External assurance on the Trust's Quality Report

Oxford Health Foundation Trust

Audit 2011/12

audit commission

Contents

Key messages 3

Content of the Quality Report 4

Mandatory performance indicators 5

Performance indicator selected by governors 6

Other matters 8

Appendix 1 – The scope of my work 11

Appendix 2 – Limited assurance report 12

Appendix 3 – Follow up of previous recommendations 16

Appendix 4 – Action Plan 18

Key messages

This report summarises the findings from my external assurance work on your Quality Report for 2011/12. It includes a summary of:

- **my limited assurance work on the content of the Quality Report and the two indicators mandated by Monitor; and**
- **the findings from my work on the indicator selected by Governors.**

I include at appendix 1 the scope of my work and at appendix 2 a copy of my limited assurance report. Appendix 3 assesses action in response to the recommendations made in last year's report. I include at appendix 4 an action plan with management's responses.

Limited assurance report

I found that the content of the Quality Report was prepared in accordance with Monitor guidance and is consistent with supporting information.

My testing the two mandated indicators found that, on testing, the performance indicators were reasonably stated in all material respects.

Testing of the indicator selected by Governors

My testing of the indicator selected by Governors found that, on testing, the performance indicator was reasonably stated in all material respects.

I identified improvement opportunities around both setting and reporting of the indicator, and in documenting of indicator reviews.

Other

Whilst the timetable is tight, production of the report could be improved. Earlier production of the Quality Report would give stakeholders time to comment, and the Trust to consider these responses before its submission deadline. A number of versions of the Quality Report were produced and amendments were still being made the day before the Trust needed to submit a copy to Monitor. It would also facilitate a more efficient audit.

I also identified that the Trust does not disseminate relevant audit findings and improvements across all indicators and performance measures, which would improve its data quality arrangements.

Content of the Quality Report

I have not identified anything to cause me to believe that the Quality Report is not:

- prepared in line with the criteria in Monitor's *Annual Reporting Manual* (ARM); and
- consistent with the other information specified by Monitor.

Mandatory performance indicators

I have not identified anything to suggest that the indicators mandated by Monitor for a limited assurance review are not reasonably stated.

I reviewed the Trust's systems for collecting the necessary information to support the Seven Day Follow Up and Delayed Transfers of Care indicators mandated by Monitor. I also tested a sample of individual cases to test that they were supported by evidence. The assurance is limited and does not extend to the population as a whole.

Seven Day Follow Up:	Delayed Transfers of Care:
Results from audit testing I found that the performance indicator was reasonably stated in all material respects. My work in advance of the quality report's preparation did identify that the IT report parameters were incorrectly set. This resulted in incorrect classification of a breach as a non-breach. The parameters were amended, and no further errors were identified. The correct figure based on correct parameters was included in the draft quality report.	**Results from audit testing** I found that the performance indicator was reasonably stated in all material respects. Once the data is prepared, it is good practice for an independent officer to review and approve the final indicator scores. This is not in place for Delayed Transfers of Care and Skin Breakdown indicators.
Recommendations **R1** IT report parameters should be reviewed for accuracy before being used.	**Recommendations** **R2** An independent senior manager should review and sign-off each indicator prior to distribution. This will provide some assurance to the Board that the indicators are accurate and complete.

Performance indicator selected by governors

Findings from my review of the system for reporting Skin Breakdown Compliance

The Governors selected Skin Breakdown Compliance for me to review. I reviewed the Trust's system for collecting the necessary information to support the indicator. I also tested a small sample of individual cases to check that the reported indicator was supported by evidence.

Definition

The indicator reports on the percentage of skin breakdown tests undertaken on first visit or within six hours of admission. This test is an important procedure to help prevent pressure ulcers.

The Trust conducts two clinical audits each quarter of approximately 30 patient records in which an officer assesses whether the skin breakdown test has been undertaken within the specified target. The results are then reported to management in the quarterly quality reports to Board.

Overall conclusion

I found that, on testing, the performance indicator was reasonably stated in all material respects.

During my testing I identified a number of areas for improvement, which I set out below.

