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Oxford Health NHS Foundation Trust

Findings and Recommendations from the 2015/16 NHS Quality Report External Assurance Review

Final report: 25th May 2016

the Distinctive audit

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Executive Summary

We have completed our Quality Report testing and are in a position to issue our limited assurance opinion

Status of our work

- We have completed our review, including validation of the reported indicators. On receipt of the signed Quality report and letter of representation we will issue our unmodified opinion.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by Monitor in their "Detailed Guidance for External Assurance on Quality Reports 2015/16".
- We will issue an unmodified opinion for inclusion in your 2015/16 Annual Report.

Q3 Governance Risk Rating: **Green**

The Care Quality Commission inspection in the year resulted in "requires improvement" rating.

	2015/16	2014/15
Length of Quality Report	116 pages	117 pages
Quality Priorities	4	8
Future year Quality Priorities	4	4

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in Monitor's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in Monitor's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected minimising delayed transfer of care and 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital as its publically reported indicators – the alternative was admissions to inpatient services had access to crisis resolution home treatment teams.
  - For 2015/16, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected days between serious incident pressure damage grade 3 and 4 in community teams and hospitals.
  - The scope of testing includes 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.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to 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; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the minimising delayed transfer of care and 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
  - Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested: minimising delayed transfer of care,100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital, and days between serious incident pressure damage grade 3 and 4 in community teams and hospitals.

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Executive Summary (continued)

We have not identified any significant issues from our work.

Content and consistency review

Review content → Document review → Interviews → Form an opinion

We have completed our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM.

	Overall conclusion
Content Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	G
Consistency Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)? Certain feedback from commissions is still awaited as at the issue of this report.	G

Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

Monitor requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators and a further indicator specified by the Governors. We perform our testing against the six dimensions of data quality that Monitor specifies in its guidance.

From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Guidance for External Assurance on Quality Reports 2015/16".

Performance indicator testing (continued)

	Delayed transfers	7 day follow up	Reduction of pressure ulcers
Accuracy Is data recorded correctly and is it in line with the methodology.	B	B	B
Validity Has the data been produced in compliance with relevant requirements.	B	G	G
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	B	B	G
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	B	G	G
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	G	G	G
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	G	B	B
Recommendations identified?	✓	✓	✓
Overall Conclusion	Unmodified Opinion	Unmodified Opinion	No opinion required

G No issues noted

B Satisfactory – minor issues only

A Requires improvement

R Significant improvement required

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Content and consistency review findings

The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.

Although our work is based around reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report, based upon the points identified in our NHS Briefing on Quality Accounts.

Key questions	Assessment	Statistics
• Is the length and balance of the content of the report appropriate?	A	Length: 116 pages
• Is there an introduction to the Quality Report that provides context?	G	
• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	G	Patient Safety: 1 Clinical Effectiveness: 1 Patient Experience: 2
• Has the Trust set itself SMART objectives which can be clearly assessed?	G	
• Does the Quality Report clearly present whether there has been improvement on selected priorities?	G	
• Is there appropriate use of graphics to clarify messages?	A	
• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?	G	
• Does the Annual Governance Statement appropriately discuss risks to data quality?	G	
• Is the language used in the Quality Report at an appropriate readability level?	G	

G No issues noted A Acceptable but could be improved R Requires significant improvement

Deloitte view

Overall, the Quality Account is a clear account of the performance of the Trust in the year.

Particular areas of good practice are:

- The recognition and transparency with regards to the issues surrounding the implementation of Carenotes
- Having just four priorities rather than eight in previous years, has allowed the Trust to focus their efforts to achieve success in these areas. We would not recommend any further reductions in the number of overall priorities.

Possible areas for improvement next year include:

- The document remains relatively long, although we acknowledge that there is a lot of content to cover, with the Trust having both Mental Health and Community services within its remit. We recommend that the Trust further reviews the report to identify any areas which could be simplified.
- Minor recommendations as highlighted above include considering use of additional graphics to clarify points report to assist readers.

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Performance indicator testing

