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Sherwood Forest Hospitals NHS Foundation Trust

Quality Report 2017/18

24th May 2018

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Contents

Scope of this work

We have performed this work in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2017/18" issued by Monitor (operating as NHS Improvement ("NHSI")).

Reports and letters prepared by external auditors and addressed to governors, directors or officers are prepared for the sole use of the NHS Foundation Trust, and no responsibility is taken by auditors to any governor, director or officer in their individual capacity, or to any third party. The matters raised in this report are only those which have come to our attention arising from or relevant to our work that we believe need to be brought to your attention. They are not a comprehensive record of all the matters arising, and in particular we cannot be held responsible for reporting all risks in your business or all internal control weaknesses. This report has been prepared solely for your use in accordance with the terms of our engagement letter dated 23rd March 2018 and for no other purpose and should not be quoted in whole or in part without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose.

Background and scope

Background

NHS foundation trusts are required to prepare and publish a Quality Report each year. The Quality Report has to be prepared in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2017/18" issued by NHS Improvement ("NHSI").

As your auditors, we are required to undertake work on your Quality Report under NHSI's "Detailed requirements for external assurance for quality reports 2017/18" ('the detailed guidance') which was published in February 2018.

The purpose of this report is to provide the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust ("the Trust") with our findings and recommendations for improvements, in accordance with NHSI's requirements. It is referred to by NHSI as the "Governors report".

Scope of our work

We are required by NHSI to review the content of the 2017/18 Quality Report, test three performance indicators and produce two reports:

- Limited assurance report: This report is a formal document that requires us to conclude whether anything has come to our attention that would lead us to believe that:
  - The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports 2017/18";
  - The Quality Report is not consistent in all material aspects with source documents specified by NHSI; and
  - The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports 2017/18".

  A limited assurance engagement is less in scope than a reasonable assurance engagement (such as the external audit of accounts). The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited compared to a reasonable assurance engagement.
- Governors report: A private report on the outcome of our work that is made available to the Trust's Governors and to NHSI.

Our limited assurance report is restricted, as required by NHSI, to the content of the Quality Report, consistency of specified documents to the Quality Report; and two mandated performance indicators only. The Governors report covers all of our work and, therefore, the third local indicator which is chosen by the Governors.

Content of the Quality Report

We are required to issue a limited assurance report in relation to the content of your Quality Report. This involves:

- Reviewing the content of the Quality Report against the requirements of NHSI's published guidance, as specified in the FT ARM and the "Detailed requirements for quality reports 2017/18"; and
- Reviewing the content of the Quality Report for consistency with the source documents specified by NHSI in the detailed guidance.

Performance indicators

We are required to issue a limited assurance report in respect of two out of four for acute national priority indicators specified by NHSI in their detailed guidance.

The indicators for the year ended 31 March 2018 which were chosen by the governors and subject to our limited assurance (the "specified indicators") are marked with the symbol Ⓐ in the Quality Report and consist of:

Specified Indicators	***Specified indicators criteria*** (exact section where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways.	Appendix 3 of the Quality Report.
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	Appendix 3 of the Quality Report.

Our procedures included:

- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgments made by the Trust in preparation of the specified indicators; and
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosure.

Local indicator

We are also required to undertake substantive sample testing of one further local indicator. This indicator is not included in our limited assurance report. Instead, we are required to provide a detailed report on our findings and recommendations for improvements in this, our Governors report. The Trust's Governors select the indicator to be subject to our substantive sample testing. The indicator selected is maximum waiting time of 62 days from urgent GP to first treatment for all cancers with detailed guidance on the definition in appendix 3 of the Quality Report.

Summary of findings

Content of the Quality Report

No issues have come to our attention that lead us to believe that the Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports 2017/18".

For further information refer to page 8.

Limited Assurance Report
As a result of our work, we provided an unqualified limited assurance report in respect of the content of the Quality Report.

Consistency with Other Information

No issues have come to our attention that lead us to believe that the Quality Report is not consistent with the other information sources defined by NHSI's "Detailed requirements for quality reports 2017/18".

For further information refer to page 8.

Limited Assurance Report
As a result of our work, we provided an unqualified limited assurance report in respect of the consistency of the Quality Report with the "Detailed requirements for quality reports 2017/18".

Selected Performance indicators

Our findings relating to the performance indicators are summarised as follows:

Performance indicators included in our limited assurance report	**Findings**
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	Nine issues identified; three impact on our limited assurance opinion

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.	Five issues identified; three impact on our limited assurance opinion

For further information refer to page 7.

