Report to Governors on your Quality Report

Sheffield Teaching Hospitals NHS Foundation Trust

25 May 2016

Our audit opinions:	
Content of Quality Report: Clean	
Indicators	National indicator 1: Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period. Clean.
	National indicator 2: Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers Clean.
	Local indicator: Emergency re-admissions within 28 days of discharge from hospital. Clean - had we been required to give an opinion on this indicator.

Content

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Scope

Introduction

In March 2016, Monitor released their '2015/16 Detailed guidance for external assurance on quality reports'. 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.

Scope

In relation to the **content** of the quality report, the detailed guidance requires us to:

- review the content of the quality report against the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2015/16* (the ARM) as well as Monitor's accompanying guidance *Detailed Requirements for Quality Reports 2015/16*;
- review the content of the quality report for consistency against the other information sources specified by Monitor; and
- provide a signed limited assurance report on the quality report on whether anything has come 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 and accompanying guidance or is not consistent with the other information sources specified by Monitor.

In relation to specific indicators, the guidance requires us to:

- undertake substantive sample testing on two mandated performance indicators and one locally selected indicator (to include, but not necessarily be limited to, 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); and
- provide a signed limited assurance report on the quality report on whether there is evidence to suggest that the two mandated indicators have not been reasonably stated in all material respects in accordance with the ARM and supporting guidance.

Finally, the guidance requires us to provide a report addressed to the NHS foundation trust's council of governors and board of directors (this report) which sets out our findings and recommendations for improvement concerning the content of the quality report, the mandated indicators and the locally selected indicator.

Status

Our work is now complete.

Our recommendations are set out in Appendix 1 and the results of our work to follow up recommendations raised last year are set our in Appendix 2.

Quality Report

Conclusion on content of Quality Report

We are satisfied that there is sufficient evidence to provide a limited assurance opinion on the content of the quality report.

Work performed and findings

We consider two criteria:

- Review of content to ensures it addresses the requirements set out in the ARM; and
- Review of content in the quality report for consistency with other information specified by Monitor.

Our findings are set out below:

Issue considered	Findings
Inclusion of all mandated content	The content of the quality report presented for audit was accurately reported in line with the quality report regulations.
Are significant matters in the specified information sources reflected in the quality report and significant assertions in the quality report supported by the specified information sources?	We identified that: • The Trust's quality report reflected its significant matters, relevant to the selected priorities from the specified information sources; and • Significant assertions in the quality report are supported by the relevant information sources.

Quality Report

Audit of indicators within the Quality Report

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

- 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 were not able to review your A&E indicator as intended by Monitor due to issues arising from the implementation of Lorenzo. Monitor has agreed that the Trust does not need to report A&E performance in its Quality Report and, as a consequence, we were required to review the 'Cancer waits' indicator. We have referred to this in the scope section of our opinion.

In addition, we carried out work on a locally selected indicator chosen by your Council of Governors. The indicator selected was 'Emergency re-admissions within 28 days of discharge from hospital'. This indicator is not subject to a limited assurance opinion.

Conclusion

Our work on the two mandated indicators has concluded that there is sufficient evidence to provide a limited assurance opinion in respect of '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'. For the local indicator 'Emergency re-admissions within 28 days of discharge from hospital' we have concluded that, if required, we would be in a position to provide a limited assurance opinion.

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. In reaching our conclusions we were required to have assessed the design and operational of the systems of control over the data against the six data quality dimensions defined by the NAO. In reaching our conclusion we have assessed these arrangements to consider whether they can be graded as:

- **Green**: No improvement to achieve compliance with the dimensions of data quality noted.
- **Amber**: Opportunities to achieve great efficiency or better control in compliance with the dimensions of data quality noted.
- **Red**: Concern that systems will not achieve compliance with one or more aspects of the dimensions of data quality and therefore a limited assurance opinion cannot be provided.

Quality Report

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated Indicator: 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 Report: 93.5%					
Accuracy	●	●	The data reported substantially agreed to the system although minor errors were identified. 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 2015/16 period. This sample related to referrals that are being reported on. Through our testing we identified one instance where a new pathway had been created for a patient that was already on an open pathway. This 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.	We have not comes across any indications that data for this indicator is not produced in line with national guidance. We have made two recommendations for improvement and have rolled forward a recommendation from 2014/15 that has not been fully implemented. See appendices 1 and 2 for detail.
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. However, although our completeness testing identified no issues, the live error report introduced as a result of the Deloitte review in 2014/15 'Waiting List not attached to a RTT Pathway', which is available to all directorates, should be validated on a monthly basis to ensure all patients are being captured on a pathway. This will ensure data for reporting purposes is complete. We also reviewed a 'created but not accepted pathway' report. Your view is that such pathways lead to over reporting and we are advised that this report is not routinely validated.		
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 Lorenzo system (PAS) and a series of validations are run, including all clock stops. However, we consider that there is scope to improve the validation process further.		
Overall	●	●	Overall we can provide assurance that the system accurately records the true percentage of incomplete pathways within 18 weeks for patients on an incomplete pathway.		