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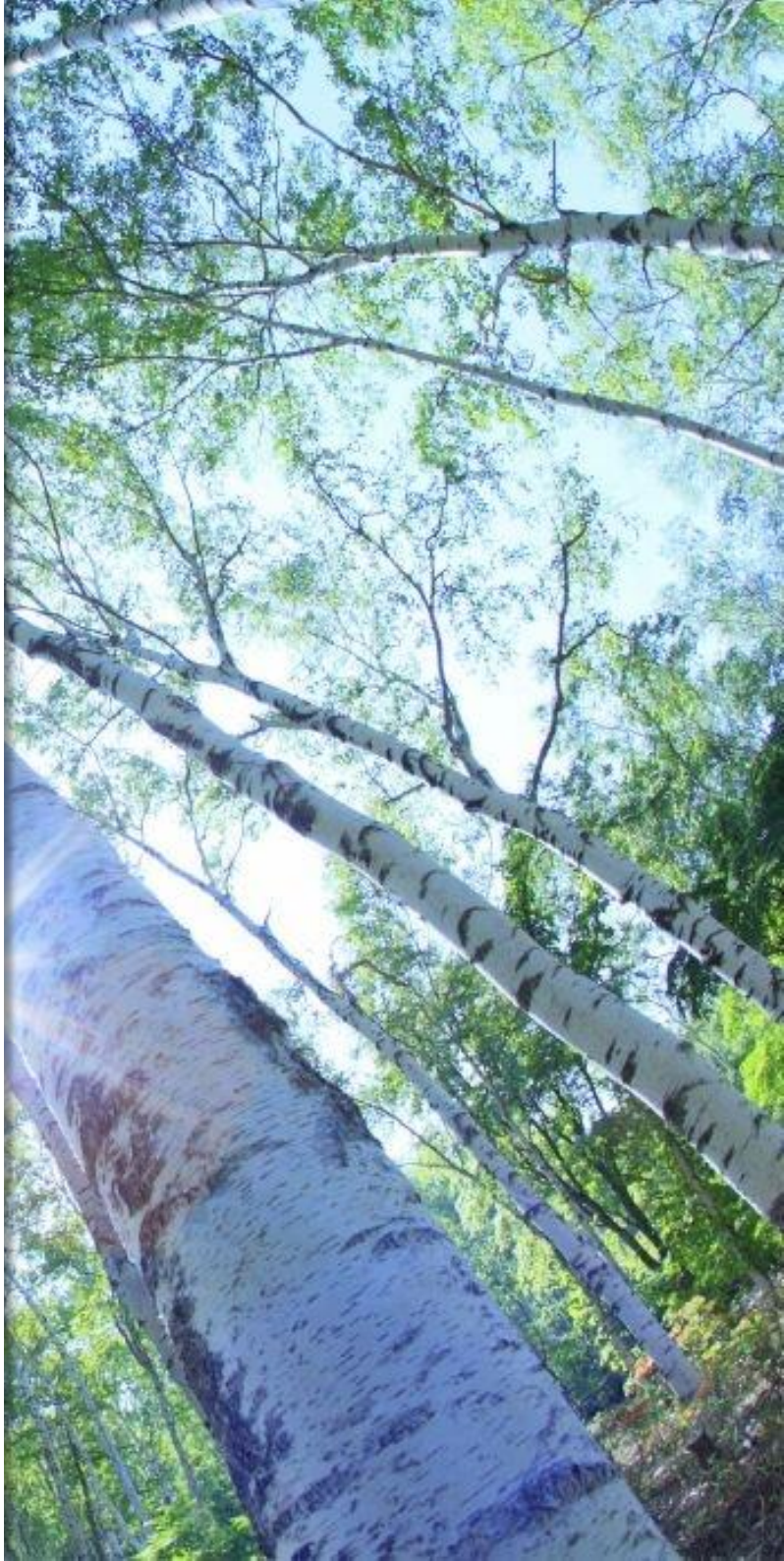


Delayed transfers of care

	Trust reported performance	Target	Overall evaluation
2015/16	2.5%	<7.5%	B
2014/15	1.9%	<7.5%	A
2013/14	1.5%	<7.5%	B

We note significant improvement on the delayed transfer of care indicator on prior year; however, on the basis of the estimation in the denominator still consider need for further improvement

Indicator definition and process

Definition: "The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus). A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

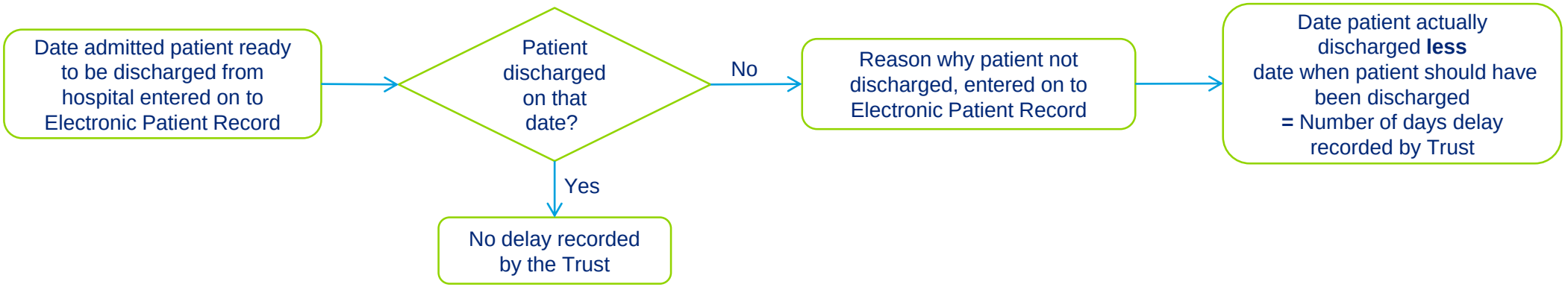
[a] a clinical decision has been made that the patient is ready for transfer AND

[b] a multi-disciplinary team decision has been made that the patient is ready for transfer AND

[c] the patient is safe to discharge/transfer."