Limited Assurance Report

As a result of our work, our limited assurance report in respect of the mandated performance indicators is qualified as follows.

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The 18 week indicator is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. The data reported is subsequently updated by Sherwood Forest Hospitals NHS Foundation Trust for any identified errors through a continuous validation process. However, the process is not applied to the whole data set and focuses only on the longest waits, working backwards through the waits as far as capacity allows. This process operates similarly across the NHS.

In our testing we found a number of errors in the data: one where the clock had not been stopped when it should have been; one where a start clock had not been started when it should have been; and another where the clock had been incorrectly stopped when it should not have been. Each of these resulted in the patient's wait being reported, or not reported, incorrectly.

Sherwood Forest Hospitals NHS Foundation Trust was not able to review and update the whole data set used to calculate the indicator. Therefore, we were unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

Basis for Disclaimer Conclusion - Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

We identified that due to the current configuration of System One, the system used by Sherwood Forest Hospitals NHS Foundation Trust in A&E, we are unable to confirm the start and stop clocks to supporting evidence. This is because the system does not capture a history of supporting evidence for amendments to this data and there is no supporting evidence retained outside the system.

We also found that start clocks for ambulance arrivals are not being captured in line with NHSI's definition for "the Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge", which specifies that the clock start time for patients arriving by ambulance is when hand over occurs, or 15 minutes after the ambulance arrives at A&E, whichever is earlier. Sherwood Forest Hospitals NHS Foundation Trust currently uses the arrival time in department without adjustment, which would fall after ambulance arrival but before handover. The total number of arrivals by ambulance make up 22.5% of patients who attended A&E. The issue of difficulty in measuring ambulance arrival time due to lack of accurate data has been identified across a number of trusts, nationally.

In addition, we found stop clocks for admissions to wards in the hospital did not appear to be calculated in line with guidance that this should be based on physical departure time, but instead use the time of the decision to refer to ward. Sherwood Forest Hospitals NHS Foundation Trust admitted 19.84% of patients attending A&E to wards during 2017/18.

Performance indicator not included within our limited assurance report	Findings
62 days from urgent GP to first treatment for all cancers	No errors identified in sample tested. Two control issues identified.

For further information refer to page 12.

Annual Governance Statement

We identified the following issues relevant to the Quality Report:

- There was a lack of consistency between statements made in the Annual Governance Statement and the conclusions in our limited assurance report. We suggested the Trust should amended wording once our work on the Quality Report was complete. The Trust updated the AGS accordingly.

For further details, see page 13.

Detailed findings

Review against the content requirements

We reviewed the content of the Quality Report against the content requirements which are specified in the FT ARM and the "Detailed requirements for quality reports 2017/18".

A number of amendments were made to the draft Quality Report as a result of the work we performed. These are summarised in Appendix A. Once the amendments were made by the Trust, no further issues came to our attention that led us to believe that the Quality Report has not been prepared in line with the FT ARM and the "Detailed requirements for quality reports 2017/18".

Review consistency against specified source documents

We reviewed the content of the 2017/18 Quality Report for consistency against the following source documents specified by NHSI:

- Board minutes for the period April 2017 to March 2018;
- Papers relating to Quality reported to the Board over the period April 2017 to March 2018;
- Feedback from the Commissioners, Mansfield and Ashfield and Newark and Sherwood Clinical Commissioning Group dated 27/04/18;
- Feedback from local Healthwatch organisations, Healthwatch Nottinghamshire, dated 03/05/18;
- Feedback from the Overview and Scrutiny Committee, dated 10/05/18;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, for the annual complaints 2016/17, dated 02/06/17;
- The latest national patient survey (2016) dated 31/05/17;
- The latest national staff survey dated March 2018;
- Care Quality Commission inspection report, dated 09/11/16; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16/05/2018.

A number of amendments were made to the draft Quality Report as a result of the work we performed. These are summarised in Appendix A. Once the amendments were made by the Trust, no further issues came to our attention that led us to believe that the Quality Report is not consistent with the other information sources detailed above.

