External Assurance on the Trust's Quality Report

Sheffield Teaching Hospitals NHS Foundation Trust

Audit 2010/11

audit commission

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Summary of my external assurance on your Quality Report

Overall comment

1 The Trust has put considerable effort into improving its arrangements for the production of the Quality Report and strengthening the systems generating the performance information. The Trust responded positively and promptly to our feedback on the draft Quality Report and incorporated our recommendations in the final version. With the help of Internal Audit the Trust has begun the process of making sure the information systems that feed the Quality Report are fully documented.

2 The style and structure of the Quality Report is good. It strikes a very effective balance between the Trust's desire to make the Quality Report easily accessible and the need to comply with Monitor and the Department of Health's requirements.

Content of the Quality Report

3 On 27 May 2011 I issued my independent assurance report to the Governors' Council on the Trust's annual Quality Report. I concluded the Quality Report was:

- in line with Monitor's guidance; and
- not inconsistent with the information specified by Monitor.

4 I include my limited assurance report at appendix 1.

Testing of performance indicators

5 I tested the two performance indicators mandated by Monitor and the one indicator selected by Governors. In all cases, I found that the data supporting the indicators was substantiated. However, there are opportunities to improve the control over performance reporting by reducing the manual intervention required by managers responsible for performance.

6 Looking ahead to the external assurance of the Quality Report for 2011/12, your auditors will be required to give a limited assurance report on the two mandated indicators. This is not required for this year where reporting on the indicators is in this long form report.

Table 1: **Summary of performance indicator testing**

	Indicator	Outcome of system review and sample testing
M	Clostridium Difficile	The system is adequate for the purposes of compiling the indicator. I checked the performance you reported in your Quality Report and sample tested 22 cases. All were consistent with underlying sources of evidence.
M	62 day max wait between urgent GP referral and first treatment for all cancers	The system is adequate but there is an inherent control weakness. The manager responsible for achieving the target is also involved in determining whether cases should be adjusted or excluded. However my sample testing indicates that this potential weakness has not impacted on the quality of the reported information. I checked the performance you reported in your Quality report and sample tested 30 cases. The reported status of all cases tested was consistent with the underlying sources of evidence.
G	Percentage of patients that were readmitted to hospital	The system is adequate for the purposes of compiling the indicator. I checked the performance you reported in your Quality Report and sample tested 37 cases. All were consistent with underlying sources of evidence.

(M = mandated, G = Selected by Governors)

7 I have agreed recommendations with management that aim to support the Trust to improve for 2011/12.

Background to the review

Outline of Monitor's requirements

8 The health service is facing funding constraints and change. Monitor has recognised that at such times, there needs to be continued focus on quality, and in particular, the arrangements governing quality within foundation trusts (FTs). While the Care Quality Commission assesses compliance with essential standards, the primary responsibility for maintaining and improving quality remains with foundation trust boards.

9 Following the events at Mid Staffordshire NHS Foundation Trust, Monitor reviewed its approach to assessing how effectively the board of an applicant trust ensured good governance of the quality of care provided by the trust. This led to a new framework and approval for evaluating quality governance in applicants. Through consultation, Monitor has sought to strengthen the annual reporting process for existing foundation trusts through additional requirements on quality governance for the Statement on Internal Control in the Annual Report. This includes requiring FTs to obtain external assurance on the Quality Reports included in their annual reports.

10 Following a detailed evaluation of the dry run external assurance of 2009/10 Quality Reports in March 2011 Monitor updated its requirements for 2010/11. Monitor requires external auditors to:

- review whether the content of your Quality Report is in line with Monitor guidance and not inconsistent with other specified information and issue a limited assurance report concluding the work; and
- test two performance indicators mandated by Monitor and one indicator selected by Governors from the Quality Report and report their findings to the Board of Directors and the Board of Governors.

My approach

11 I recognised the challenging timescale that Monitor presented to your staff to complete the Quality Report and obtain the required external assurance. I am grateful for the cooperation provided by Trust staff to enable me to complete the review. Where possible I have highlighted to the Trust opportunities for improving the Quality Report. I have accessed the wide knowledge base that my colleagues in the Audit Commission's Audit Practice have by being the auditor of 47 of the 137 NHS Foundation Trusts.