This indicator measures the impact of community-based care in facilitating timely discharge from hospital and the mechanisms in place within the hospital to facilitate timely discharge. People should receive the right care in the right place at the right time and mental health trusts must ensure, with primary care organisations and social services, that people move on from the hospital environment once they are safe to transfer.

Process flow



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Delayed transfers of care (continued)

Approach

- We met with the Trust's leads to understand the process from an individual being ready to transfer care to the overall performance being included in the Quality Report.
- The finding raised in the prior year was discussed with the Trust's leads as discussed in our "recommendations for improvement" section.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 24 from 1 April 2015 to 31 March 2016 of patients that were identified as a delayed transfer of care and agreed the information from the calculation to the underlying information held within the CareNotes system as well as to the initial and final sitrep returns.
- We additionally selected a sample of 24 of discharges and transfers from CareNotes generated discharge report in order to test whether they should have been included in the delayed transfers of care data this was reviewed against the underlying information held within the CareNotes system as well as to the sitrep returns.
- With the denominator of the indicator being based on a 95% occupancy, we have performed sensitivity analysis on the bed days and verified whether this is a reasonable estimate based on historic and post year-end occupancy.

Findings

From our testing of the sample of 24 identified as delayed transfers of care:

- We did not identify any issues with recalculation of delayed bed days based on the date fit for discharge and date of discharge obtained from CareNotes and sitrep returns.
- One instance was noted with error in the start date of the delay, but this was before 31 March 2015 and therefore did not impact on the current year calculation.
- There were two instances whereby the commencement of the delay was not reported in the earliest sitrep report indicating a delay in the timeliness of reporting. This did not impact our calculation and we have reviewed post year-end sitrep reports to ensure completeness of reporting.
- From our testing of the sample of 24 selected from the discharge and transfer listing, we did not identify any delayed transfers from the sitrep reports that were not included within the indicator calculation.
- The calculation of the indicator is a very manual process. Although the quarterly external reported data, selected the correct months and occupation of beds for the calculation, it was noted that for three months monthly data reported internally to the board was calculated with the wrong month occupied bed days or the available bed days rather than occupied bed days. This was only identified as part of the Deloitte audit. We note that this year was a one-off in method of calculation and therefore more prone to mistakes; however, even following the return to the previous year's format of the calculation using occupancy reports, we recommend implementation of a review process prior to submission of indicators to board and monitor.
- As has been raised to the board, the indicator has been calculated based on an estimated occupancy of 95% for total number of bed days. This is due to occupancy reports generated from Carenotes in the year not being an accurate reflection of what the average occupancy is in a month. We have performed sensitivity analysis based on average prior year reported occupancy and the first month for 2016/17 generated report, with variation less than 0.1%. It has been noted that occupancy would have to reduce to below 29% before a breach in indicator is observed. Due to these issues, disclosure of the performance indicator will be reported to the nearest 0.5%. We have raised recommendations with respect to the use of Carenotes which we have noted have already started to be enacted for increased validation of the report and messages to users to appropriately record patient movements. In addition, we recommend further training for users and implementation of prompts within the system that may prevent user errors.

Deloitte View:

Whilst we have reached a position where we can give an unqualified opinion on the indicator, the reliability of the Carenotes report requires significant improvement.

Care programme approach 7 day follow up

	Trust reported performance	Target	Overall evaluation
2015/16	96%	95%	G
2014/15	n/a	n/a	Not selected
2013/14	n/a	n/a	Not selected