Performance indicators on which we are required to issue a limited assurance conclusion

As required by NHSI we have undertaken sample testing of two performance indicators on which we issued our limited assurance report:

1. The percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

2. The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

We are required to obtain an understanding of the key processes and controls for managing and reporting the indicators and sample test the data used to calculate the indicator. Our work is performed in accordance with the detailed guidance and included:

- Identification of the criteria used by the Trust for measuring the indicator;
- Confirmation that the Trust had presented the criteria identified above in the Quality report in sufficient detail that the criteria are readily understandable to users of the Quality Report and are in accordance with NHSI mandatory performance indicator definitions set out in Annex C of the NHSI Detailed requirements for external assurance for quality reports 2017/18';
- Obtaining an understanding of the key processes and controls for managing and reporting the indicator through making enquiries of Trust staff and through performing a walkthrough;
- Checking the Trust's reconciliation of the reported performance in the Quality Report to the data used to calculate the indicator from the Trust's underlying systems;
- Testing a sample of relevant data used to calculate the indicator; and
- Obtaining representations that the data used to calculate the indicator is accurately captured at source and that no sources of information/data relevant to the indicator performance have been excluded.

We tested only a sample of data, as stated above, to supporting documentation. Therefore, the errors reported below are limited to this sample.

We have also not tested the underlying systems, for example the patient administration system and the data extraction and recording systems.

Our findings are set out below. Recommendations arising from these findings are presented in Appendix B.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	
Reported performance:	
2017/18 Threshold: 92%	2017/18 Actual: 91.5%
Criteria identified:	
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period; • The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2017 to March 2018; • The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the NHSI guidance; and	

• The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.		
Issues identified through work performed:		
No.	**Issue**	**Impact on limited assurance report**
1.	Due to limited capacity, the Trust begins its validation work to determine data is accurately recorded with the longest patient waits and works backwards to the shorter wait cases over the month. In our testing we identified one case where the clock was not stopped on a timely basis after treatment, resulting in the patient being incorrectly included in month end reporting in September 2017 as still waiting for treatment.	We disclaimed our limited assurance report in respect of this matter. This issue has been identified in a number of trusts across the country due to the retrospective nature of the validation processes undertaken across most trusts.
2.	The Trust applies a good practice element of the suite of rules on RTT clocks whereby when they do not have enough capacity to service a planned follow up appointment following treatment, the Trust will trigger a new clock start to monitor the patient's wait. We saw two instances of this, but in one instance we found that requirement for a clock start was only identified the month after the appointment was due. As a result, in September 2017, a start clock was backdated to 24th August 2017. This should have been reported as an open clock at the end of August 2017 but was omitted.	We disclaimed our limited assurance report in respect of this matter.
3.	In one case we identified a clock had been stopped in error upon a diagnostic test being run. The case was then not reported between August 2017 to October 2017 until the validation team identified the clock had been stopped in error and amended it back to open.	We disclaimed our limited assurance report in respect of this matter. We note that in isolation (excluding issues referred to above), this would be a basis for qualification.
4.	We identified that the Trust had been calculating the indicator incorrectly for year-end reporting. This should be an arithmetic average of the monthly reporting. Instead the Trust has totalled the number of compliant pathways each period end and divided it by the total number of pathways. Amending this calculation changes overall marginally performance from 91.4% to 91.5%.	No impact on our limited assurance report as amendment made.

5.	We identified that the Trust had not included sufficient detail about the definition of the indicator, how it was calculated and the completeness of the population, in the first draft of the quality report. The Trust has since amended this.	No impact on our limited assurance report.
6.	In our testing we identified an instance where the wrong start clock had been entered, using the date on the referral letter and not the date of receipt of the letter. This added a week to the overall clock, but did not change whether it would have been compliant or not in reporting.	No impact on our limited assurance report.
7.	In our testing we identified an instance where the patient had been referred electronically and when they logged in to convert their 'choose and book' option to an appointment it was 'deferred to provider' (referring to when the appointment slot is unavailable so the request reverts onto a wait list with the provider for them to book into an available slot). The staff member who rebooked this at the Trust used the following day, when they booked an appointment, instead of the day the patient had attempted to book.	No impact on our limited assurance report.
8.	When reconciling the data in our complete listing of the Trust's raw data to the figures in the Quality Report we found a number of small differences (8 cases). This is because the Trust had used the numbers reported by NHS England, not their own submission.	No impact on our limited assurance report.
9.	We identified that the Trust applies a bucketing process to round days over each week down to a full week for reporting purposes. However, it also reports 18 weeks as breaches, so no understatement occurs. The guidance proposes rounding in the opposite direction for reporting.	No impact on our limited assurance report.
Overall Conclusion:		
Our substantive testing of the indicator identified nine issues. Three impacted on our limited assurance report resulting in a disclaimed report in respect of this indicator.		

