and report them.

Results of our work

We have set out overleaf the key findings from our work as described above in relation to the two mandated indicators and the locally selected indicator.

Performance indicators

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated indicator one: percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period. **Performance target: 92%** **Performance recorded in Quality Account: 92.8%**					
Accuracy	●	●	The data reported as per the reports generally agrees to the system. However, some data is validated due to the complexity of the system and this can lead to changes.	We selected a sample of 25 cases from across the 2014/15 period. This sample related to referrals that are being reported on. Through our testing we identified two instances where the referral form had not been date stamped on receipt as required by the Trust's procedures. This minor point was the only issue we identified through this particular test. To ensure completeness we selected ten cases from the inpatient and first outpatient waiting list and confirmed they had been included on the RTT pathway report and then whether this pathway was included on the incomplete submission. Of this sample, we identified no issues.	Although we identified two cases where the referral date was not recorded we are satisfied that Trust procedures are generally being followed. We identified no issues testing the completeness of the RTT incomplete submission data. However, we suggest a consistent approach to monitoring validation and error reports is implemented across all directorates.
Completeness	●	●	A number of validations are carried out to ensure completeness of the data. For example, a number of live error reports are available through the Information Centre that can be used by Directorate leads and service managers to show the number of referrals with no activity or the number of referrals not linked to a pathway. In addition, specific validations and error reports were introduced as a result of a Deloitte review that identified RTT data pathways that were being omitted. The new process now amalgamates reporting on patients who are on an inpatient or first outpatient waiting list but not on a live RTT pathway. This formed the basis of our completeness testing. The validation exercises have improved the quality of the reported data but we suggest a consistent approach to monitoring validations and error reports across all directorates.		
Relevance	●	●	The reports produced appropriately show all relevant individuals that are present on a pathway at one time.		
Reliability	●	●	The data present on the reports was agreed through to case notes or other relevant information.		
Timeliness	●	●	Reports are run based on current data, therefore the information provided is very timely.		
Validity	●	●	The data is taken directly from the Patient Centre system and a series of validations are run. However, we consider that there is scope to improve the validation process further.		
Overall	●	●	Overall we can provide limited assurance that the system accurately records the true percentage of incomplete pathways within 18 weeks for patients on an incomplete pathway.		

Performance indicators

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated indicator two: Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers **Performance target: 85%** **Performance recorded in Quality Account: 85%**					
Accuracy	●	●	Following last year's audit, improvements have been made to the accuracy of this indicator by undertaking checks of the reasons for clock stops within the cancer treatment pathway.	Of 55 records tested by ourselves or internal audit, the treatment pathway was correctly captured on the Infoflex cancer tracking system in 100% of cases.	We have not identified any issues which have an impact our overall opinion
Completeness	●	●	Following last year's audit, improvements have been made to the completeness of this indicator to ensure data quality by improving systems to ensure that all GP referrals are received and actioned in the most effective and timely manner.		
Relevance	●	●	We did not identify any issues in this area of our work.		
Reliability	●	●	We did not identify any issues in this area of our work.		
Timeliness	●	●	We did not identify any improvements required with regard to the Trust's timeliness in relation to this indicator.		
Validity	●	●	We did not identify any issues in this area of our work.		
Overall	●	●	Satisfactory.		

Performance indicators

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	Design	Operation	Commentary on ratings		
Locally selected indicator Data Completeness for Community Services **Performance target: 50% for each facet of the three indicators*** **Performance recorded in Quality Account: Referral to treatment 66%. Others 100%.**					
Accuracy	●	●	For Referral to Treatment the figure in the quality report represents an estimate of the data obtained. The Physioworks system does not record the data correctly as an earlier indicator related to treatment within four weeks. It records the first appointment but does not record patient choices, pauses or sufficient documentation to ensure that the appointment constitutes appropriate 'treatment' for the current RtT requirements.	No issues with two of the indicators. For the Referral to Treatment indicator we have assurance that the Trust is compliant with the 50% target but cannot specify the accurate figure for the indicator.	The system now has the required functionality to report fully. We have recommended that the necessary changes are made.
Completeness	●	●	No issues		
Relevance	●	●	No issues.		
Reliability	●	●	See comments re Accuracy.		
Timeliness	●	●	No issues.		
Validity	●	●	No issues.		
Overall	●	●	Generally sound but the processes and systems behind the Referral to Treatment reporting are insufficient to produce or report the indicator appropriately		

* This indicator is applicable for all patients on an Allied Health Professional or consultant-led treatment pathway in the Community. It is designed to monitor the completeness of the data maintained by the Trust regarding the patient. It is split into three areas: information about referral, about activity and regarding the referral to treatment time.

Scope of work performed and our approach

Background

In February 2015, Monitor released its ‘2014/15 Detailed guidance for external assurance on quality reports’. This document provides an overview of the external assurance requirements for the quality report.

The publication of *High Quality Care for All* in 2008 placed quality and quality improvement at the heart of current debate in the NHS. The Health Act 2009 and associated regulations require all providers of NHS healthcare services in England to publish a quality report each year about the quality of NHS services they deliver.