Indicator definition and process

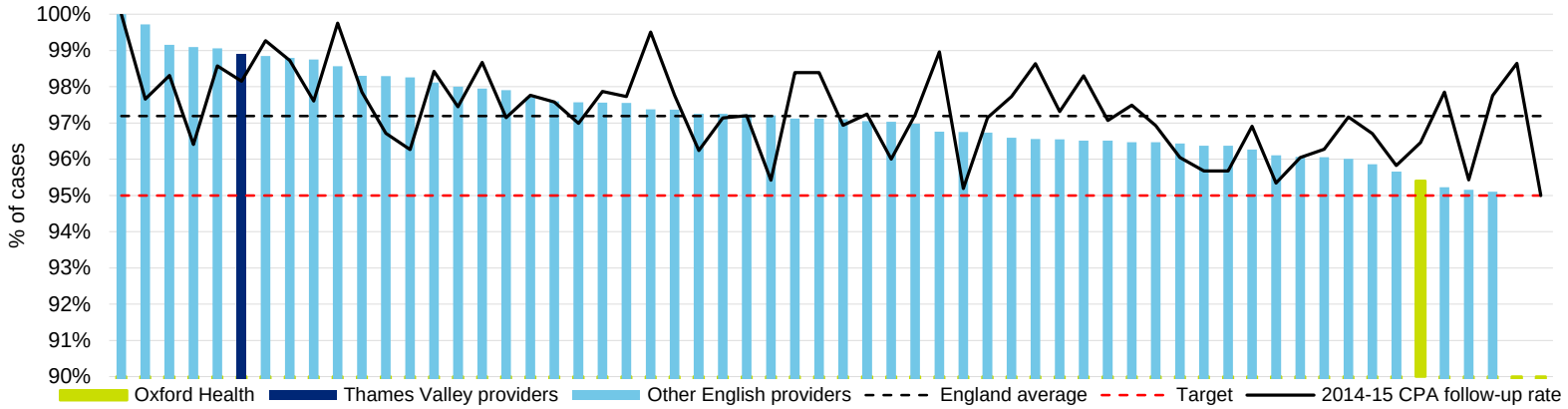
Definition: "The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period."

Patients who are discharged from a mental health in-patient episode on a Care Programme Approach should receive a follow-up contact within seven days of the discharge. Relevant discharges include patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care. All avenues must be exploited to ensure that the patients are followed up within seven days of discharge.

National context

The chart below shows how the Trust compares to other organisations nationally for 2015/16, the latest national data available. It is noted that although achieving over the 95% national target, in comparison to other Trusts, Oxford Health is not performing as well despite the additional exclusions taken and is markedly under the national average.

Care Programme Approach patients receiving follow-up within 7 days - 2015-16



Source: Deloitte analysis of Health and Social Care Information Centre data

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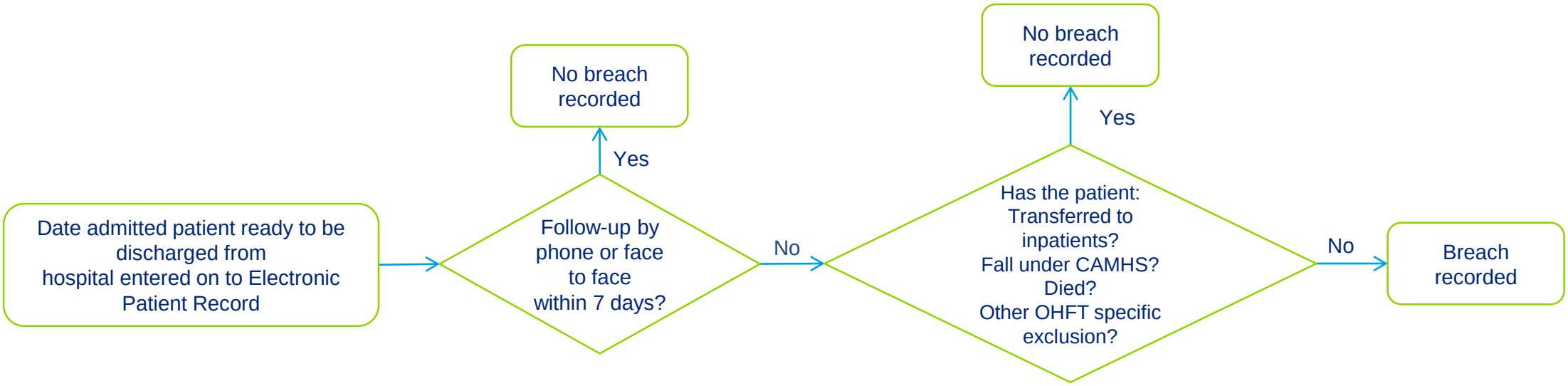
Care programme approach 7 day follow up (continued)

Process flow



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Care programme approach 7 day follow up (continued)

Approach

- We met with the Trust's leads to understand the process from discharge of a service user to the overall performance being included in the Quality Report. There were no recommendations from the review of last year's Quality Report as this indicator was not part of the external assurance work.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 24 from 1 April 2015 to 31 March 2016 including in our sample service users who had and had not been followed up within 7 days. We agreed our sample of 24 to the underlying information (patient progress notes) attached to Carenotes.
- We selected a sample of 24 from 1 April 2015 to 31 March 2016 including in our sample service users who were excluded from the indicator calculation to determine whether the exclusion was allowable based on DoH guidance.
- We considered the completeness of the data set by agreeing patient IDs per discharge listing to the underlying data used within the calculation

Findings

- In our testing of 24 samples from the calculation, it was noted in seven instances that the date of follow up was earlier than that recorded per Carenotes. For samples with follow up within the seven days, this has no impact on the calculation. For samples where a breach was initially identified, but patient notes recorded follow up within the seven day period, these samples were appropriately recorded as being valid follow ups. Although there are no issues identified in the calculation, we recommend stressing the importance to users of Carenotes to record appointments with patients in a timely manner, thus avoiding the requirement for later validation.