Detailed findings

Review of the content of your Quality Report

12 I reviewed your Quality Report against Monitor's published guidance and the sources of information it specified (see appendix 2). Table 2 outlines my findings.

Table 2: **Findings of my review of your Quality Report**

Area of review	Findings	Recommendations
Is the Trust's Quality Report in line with Monitor's published guidance as set out in paragraph 7.73 of the NHS FT Annual Reporting Manual (ARM) published on 31 March 2011?	Yes. I highlighted some changes that were required in order to ensure full compliance with Monitor's guidance. The Trust updated its Quality Report in response to these comments and the Quality Report now complies with Monitor's guidance.	
Is the Quality Report consistent with the information sources specified by Monitor?	Yes. I highlighted some changes that were required in order to ensure consistency with the specified documents. The Trust updated its Quality Report in response to these comments. Areas in which further improvements could be made in the future include: ■ providing additional outcome measures for priority areas, for example numbers of falls within hospital that cause harm; and ■ analysis of complaints as requested by LINks.	Include additional outcome measures for priority areas in the Quality Report Include analysis of complaints within the Quality Report

13 The 2010/11 Quality Report is consistent with the information available to the Trust at the time of its compilation. I make the recommendations above to provide an indication of how future Quality Reports could better meet the needs of their readers.

Recommendations

R1 Include additional outcome measures for priority areas in the Quality Report

R2 Include analysis of complaints within the Quality Report

Testing of performance indicators

Objective

14 The main objective of my approach to testing performance indicators is to consider whether the Trust is:

- producing relevant and reliable data to underpin the indicators report in its quality account; and
- calculating the indicators according to the required definition and guidance.

Monitor requirements

15 Monitor did not specify a testing strategy for the indicators selected. However it has stated the approach for 2010/11 is in anticipation of external auditors providing a limited assurance report from 2011/12 on whether two mandated indicators included in the Quality Report have been reasonably stated in all material respects.

16 In its '*Detailed guidance on external assurance on Quality Reports 2010/11*', Monitor stated that auditors will need to:

- document the systems used to produce the specified indicators;
- perform a walkthrough of the system to gain an understanding of the data collection process; and then
- test the indicators substantively back to supporting documentation to gain assurance over the six dimensions of data quality.

17 These are:

- Accuracy – Does the Trust record data recorded correctly and is it in line with the methodology for calculation?
- Validity – Does the Trust produce data that complies with relevant requirements?
- Reliability – Does the Trust collect data using a stable process, consistently over time?
- Timeliness – Does the Trust capture data as close to the associated event as possible and available for use within a reasonable time period?
- Relevance – Does all data used to produce the indicator meet eligibility requirements as defined by guidance?
- Completeness – Does the Trust include all relevant information, as specified in the methodology, in the calculation?

Indicators selected for testing

18 For an acute trust Monitor mandated two performance indicators from the Trust's Quality Report for testing. I agreed the following with the Trust:

- Clostridium difficile (C-Diff); and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

19 In addition, Governors selected the percentage of patients that were readmitted to hospital for testing.

Findings

20 I have included at appendix 3 my detailed findings on testing indicators.

21 For the C-Diff indicator, the starting point for our testing is the result from the laboratory test. The earlier stages of the process were not tested as these involve clinical judgement and are outside the scope of our review.

22 Internal audit have compiled a detailed analysis of the systems in place for each of the three indicators tested. This will provide a good starting point to aid future improvement in controls and documentation for these indicators. The Trust could use this as a basis for reviewing other key indicators that feed into the Quality Report.

Appendix 1 Limited assurance report on the content of the Trust's Quality Report

Independent Assurance Report to the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Sheffield Teaching Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

I 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 my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

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 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

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

- Board minutes for the period April 2010 to March 2011;
- Papers relating to Quality reported to the Board over the period April 2010 to March 2011;
- Feedback from NHS Sheffield dated 5 May 2011;
- Feedback from Governors dated 20 May 2011;
- Feedback from LINks dated 6 May 2011;
- The Trust's Healthcare Governance Committee Annual Complaints Report for 2009/10 dated 29 November 2010;
- The 2010 national patient survey;
- The 2010 national staff survey;

- The Head of Internal Audit's annual opinion over the Trust's control environment dated 26 May 2011; and
- Care Quality Commission quality and risk profiles dated March 2011.