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated Indicator: Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers Performance target: 85% Performance recorded in Quality Report: 83%					
Accuracy	●	●	Appropriate arrangements are in place to ensure the accuracy of data. For example, checks are carried out of the reasons for clock stops within the cancer treatment pathway.	We found the system to be accurately recorded and operating as intended. The data in the Trust's systems was successfully traced back to patients' records for a sample of 25 items. A finding common to our work for the year was that the patients' records were not easy to navigate and we required assistance from staff members to find the relevant information. We note that the migration to electronic records and the use of 'skinny files' is expected to address this	We have not comes across any indications that data for this indicator is not produced in line with national guidance.
Completeness	●	●	Improvements made in previous years to ensure the completeness of this indicator were found to be operating effectively.		
Relevance	●	●	Data was found to be relevant.		
Reliability	●	●	Data was found to be reliable.		
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.		

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	Design	Operation	Commentary on ratings		
Local Indicator: Emergency re-admissions within 28 days of discharge from hospital Performance recorded in Quality Report: 0.3% for patients aged '0 to 15' and 11% for patients aged '16 and over'					
Accuracy	●	●	The data originally included within the quality report was that for a similar indicator required by Sheffield CCG. The extraction routines were revised following our audit and this resulted in accurate reporting of the indicator. The revisions were incorrectly analysed by age as patients aged zero were originally not separated out. This was corrected.	Our testing indicated that the revised published figures were underpinned by accurate data in the PAS that was consistent with patient records.	Data for this indicator is now produced in line with national guidance. We have recommended that guidance is shared with relevant personnel on receipt and that data is validated by an independent member of the Information Services Strategy and Operations Department to ensure accuracy following any changes in guidance. See appendix 1 for detail.
Completeness	●	●	Completeness is ensured by the unique coding of emergency readmissions.		
Relevance	●	●	Reporting indicated that the data was substantially relevant following redrafting of the extraction criteria. However, a recoding of activity following the change to Lorenzo meant that some obstetrics patients were selected that should have been excluded. A second revision of the parameters resulted in relevant data.		
Reliability	●	●	Our testing confirmed that the data was reliably recorded in the Trust's PAS systems and in the patient records.		
Timeliness	●	●	Data can be extracted in a timely manner.		
Validity	●	●	The issue with the incorrect reporting of the indicator required by Monitor arose because the detailed guidance was not shared with appropriate personnel within the Information Services Strategy and Operations Department.		
Overall	●	●	Appropriate arrangements are now in place to ensure the quality of data for this indicator. The required information was readily extracted from the Trust's Lorenzo system once it was pointed out that the Monitor requirements were different from those that the Trust was reporting on throughout the year.		

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Appendices

Appendix 1

Recommendations raised

The recommendations raised as a result of our work in the current year are as follows:

Priority rating for recommendations					
1	Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2	Priority two: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3	Priority three: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Quality Accounts			
1 2	3	**18 week waits** We noted during our review that Lorenzo requires pathways to be 'created' and then 'accepted' by a clinician before they can be tracked. Throughout the year, as evidenced by an error report run by the Data Quality Assurance Manager, there are high numbers of individuals being reported as created but not accepted. As a consequence validation of those pathways for the purposes of 18 week waits cannot be carried out. The risk to the Trust is over-reporting against the indicator. The Trust carried out an analysis of the 'created but not accepted' report for the purposes of our review and was assured that although over reporting was inevitable, the monitoring and validation of cases captured by this report had reduced significantly over the year. We recommend that the 'created not accepted' report is validated on a monthly basis to ensure more accurate and robust reporting. In 2014/15 a validation exercise carried out, as part of an external review by Deloitte, of 4,927 patients on the inpatient waiting list, resulted in 542 patients being moved onto an RTT pathway. An error report, introduced as a result of the review, available to all directorates 'Waiting List not attached to a RTT Pathway' is produced but not routinely validated. Although our completeness testing identified no issues, we recommend that the error report should be validated on a monthly basis to ensure all patients are being captured on a pathway. This will ensure data for reporting purposes is complete.	Both recommendations are agreed. Annette Peck Head of Information 30 September 2016

Appendix 1

Recommendations raised continued

The recommendations raised as a result of our work in the current year are as follows:

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Quality Accounts			
3	3	**Emergency readmissions** The data originally included within the quality report was not consistent with that required by Monitor. Rather it was for a similar indicator required by Sheffield CCG. The issue with the incorrect reporting of the indicator arose because the detailed guidance was not shared with appropriate personnel within the Information Services Strategy and Operations Department. The procedure to extract the required data was not sufficiently validated to ensure that it was reporting the correct data and it had to be revised. We recommended that Monitor's guidance is shared with relevant personnel on receipt and that data extraction is validated by an independent member of the Information Services Strategy and Operations Department to ensure accuracy following any changes in guidance.	Agreed Annette Peck Head of Information For 2016/17 Quality Report

Appendix 2

Recommendations followed up

We have also followed up the recommendations from the previous year's audit, in summary:

Total number of recommendations	Number of recommendations implemented	Number with ongoing relevance (Repeated below):
2	1	1

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (May 2016)
Quality report				
1	3	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 Responsible Officer: Annette Peck September 2015	The roll out of Lorenzo has meant that this recommendation is yet to be implemented.

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