In our testing of 24 samples excluded from the calculation:

- We noted 5 patients had not been discharged and actually transferred between wards and therefore should not have been included in the calculation, these patients were appropriately excluded from the calculation after manual validation. Although no impact on the indicator calculation, we note this is a Carenotes issue and recommendations raised in the delay transfer of care indicator are also applicable to this indicator
- We noted that in addition to the allowable exclusions per DoH guidance, patients discharged from the eating disorder facility at Cotswold House are not included within the calculation if the CCG contracting the care is outside Oxford and Buckinghamshire. This is consistent with previous years' treatment. From our sample we noted seven such instances. Appropriate disclosure is required within the quality accounts.
- In review of the completeness of the data used in the indicator, we noted that two patients that were on the original discharge listing and therefore included in the indicator calculation but were not on subsequent listings. Per review of patient notes, these were valid discharges, but aligned to the incorrect episode in Carenotes and therefore not recorded on the discharge listing. Although this does not have an impact as appropriately included in the indicator calculation, we have raised as a recommendation included within delayed transfer of care indicator to prevent multiple episodes being opened to the same patient.

Deloitte View:

We note the Trust is applying a further two exclusions to the guidance being those patients who are discharged directly to the care of another mental health provider trust (whether inpatient or community services) and for eating disorder patients in Swindon who are discharged to the care of their GP. With the appropriate disclosures added for these additional exclusions applied, we can give an unqualified opinion on the indicator

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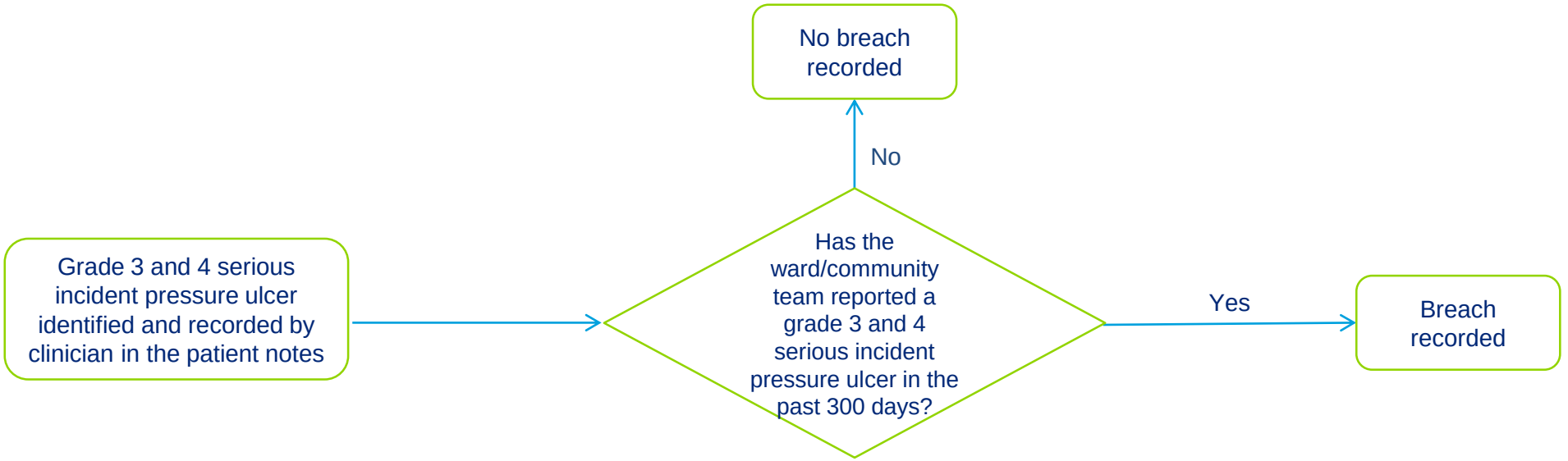
Days between serious incident pressure damage grade 3 and 4 in community teams and hospitals

	Trust reported performance	Target	Overall evaluation
2015/16	9	10% reduction	G
2014/15	n/a	n/a	Not selected
2013/14	n/a	n/a	Not selected

Indicator definition and process

Definition: Days between avoidable pressure damage grade 3 and 4 in community teams and community hospitals; with the target being 300 days between incidents of avoidable pressure damage in community teams and community hospitals. Oxford Health will therefore report a serious incident in a community team/hospital that has had an incident within the 2015/16 that has previously had an incident on that team/hospital within the past 300 days.