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	
Reported performance:	
2017/18 Target: **>95%**	2017/18 Actual: **92.33%**
Criteria identified:	
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is defined within the technical definitions that accompany ***Everyone counts: planning for patients 2014/15 - 2018/19*** and can be found at **www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf**. • Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at **https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf**.	
Issues identified through work performed:	

No.	**Issue**	**Impact on limited assurance report**
1.	We identified that A&E employees were able to alter the clocks of patients without an audit trail on the system. This issue is more significant as paper based support for clock starts and stops is no longer being relied upon. For the two instances we identified during sample testing, start clocks had been amended by a small number of minutes but there was no explanation or evidence recorded to give a reason for the alteration. The lack of audit trail in the system may mean other, more significant changes have not been identified.	We disclaimed our limited assurance report in respect of this matter.
2.	Where the decision is taken to admit a patient onto a ward, the clock stop should be at the time the patient physically leaves A&E to be moved to the bed on the ward assigned to them. During our walkthrough, we identified one case where the clock was stopped 1 hour, 3 mins before the patient arrived on the ward, at the time the decision to admit was taken. Depending on when the patient physically left A&E, the additional wait may have made this patient a breach.	We disclaimed our limited assurance report in respect of this matter.

	We are unable to confirm that this is not happening in other cases. Patients admitted onto a ward during 2017/18 total 19.84% of all A&E attendances.	
3.	As is consistent with other acute Trusts, the Trust is not capturing the arrival time for the ambulance in order to calculate the start clocks in line with the guidance: '*For ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier. In other words if the ambulance crew have been unable to handover 15 minutes after arrival that patient is nevertheless deemed to have arrived and the total time clock started.*'	We disclaimed our limited assurance report in respect of this matter. This issue has been identified in a number of trusts across the country.
4.	We identified that triage times are recorded on the paper patient records. It is then the responsibility of the doctor or nurse to enter the triage time into System One, the ED system. We found that for two patient records the time had not been altered to reflect the actual triage time which indicated that triage occurred later than it actually did. However, this does not affect the indicator reporting as triage time is not used to record clock start times in this Trust.	No impact on our limited assurance report.
5.	Validation does not occur before reporting on the A&E indicator. A reasonableness check is performed by the Chief Compliance Officers daily but this is only to ensure that major outliers are checked before reporting commences.	No impact on our limited assurance report.
Conclusion:		
Our substantive testing of the indicator identified five issues. Three impact on our limited assurance report resulting in a disclaimed report in respect of this indicator.		

Performance indicators not included within our limited assurance report

NHSI also requires us to undertake substantive sample testing of a local indicator selected by the Governors, the results of which are not included within our limited assurance report.

We obtain an understanding of the key processes and controls for managing and reporting the indicator and sample test the data used to calculate the indicator back to supporting documentation.

We tested only a sample, as stated above. Our reported errors below are limited to this sample.

Our findings are detailed as follows:

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers		
Reported performance:		
2017/18 Actual: 84.32%		
Criteria identified:		
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; • An urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant; • The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date that the referral is *received* by the Trust; and • The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.		
Issues identified through work performed:		
No.	**Issue**	**Impact**
1.	We were unable to conclude that the reported figures matched the raw data provided to us for the 2017/18 year. The Trust has been understating its performance by 0.22% according to our calculations. However, this could be due to month end reporting being at a fixed moment in time	The Trust may have been understating its performance.

	whereas Open Exeter will allow adjustments for the rest of the quarter.	
2.	During our time reviewing the indicator we identified that removal of excluded patients is manual. There are a sample of patients, who are marked as deceased, and checked each month to ensure patient records confirm the patient has passed away and thus should have been removed. Where the patient is removed for another reason, such as choosing not to go ahead with treatment or switching to a private facility, there is no further validation which occurs. We have not found any instances within our testing where a patient had been removed incorrectly.	Patients may be removed from the pathway in error, culminating in their not receiving treatment.
Conclusion:		
Our substantive testing of the indicator identified two control issues.		

Through our sample testing of data for each of the above indicators, we did not find any evidence of any deliberate manipulation of the data.

The recommendations associated with these findings are presented in Appendix B.