Scope, approach and outputs

Our work has been based on the principles of ISAE 3000 (*Assurance Engagements other than Audits and Reviews of Historical Financial Information*) in order to provide an independent assurance opinion. We have set out our approach below

Requirement	Approach	Output
Review the content of the quality report against the requirements specified by the quality reports Regulations	■ Desktop review of the Trust’s quality report against the checklist of requirements as set out in Monitor’s guidance. This work addressed: – Significant matters in the specified information sources relevant to the priorities selected by the Trust for the quality report to be reflected in the quality report; and – Significant assertions in the quality report to be supported by a suite of specified information sources.	**Limited assurance opinion over**: ■ Compliance with the regulations ■ Consistency with specified documentation ■ Two indicators in the quality report
Review the content of the quality report for consistency against the other information sources detailed in Monitor’s guidance.	■ Desktop review of the Trust’s quality report against the Trust’s file of evidence.	
Testing of two indicators agreed with the trust	■ We will: – confirm the definition and guidance used by the Trust to calculate the indicator; – document and walk through the NHS trust’s systems used to produce the indicator; and – undertake substantive testing on the underlying data against six specified data quality dimensions.	
Testing of a locally selected indicator as chosen by the Council of Governors	■ See above. Our approach is consistent with our approach for the mandated indictors.	Report to the Council of Governors

Recommendations

We have raised four recommendations, none of which are high priority. The Trust has agreed to all four recommendations and has provided management responses.

High priority	Fundamental issues which have resulted or could result in a qualification of the limited assurance opinion and require immediate action	Medium priority	Improvements which are required but may not need immediate action. In isolation this issue may not prevent an assurance opinion being issued but it may contribute to a group of issues that could prevent an assurance opinion being sought	Low priority	Minor improvements which, if corrected, would benefit the organisation but would not in isolation be likely to prevent an assurance opinion being sought

	Priority	Issue and Recommendation	Management Response	Responsible Officer/Due Date
	Low priority	**Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period** During our sample testing of 25 patient pathways, we found two where the referral letter had not been date stamped and therefore we could not verify when the referral had been received and subsequently when the clock was started. R1. We recommend the Trust reinforces to staff the need to date stamp all referral letters that will lead to more accurate input and reporting of the data. **Improvement opportunity 1** The process to validating pathways is devolved across the Trust by individual Directorates and service areas. There is a risk differing levels of validation could result in gaps in the quality of the data output that is reported through the monthly submission. R2. In order to implement a more consistent approach to monitoring validation, the Trust should set a minimum level of validation across all directorates. The Trust should then monitor how each directorate is performing against the required level of validation.	**Agreed** Recommendation agreed	**Responsible Officer: Annette Peck** **Due Date:** **June 2015** **September 2015**

Recommendations (continued)

	Priority	Issue and Recommendation	Management Response	Responsible Officer/Due Date
	Low	**Data Completeness for Community Services** Data completeness for the Referral to Treatment indicator is an estimate due to system incompatibility issues. However, these have now been resolved and the functionality is capable of being rolled out across all services. We consider that being on an RtT pathway should be set as the default to 'yes'. Requiring staff to opt-out rather than opting in to provide this information will improve the data reported. In addition, further checks are possible to identify referrals that should have been closed. R3. The Referral to Treatment functionality should be rolled out across all services and be accompanied by appropriate training. R4. The Trust should run monthly reports of open referrals to identify referrals which should have been closed.	Recommendations agreed	**Responsible Officers:** Kevin Randall and Tom Boyle **Due Date (for both recommendations):** September 2015.

2014/15 Limited Assurance Opinion on the content of the quality report and performance indicators

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Teaching Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the Quality Report) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these two national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 (the Guidance); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes for the period April 2014 to May 2015;
- papers relating to quality reported to the board over the period April 2014 to May 2015;
- feedback from Commissioners, dated 14 May 2015
- feedback from Governors, dated 30 April 2015
- feedback from Healthwatch Sheffield, dated 22 April 2015
- feedback from Overview and Scrutiny Committee dated 27 April 2015;
- the Trust's draft complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015;

- the latest national inpatient survey May 2015, the latest national Accident and Emergency Department Survey September 2014 and the national Cancer Patient Experience survey September 2014;
- the latest national staff survey February 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 20 May 2015; and
- CQC Intelligent Monitoring Reports published between April 2014 and March 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.
We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Teaching Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

2013/14 Limited Assurance Opinion on the content of the quality report and performance indicators

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Sheffield Teaching Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

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21 May 2015

Responsibilities of the Board of Directors and limitations associated with this engagement

It is important that the Board of Directors and Council of Governors, as the intended users of this report, understand the limitations associated with the procedures performed for this engagement:

- Procedures designed to assess the content of the Quality Report in order to be able to provide a 'limited assurance' opinion have been performed. Where an opinion has been issued, we have carried out sufficient work to ensure that there is nothing that has come to our attention in the Quality Report that is not inconsistent with other information as specified in Monitor's Detailed Guidance for External Assurance on the Quality Report. This is not as detailed as providing a reasonable assurance opinion because we only have been required to review a limited amount of information. We have set out this limited information on the following page.
- Procedures designed to assess readiness for a 'limited assurance' opinion on the mandated indicators requiring a limited assurance report are not as detailed or as challenging as those designed for 'reasonable assurance'. A limited assurance opinion on a performance indicator does not mean that indicator has been confirmed as accurate only that, based on the limited procedures performed including identification of controls and walkthroughs of systems nothing has come to our attention to suggest the indicator is inaccurate.

The Statement of Directors' Responsibilities in respect of the Quality Accounts outlines the directors' responsibilities under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 in preparing Quality Accounts and the expectations of Monitor, the Independent Regulator. This work, and any subsequent work to provide an assurance opinion in future periods, is not a substitute for these responsibilities which remain with the Board of Directors of the Trust.

As set out in the Executive Summary next steps paragraph, we will require a management representation around the responsibility of the Board for data quality and the inclusion of all relevant content, as well as a signed Statement of Directors' Responsibilities before we issue any opinion.

cutting through complexity

The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavour to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.

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