Process flow



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Days between serious incident pressure damage grade 3 and 4 in community teams and hospitals

Approach

- We met with the Trust's leads to understand the process for identifying days between serious incident pressure damage grade 3 and 4 in community teams and hospitals to the overall performance being included in the Quality Report. There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 23 (being 100% of incidents) from 1 April 2015 to 31 March 2016 from a report generated from Ulysses for serious incident pressure ulcers grade 3 and 4 and agreed to Ulysses patient details and independent serious incident database. We have then reviewed for each incident whether there has been another incident within the past 300 days on the ward/community team reported. We have also reviewed post year-end report for serious incidents to ensure listing complete.
- For the avoidance of doubt, we categorically have not checked whether the clinical assessment is accurate, as that is not within the scope of our work, or our area of expertise.

Findings

- From our testing of the sample of 23, we have not identified any issues with the data provided in agreement to Ulysses patient details, and the serious incident database. The majority of patient notes were paper documentation, we recognise electronic records are being implemented as would be our recommendation.
- It was noted from this sample of 23 that 5 incidents were reported over 7 days later than the date of the incident and 3 of these were reported over 2 weeks later from the date of the incident. We have raised a recommendation to review the procedure for reporting to determine if appropriate and sufficient for timely reporting and ensuring that the procedure is appropriately carried out.
- As at 25 April 2016, there have been no serious incidents grade 3 and 4 pressure ulcers reported not included in the 2015/16 data or reported in the 2016/17 data thereby we have concluded no issues in completeness of the data provided.
- In considering each serious incident reported, whether the ward/community team has had another incident within the 300 day time limit, we noted one exception that had not been reported. This was corrected and we have not extended the sample on the basis that 100% of the reported incidents have been tested. Given the error noted and subsequently corrected, we recommend implementing a clearer audit trail to enable a more effective review.
- It is also noted that Chipping Norton has been excluded from reporting this is due to OHFT not being responsible for providing the intermediate beds at this location, as these are commissioned by Oxfordshire County Council and provided by the Order of St John. However, some of OHFT staff have been provided on a bank basis to work at Order of St John which is why there are incidents reported on Ulysses.

Deloitte View:

Although we do not issues an opinion on this indicator, we have not identified any significant issues; however, we recommend the implementation of a more detailed review of the calculation and review of the procedure for reporting serious incidents and ensuring staff are following appropriately.

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Recommendations for improvement

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Recommendations for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
Delayed transfer of care/Seven day follow up	**Improve reliability of Carenotes reports generated** We recommend: • increased validation of reports generated by Carenotes to identify source of the issues and develop action plan to prevent repetition of issues; • increased communication to users of Carenotes to appropriately record movement and activities of patients and other common pitfalls; • further training for users; • prevent multiple episodes to be opened simultaneously; • embed prompts within system as reminders for best practice and prevention of common pitfalls	The Programme Board for the implementation of Carenotes continues to oversee the actions necessary to ensure Carenotes meets the original specifications. Actions are being implemented to address all of the recommendations made but have to be considered as an integral part of improving the overall system. As an interim measure, the processing of bed management data, admissions, discharges and transfers will be carried out by a central team to ensure system data accuracy which in turn will ensure reporting accuracy. **Responsible Officer:** Director of Finance **Timeline:** on-going **Process for updating Council of Governors:** TBC	H
Delayed transfer of care	**Review of calculation prior to reporting to board or monitor** We recommend a review of the working paper required for the calculation of the indicator prior to reporting to board and monitor	Agreed, an arms length review prior to report submission will be implemented. **Responsible Officer:** Director of Finance **Timeline:** July 2016 **Process for updating Council of Governors:** TBC	M
Seven day follow up	**Accurate recording of follow up directly to Carenotes** We recommend communication with staff to stress the importance of recording appointments with patients directly to Carenotes to ensure accurate reports.	Will be actioned as part of review of Carenotes user training and communications and as part of the wider Carenotes Programme. **Responsible Officer:** Directors of Finance and Nursing **Timeline:** on-going **Process for updating Council of Governors:** TBC	M

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Recommendations for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
Reducing serious incident pressure damage	**Implementation of review** • Present indicator calculation with a clear audit trail to allow for effective review: include additional data to allow reviewer to reperform calculation.	Agreed, pressure ulcer grade 3 and 4 and serious incident data to be cross checked at least quarterly, prior to reporting and to allow a YTD refresh. **Responsible Officer:** Director of Nursing **Timeline:** Quarterly testing from Q1, July 2016 **Process for updating Council of Governors:** Updates on objectives in quality account, report formally to governors at least six monthly	M
Reducing serious incident pressure damage	**Reporting pressure ulcers in a timely manner** • Review procedure for the reporting of serious incident pressure ulcers to determine if appropriate and sufficient for timely reporting • Take steps to ensure the procedure to report is carried out by staff.	Agreed with recommendation and will complete a review of the procedure to report serious incident pressure ulcers **Responsible Officer:** Director of Nursing **Timeline:** 30th September 2016 **Process for updating Council of Governors:** Report on progress against objectives for 2016/17	M