Annual Governance Statement

NHSI require Foundation Trusts to include a brief description of the key controls in place to prepare and publish a Quality Report as part of the Annual Governance Statement ("AGS") in the 2017/18 published accounts. The requirements for the content of the AGS are set out in Annex 5 of Chapter 2 of the NHS Foundation Trust Annual Reporting Manual 2017/18.

The Annual Governance Statement, within the Foundation Trust's 2017/18 Annual Report, includes the following statement specific to the Quality Report:

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on theform and content of Annual Quality Reports, which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Quality Report presents a balanced picture our performance over the period covered from April 2017 to 31 March 2018 and indicates that there are appropriate controls in place to ensure the accuracy of data. These controls include:

- Corporate level leadership for the quality account is assigned to the Chief Nurse
- Quality governance and quality and performance reports are included in our performance management framework
- Internal audits of some of our indicators have tested how the indicators included in the Quality Report are derived, from source to reporting, including validation checks
- Key individuals involved in producing the report are recruited on the basis that they have the appropriate skills and knowledge to deliver their responsibilities

The Quality Report is included within the Annual Report and Accounts and describes how we have engaged with a wide range of stakeholders in our activity to improve the quality of care provided. The same assurance processes are utilised for other aspects of performance.

The Advancing Quality Programme will remain the vehicle to drive the Quality Priorities. The Programme will be closely monitored, updated and amended as required throughout the year with regular progress reports through the Advancing Quality Programme Board, the Trust Quality Committee and Board of Directors as part of the routine cycle of business.

We have used the following intelligence sources to identify and agree the Quality Priorities for 2018/19:

- Stakeholder and regulator reports and recommendations
- Clinical Commissioning Group (CCG) feedback and observations following their quality visits
- Commissioning for Quality and Innovation (CQUIN) priorities
- National inpatient and outpatient surveys
- Feedback from our Board of Directors and Council of Governors
- Emergent themes and trends arising from complaints, serious incidents and inquests
- Feedback from senior leadership assurance visits and ward accreditation programme
- Nursing and midwifery assurance framework and nursing metrics
- Quality and safety reports

- Internal and external reviews
- National policy
- Feedback and observations from Healthwatch through joint partnership working
- Feedback from Stakeholders, partners, regulators, patients and staff in the development of our Advancing Quality Programme

The indicators within the Quality Reports are shared with each of the Trust's five Clinical Divisions and through to the Board of Directors. Specific indicators within the report are monitored and reported via the Trust performance and governance framework namely the:

- Monthly divisional performance management meetings
- Patient Safety and Quality Group
- Quality Committee

We assure the quality and accuracy of our elective waiting time data through the following measures:

- Weekly PTL meetings for RTT and Cancer including;
  - A review of current position at reporting specialty level and action plans to address failing services
  - Patient level review of long waits
  - Monitoring of operational reports that impact on elective care data e.g. outpatient referral and waiting list management reports
  - Access to live self-service RTT PTL
- Elective Care Training programme for administrative staff involved in the management and validation of elective care pathways .
- RTT and Data Quality educator with remit to improve data accuracy of reported information through various mediums.
- Clear lines of responsibility for the management of patient pathways including the Central Booking Team, Operational Managers, waiting list staff, Cancer Tracking Team, Operational Outpatient Teams, Patient Pathway Coordinators, Data Quality Validation Staff.
- Chief Operating Officer nominated and responsible for the sign-off of RTT and cancer returns.

We acknowledge that there are risks to the quality and accuracy of this data and have the following mitigating actions in place:

- Trust wide Data Quality Strategy which sets out the organisational expectations for all colleagues relating to internally and externally reported data. The Strategy defines both ours strengths and known weaknesses and plans for improvement.

- Data Quality Oversight Group provides updates to the Board regarding known data quality issues to ensure both visibility of issues and assurance.
- Data quality dashboard with KPIs that reflect known risks to the accuracy of our data for example unreconciled outpatient attendances, mismatched RTT information in our PAS (e.g. incompatible codes) etc.
- Internal audit programmes designed to highlight and assure the quality of our elective care data with feedback mechanisms to address themes and inform training requirements.
- External audit review and testing of reported data.
- Validation Team who validate and correct data on a daily basis to ensure accuracy of reported data.

We have developed a robust governance and performance framework that is now well established throughout the organisation. This ensures that risks to the safety and quality of patient care, in addition to financial stability are identified and well managed resulting in the maintenance of clinical sustainability and financial viability.