I consider the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust as a body, to assist the Governors' Council in reporting Sheffield Teaching Hospitals NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Governors' Council to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Governors' Council as a body and Sheffield Teaching Hospitals NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I 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'). My limited assurance procedures included:

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is less 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.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

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27 May 2011

Appendix 2 Information specified by Monitor on the content of the Quality Report

- Board minutes for the 2010/11 financial year and up to the date of signing the opinion (the period).
- Papers relating to the Quality Report reported to the Board over the period.
- Feedback from commissioners.
- Feedback from governors.
- Feedback from Local Involvement Networks (LINks).
- The Trust's complaints report published under Regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009.
- Feedback from other named stakeholder(s) involved in the sign off of the Quality Report.
- Latest national patient survey.
- Latest national staff survey.
- The Head of Internal Audit's annual opinion over the trust's control environment.
- Care Quality Commission quality and risk profiles.

Appendix 3 Detailed findings of performance indicator testing

Table 3: **Findings of performance indicator testing**

	Indicator	System for data collection	Outcome of sample testing	Recommendations
M	C-Diff – count of positive identifications attributed as hospital acquired. Based on the national guideline of positive samples taken after 3 days in hospital.	Adequate	The starting point for my testing is the result from the laboratory test. The earlier stages of the process were not tested as these involve clinical judgement and are outside the scope of this review. I tested 12 positive identifications of C-Diff that were attributed as hospital acquired and 10 that were attributed as community acquired. In all cases the recorded data was consistent with other records and the attribution was determined in accordance with national guidelines. The Trust does not retain the laboratory (lab) referral forms for more than 3 months so we were unable to agree the sample collection date back to the referral forms. Instead I tracked the date of referral back to the record of this date within the lab system. In one case the lab system recorded that the sample date was based on the date of receipt of the sample by the lab because the date the sample was taken was not recorded by the clinician. This was an isolated error and did not affect the attribution of this case.	Retain the laboratory referral forms for 18 months to enable retrospective audit.

	Indicator	System for data collection	Outcome of sample testing	Recommendations
M	62 day max wait between urgent GP referral and first treatment for all cancers	Adequate, but with a potential weakness	In common with many performance management systems there is an inherent weakness in the system. The manager responsible for achieving the cancer waiting time targets is also involved in determining whether cases should be excluded from the indicator or adjusted. I sample tested 30 cases – 15 that were removed from the pathway and 15 that remained within the 62 day pathway through to their treatment. The reported status of all cases tested was consistent with the underlying sources of evidence. All 15 removed patients were excluded for valid reasons: death within 62 days; patient decision to go private; or patient decision not to be treated. I checked the breach status (breach or no breach) of all 15 patients that completed the pathway by reference to evidence within the patients' case notes of the dates of referral and first treatment. All were consistent with the reported status.	
G	Percentage of patients that were readmitted to hospital	Adequate	I looked at a sample of 37 cases, which according to data from PAS, were either readmitted as an emergency within 14 days, which is the key indicator, readmitted as an emergency within 15 to 28 days and non-emergency readmissions within 14 days. The discharge and readmission dates were checked to patients' notes. All discharge dates within patient notes agreed to the dates held in PAS, with only one exception. The difference was one day, which did not have an impact on the indicator. There were no issues identified with readmission dates.	

(M = mandated, G = Selected by Governors)

Appendix 4 Action Plan

Recommendations	
Recommendation 1	
Include additional outcome measures for priority areas in the Quality Report	
Responsibility	Head of Patient and Healthcare Governance (Sandi Carman)
Priority	2
Date	31 March 2012
Comments	Agreed.
Recommendation 2	
Include analysis of complaints within the Quality Report	
Responsibility	Head of Patient and Healthcare Governance (Sandi Carman)
Priority	1
Date	31 March 2012
Comments	Agreed.
Recommendation 3	
Retain the laboratory referral forms for 18 months to enable retrospective audit.	
Responsibility	Consultant Microbiologist (Christine Bates)
Priority	3
Date	31 March 2012
Comments	Need to assess the feasibility of storing additional records

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