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Update on prior year recommendations

Indicator	Deloitte Recommendation	Current year status
Delayed transfers of care	**Review of Trust wide process** A wholescale review is recommended to ensure consistency across wards and compliance with Monitor guidance: • Process of recording delays; • Ensuring three criteria are met; • Timeliness in reporting delays; • Calculation checks in spreadsheets; • Second review of information in monthly submission; • Development and implementation of automated processes in recording and reporting delays.	There has been positive progress towards the recommendations raised in the prior year. A new Standard Operating Process has been developed during the year for clarity as to the process of recording delays. There has been significant training of users implemented and increased communication between the performance team and users. The spreadsheets used to report delays include various calculation checks and automated calculations for ease of review and prevention of errors. We note that the development and implementation of automated process in recording and reporting delays is being considered and anticipated to be incorporated in Carenotes. There is still no review performed over monthly submission of indicator and as such we have raised as a recommendation in the current year.
Access to crisis resolution home teams	**Completeness check of refreshed monthly information** Due to errors noted in the completeness testing, it is recommended that each month the refreshed report is agreed back to the patients included in the prior month validation process to identify any patients that have been omitted or where information such as admission time or date has been retrospectively changed. These issues can then be resolved on a monthly basis.	Noted that the normal practice is to refresh two months prior to the month being validated to ensure completeness of the data.
Access to crisis resolution home teams	**Significant manual input required** Clinicians are often slow with finalising their appointments and may record a meeting only in patient notes and not as a calendar appointment. For this reason, once a list of potential breaches is calculated information is sent to clinical support staff at relevant wards who validate this against the additional information available to them which is not recorded in the report. This manual process is time consuming which diverts resources from normal duties. We recommend that further process improvements are made to minimise the amount of manual validation required.	With the transition to Carenotes, the process to complete the documentation for appointments is less onerous on the clinicians. However, as noted for the seven day follow up indicator, there is still work to do to ensure appointments are accurately recorded to Carenotes to allow for more reliable reporting.

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Update on prior year recommendations (continued)

Indicator	Deloitte Recommendation	Current year stature
Friends & Family	**Consider re-deploying assets to achieve better response rates** Although it does not impact on our audit procedures, we noted that some devices have been used very much more frequently than others (some only a few times a quarter). We recommend that the Trust analyses utilisation of these resources and considers re-deploying them in to maximise the benefit.	The Trust has been more closely monitoring the use of the handheld devices on the wards (the kiosks were being utilised) and every month the patient experience lead for the directorate visits the wards. In addition the Trust has been trialling the use of different feedback collection methods as part of a re-tender of the contract from January 2017
Friends & Family	**Periodically sense check data** We recommend that as part of the Trust's internal review procedures, a periodic sense check of the data is performed to identify anomalies such as surveys being completed when units are not open.	This was put in place, quarterly testing extended to include looking at time/ day of electronic responses. In addition contractor added parameters to all 30 handheld devices and kiosks so that responses received outside the following times are quarantined and not reported without a manual check as required– 07:30-18:30 Monday to Friday.
Friends & Family	**Improve the accuracy of data input by Patient Perspective** We recommend that the Trust requests physical custody of the postal surveys received by Patient Perspective and continues to sample test and validate the data received.	Quarterly testing between the physical copies of the paper surveys and data provided by the contractor has been completed and any anomalies raised with contractor.
Friends & Family	**Dates required for all survey responses** We recommend that all postal entries are stamped on the day of receipt and that Patient Perspective are requested to provide the response date in full.	Data provided in 2015/16 included full date of response. Hand stamping was completed for the first six months in 2015/16, the quarterly testing picked up no issues or delays between paper survey received in post by contractor and date survey scanned and added to data.
Friends & Family	**Investigate and prevent duplicate entries** We recommend that the Trust puts a process in place to ensure that no duplicate surveys can remain in the data reported to management and their stakeholders.	From 1st May 2015 all responses reported have a unique identifier, which again is part of quarterly testing.