As part of our report on the financial statements we were required to:

- Review whether the Annual Governance Statement reflects compliance with FT ARM Annex 5 of Chapter 2 in respect of Quality Report requirements and NHSI's "Detailed requirements for external assurance for quality reports 2017/18"; and

- Report if it does not meet the requirements specified by NHSI or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements.

The work we undertook on the Annual Governance Statement as part of our work on the financial statements identified the following issues relevant to the Quality Report**:**

- Although internal audit issued a report on the mandatory indicators for the Quality Account, no mention is made that these provided limited assurance over RTT and ED.

- The overarching statement that there are appropriate controls in place to ensure the accuracy of data with respect to preparation of the Quality Report did not appear to reflect the number of amendments that were required to the content or the modifications to our opinions which were on the basis of access to accurate data.

We suggested that additional context might be added and wording amended to focus on the requirement for a balanced view. The Trust updated the AGS in these areas.

Appendices

Appendix A: Matters arising from our limited assurance review of the Foundation Trust's 2017/18 Quality Report: Content review

We note that the table below has not yet been completed as we continue to work with the Trust around the identified issues.

	Observation	Recommendation
	Review of the content requirements	
1.	The Trust produced eighteen drafts of the Quality Report, though the last two had only trivial amendments. Nine copies (including the final two) were provided to us to review content. We did detailed reviews on four of these, with an additional check of all errors being correct in one. For the other four, we identified substantial errors when compared to the guidance on mandatory content or a failure to make requested changes so the Trust was asked to update for our comments before further checks were undertaken.	Due to the timescales required for the completion of the quality report, and the fact that there is a time lag before some final quarter data is ready for inclusion, it is inevitable that some data will not be ready for the first draft of the report, however comparable trusts have typically provided us with three or four versions, with only a maximum of three having detailed checks. The Trust should ensure the requirements of the FT ARM and associated guidance are reviewed and incorporated into the original drafts of the quality report. Where the exact wording of sentences and/or paragraphs are mandated, ensure that these are appropriately highlighted within the document to avoid inadvertent modification.
2.	Part 2 of the guidance for the completion of quality reports requires trusts to include statements of assurance by the Board on a range of measures, including: • The most recently published data for core indicators, with prior period comparisons, a national average, and the highest and lowest comparable results at other Trusts. The Trust did not include the majority of this information in	We would recommend that the Trust review the required mandatory information as part of their project plan for the production of the 2018/19 Quality Account and plan how the required information may be obtained.

	Observation	Recommendation
	initial drafts and ultimately had to include a statement that there was information it could not obtain in the quality report. We note that other comparable trusts were able to obtain this information. • Information on learning from deaths, which was a new requirement this year. The Trust had to make several amendments to this section as the guidance had not been followed. Ultimately one of the requirements has partially been omitted (a quarterly breakdown of case reviews) following re-writing of the section. Where the Trust has paraphrased or chosen an alternative form of presentation for data required to be provided in a mandated form, this has left the Trust vulnerable to ommissions and reduced comparability with other trusts.	As above, measures should be inserted into the draft reports to highlight what sections are mandatory wording and need to be retained.
3.	Part 3 of the guidance for completion of quality reports requires trusts to identify three specific indicators for the areas of patient experience, patient safety and clinical care. In the Trust's Quality Report these are called 'additional priorities' – and do not constitute one specific indicator for each area. This has consequently made it difficult for the Trust to answer the requirement of demonstrating prior period activity and benchmarks for each indicator where possible. By contrast, other trusts are specific on indicators for these three areas, and monitor and report performance against these using KPIs, all year round.	We recommend that the Trust reconsiders the need for specific indicators for the areas of patient experience, patient safety and clinical care and determines appropriate KPIs to measure these in future.
4.	Part 3 of the guidance requires a specific introduction explaining any differences in the indicators as compared to prior year, and why and how this was done. A similar statement on the progress against the Trust's core	The Trust adopt a system of signposting for occasions where they determine information has already been included elsewhere in the report.

	Observation	Recommendation
	priorities is required under part 2. The Trust elected to keep this text only in part 2 and declined to include signposting between the sections.	
5.	There is a requirement for the Trust to disclose detail about the definition of the indicators subject to audit and statements about the origin and completeness of the population. In addition to the omission of this for RTT (noted below), this was not included for the A&E four hour wait indicator or 62 day cancer waits until requested.	The requirement for this detail be documented within the project plan for the 2018/19 quality report, noting that the 62 day cancer wait may need to be updated depending on the Governor's preferred local indicator.
	Review of the consistency of the report with specified source documents	
6.	A number of inconsistencies were identified between the specified document and drafts of the Quality Report. For example, these included:. • The complaints report provided was for 2016/17 for checking consistency so we requested this for 2017/18. The Trust has now removed the section on the complaints, concerns and compliments activity that had been in the report. • The consistency statement in the 'Statement of Director's Responsibilities' included consistency with Governor's feedback, but no feedback comment had been obtained. • The Trust elected not to include a section, per regulation 5, on what changes had been made to the document between issue to third parties to comment (principally Healthwatch, the CCG, and the Overview and Scrutiny Committee). This was on the basis they perceived no change had been made. We would note there was substantial reordering and additional context required to be provided.	We would recommend that the Trust considers all documents with which consistency will need to be checked as part of a project plan. It should then be logged which version is deemed most ready for viewing by third parties, and a record of the changes made thereafter should be recorded and disclosed alongside th third party comments as part of regulation 5. This should also help ensure all members of the Trust are aware of the deadline for a substantially complete version of the quality report and ensure that the number of iterations can be produced.

	Observation	Recommendation
	• As noted above, we received a number of iterations of the report and it was ultimately version 18 that was agreed as the final form.	

Appendix B: Matters arising from our limited assurance review of the Foundation Trust's 2017/18 Quality Report: Performance indicators

	Observation	Recommendation
	Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	
1.	Due to limited capacity, the Trust begins its validation work with the longest waits and works backwards to the shorter cases over the month. In our testing we identified one case where the clock was not stopped on a timely basis after treatment was received resulting in the patient being incorrectly included in month end reporting in September 2017.	This issue has been identified in a number of trusts across the country and has arisen since the requirement for auditors to obtain and sample test data from the whole financial period is incompatible with the process trusts are required to follow for the regulator, submitting monthly data to NHSI on referral to treatment times. As it is not possible (due to the volume of cases each month) for trusts to validate the accuracy of every case prior to submission, there is an inherent risk that errors exist in the data each month and that these errors may not be identified until later periods. As trusts archive data each month after submission, it is not possible for trusts to retrospectively correct errors that are identified in a later period. Because this issue is common and inherent in the way in which referral to treatment data is currently handled across the NHS, we do not recommend the Board take significant actions to address the matter. However, we do recommend that the Board persist in reminding staff of the need to accurately record referral to treatment times in line with Trust guidance so that the number of errors that the validation team identify is minimised.

	Observation	Recommendation
2.	The Trust applies a good practice element of the suite of rules on RTT clocks whereby when it does not have enough capacity to service a planned follow up appointment following treatment, it will trigger a new clock start to monitor the patient's wait. We saw two instances of this, but in one instance we found that the need to start a clock for a follow-up appointment that couldn't be scheduled was only identified the month after a new start clock was required. As a result, in September 2017 a start clock was backdated to 24th August 2017. This should have been reported as an open clock at the end of August 2017 but was omitted.	This issue links back to capacity within the validation team. We would not recommend further action taken in this area, but work with staff on capturing this right first time at the front line would be the best use of limited resource.
3.	In one instance of testing we identified a clock had been stopped in error upon a diagnostic test being run. The case was then not reported between August and October 2017 until the validation team identified the clock had been stopped in error and amended it back to open.	That further work with staff in the applicable specialty is undertaken around eligibility criteria when instances of this are identified.
4.	We identified that the Trust had been calculating the indicator incorrectly for year-end reporting. This should be an arithmetic average of the monthly reporting. Instead the Trust has totalled the number of compliant pathways across each period end report and the total number of pathways. This changes overall performance from 91.4% to 91.5%. At the time of writing this report, we are expecting the Trust to update this figure.	That the Trust calculates this correctly in future.
5.	We identified that the Trust had not included detail about the definition of the indicator, how it was calculated and completeness of the population in the first draft of the quality report. The Trust has since amended this.	That the Trust include this in future.