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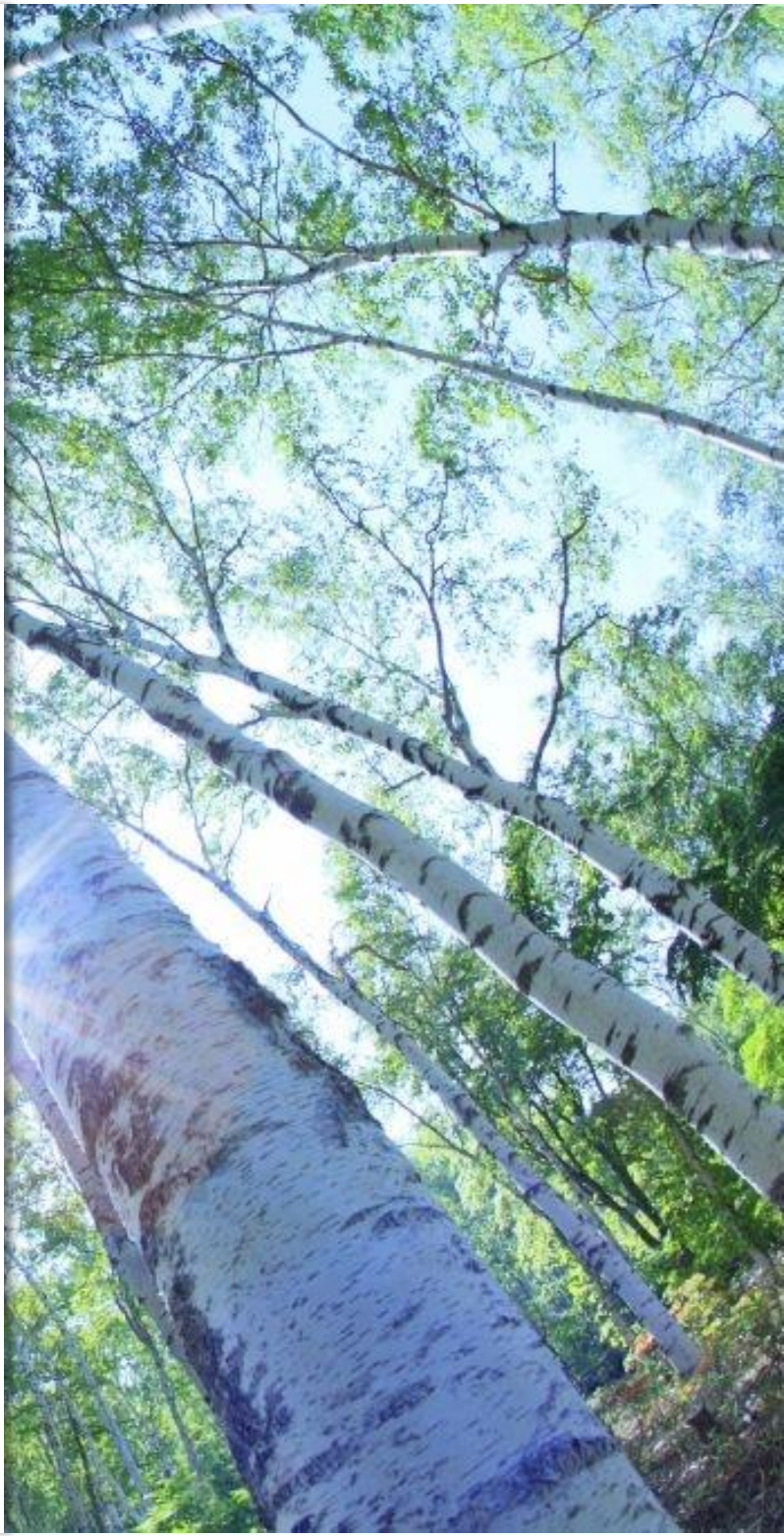
Responsibility statement and our audit report

the Distinctive audit



Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under Monitor's Audit Code to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.
- This report should be read alongside the supplementary "Briefing on audit matters" circulated to you previously.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP

Deloitte LLP
Chartered Accountants

Reading
25 May 2016

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose, but as made clear in our engagement letter dated 29th Aril 2016, only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

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Our audit report

Independent auditor's report to the council of governors of Oxford Health NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Oxford Health NHS Foundation Trust to perform an independent assurance engagement in respect of Oxford Health NHS Foundation Trust's quality report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Oxford Health NHS Foundation Trust as a body, to assist the council of governors in reporting Oxford Health NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Oxford Health NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Minimising delayed transfer of care; and
- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual, and consider the implications for our report if we become aware of any material omissions.

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Our audit report (continued)

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from the Commissioners dated XXX 2016;
- feedback from the governors dated XXX 2016;
- feedback from local Healthwatch organisations, dated XXX 2016;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 12 April 2016;
- the 2015 national patient survey;
- the 2015 national staff survey;
- Care Quality Commission Intelligent Monitoring Report dated February 2016;
- Care Quality Commission reports; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated April 2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

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

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Our audit report (continued)

Limitations

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

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

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

Deloitte LLP

Chartered Accountants

Reading, United Kingdom

XX May 2016

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