	Observation	Recommendation
6.	In our testing we identified an instance where the wrong start clock had been entered, using the date on the referral letter and not the date of receipt of the letter. This added a week to the overall clock, but did not change whether it would have been compliant or not in reporting.	The Trust is exploring data solutions which allow it to compare the date of referral against date of receipt so it can identify any others like this for exception reporting.
7.	In our testing we identified an instance where the patient had been referred electronically and when they logged in to convert their 'choose and book' option to an appointment it was deferred to provider. The individual who rebooked this at the Trust used the following day, when they booked an appointment, instead of the day the patient had attempted to book. This was understood to be done by a temporary member of staff working within the team.	Measures are put in place for reminding temporary staff of the requirements of these key criteria when they cover posts in the team processing appointments.
8.	When reconciling the data in our complete listings of the Trust's raw data to the figures in the Quality Accounts we found a number of small differences (8 cases). This is because the Trust had used the numbers reported by NHS England, not their own submission.	The Trust rely upon its own data to compile the figures for the Quality Report.
9.	We identified that the Trust applies a bucketing process to round days over each week down, however it also reports 18 weeks as breaches. The guidance proposes rounding in the opposite direction.	The Trust round up instead for reporting purposes.
	Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	
10.	We identified that A&E employees were able to alter the arrival times of patients without an audit trail. For the two instances we identified during sample testing there was no explanation or evidence recorded to give a reason for the alteration.	We recommend that SystemOne be updated to make reasons for adjustments mandatory. In addition, we recommend that the Board remind staff of the need to accurately record patient's journeys to allow accurate reporting against a key performance indicator.

	Observation	Recommendation
11.	Where the decision is taken to admit a patient onto a ward, the clock stop should be at the time the patient physically leaves A&E to be moved to the bed on the ward assigned to them. During our walkthrough, we identified one case where the clock was stopped 1 hour, 3 mins before the patient arrived on the ward, at the time the decision to admit was taken. Depending on when the patient physically left A&E, the additional wait may have made this patient a breach. We are unable to confirm that this is not happening in other cases. Patients admitted onto a ward during 17/18 total 19.84% of all A&E attendances.	We recommend the Trust seeks to update the Medway system to include a robust way of recording a patients movements and treatments throughout their attendance in the hospital.
12.	As is consistent with other acute Trusts, the Trust are not capturing the arrival time for the ambulance in order to calculate the start clocks in line with the guidance: '*For ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier. In other words if the ambulance crew have been unable to handover 15 minutes after arrival that patient is nevertheless deemed to have arrived and the total time clock started.*'	The Trust uses internal data due to concerns with the completeness and accuracy of the Ambulance Trust data. We recommend the Trust liaise with the Ambulance Trust over the data quality of the arrival time information received in order to facilitate more accurate reporting. Alternatively the Trust should seek to ensure that it captures ambulance arrival data as part of its own data capture for this indicator.
13.	We identified that triage times are recorded on the paper patient records. It is then the responsibility of the doctor or nurse to enter the triage time into System One, the ED system. We found that for two patient records the time had not been altered to reflect the actual triage time which indicated that triage occurred later than it actually did. However, this does not effect the indicator reporting as triage time is not used to record clock start times in this Trust.	We recommend that SystemOne be updated to make reasons for adjustments mandatory. In addition, we recommend that the Board remind staff of the need to accurately record patient's journeys to allow accurate reporting against a key performance indicator.
14.	Validation does not occur before reporting on the A&E indicator. A reasonableness check is performed by the Chief Compliance Officers daily but this is only to ensure that major outliers are checked before reporting commences.	The Trust should implement a robust checking and sign off process prior to reporting performance data externally to ensure any errors or inaccuracies in data are identified and corrected prior to submission.

	Observation	Recommendation
	Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	
15.	We were unable to conclude that the reported figures matched the raw data provided to us for the 17/18 year. The Trust has been understating their performance by 0.22% according to our calculations. However, this could be due to month end reporting being at a fixed moment in time whereas Open Exeter will allow adjustments for the rest of the quarter.	The Trust should implement a robust checking and sign off process prior to reporting performance data externally to ensure any errors or inaccuracies in data are identified and corrected prior to submission. In addition, the Trust should implement a monitoring process to track where adjustments are made.
16.	During our time reviewing the indicator we have identified that removal of excluded patients is manual. There is a sample of patients who are marked as deceased checked each month to ensure patient records confirm the patient has passed away and thus should have been removed. Where the patient is removed for another reason, such as chosen not to go ahead with treatment or switched to a private facility there is no further validation which occurs. We have not found any instances within our testing where a patient had been removed incorrectly.	The Trust should implement a robust checking and sign off process prior to reporting performance data externally to ensure any errors or inaccuracies in data are identified and corrected prior to submission.