Findings	Recommendations
At the start of the year, the performance target was set at 85% compliance, but performance information during the year was reported against 75%.	**R3** Performance targets should be clearly set at the appropriate level, documented and then disseminated at the start of the year. Any subsequent changes should be properly recorded and approved.

Findings	Recommendations
For two of the eight skin breakdown clinical audits, there is no traceable path back to the individual patients whose files were audited. This limits the ability of senior managers to assess the quality of the clinical audits and to address any specific concerns.	**R4** An appropriate manager should retain lists of audited patients for future audit and review. The manager should retain documents that provide evidence of percentages, numerators and denominators arising from the clinical audits and reported in the Quality Report.
In some instances, once the skin breakdown clinical audits are completed, only the percentage figures have been emailed to managers.	**R5** For each clinical audit, an audit workbook should be compiled and sent to the appropriate manager detailing each patient ID reference and the test result, plus a summary numerator and denominator. The manager should then review it and evidence that review.
The Skin Breakdown indicator assesses the time taken to run the test against the specified target. The data is held in date and time form in a database. It should be possible to extract the whole population from the database and calculate the indicator automatically, rather than extract a sample and manually calculate the indicator on a small set of data. This is likely to be more efficient, and provide greater assurance compared with quarterly reviews of small samples of data.	**R6** The Trust should calculate the indicator based on the whole population
Once the data is prepared, it is good practice for an independent officer to review and approve the final indicator scores. This is not in place for the Skin Breakdown indicator	Recommendation 1 raised above applies to this, and all other, indicators.

Other matters

Producing and auditing the Quality Report

The Trust has developed a process to manage the production of the Quality Report following the recommendations made from last years audit. Improvements were made, but the process needs to be followed more closely to allow a smoother production of the Report. In particular:

- the local indicator was not agreed with Governors until late in the process. An indicator, mandatory training, was initially selected that was not contained within the quality report and was subsequently replaced by the skin breakdown indicator; and
- a draft was not sent out to stakeholders for their comment until 30 April 2012. The required period for comment is 29 days, which meant the Trust was receiving comments right up to its submission deadline of 31 May 2012.

The Trust has arrangements in place to produce much of the information required, and consult with stakeholders. For example:

- Operational performance reports are considered by the Board on a regular basis;
- Quarterly Complaints reports are reported to the Board;
- Quality Report information is reported to the Board;
- Regular meetings are held with stakeholders;
- Regular meetings are held with Commissioners;
- Quarterly meetings are held with Governors;
- Regular meetings with Scrutiny Committees; and
- Regular returns are made to Monitor.

The Trust should use more effectively the information it has available during the year and the ongoing meetings with stakeholders, to prepare an earlier draft of the Quality Report. This would allow more time for stakeholders to respond to the report before the submission date.

During my audit it was difficult at times to identify the right person for testing the indicators and then to ensure that audit queries were being dealt with as efficiently as possible. An audit works best when there is a point of contact who is available throughout the audit and who has extensive knowledge of the Trust's operations and staff. This helps to manage audit queries, re-direct information requests to the correct staff and generally ensure the smooth running of the audit. The responsible Director retains accountability, but we would not expect the Director to have detailed operational involvement.

Generally, it is my observation that there did not seem to be an understanding throughout the organisation of the importance of the quality report, the audit, and how it impacted on the year-end submission to Monitor.

Recommendations

R7 Select any local indicator for audit as early as possible for 2012/13.

R8 Improve the process for producing the Quality Report, bringing it forward to allow sufficient time for review and consideration both internally and by stakeholders.

R9 Appoint an operational manager, with sufficient knowledge of the Trust, to manage the production of the quality report.

Data Security

Some documents, whether photocopied or scanned, were not sufficiently redacted. I could still identify patient information where it had been partially or poorly redacted.

Recommendation

R10 Review Trust policy and staff training to ensure that no personal information is unintentionally distributed.

Implementing previous recommendations

I have reviewed progress on the Trust's implementation of previous recommendations. My detailed findings against each recommendation are set out in appendix 3.

I have found that the Trust is not applying the detailed learning from previous audits across the organisation, and wider than the specific indicators involved. For example the Seven Day Follow Up and Delayed Transfers of Care indicators have both been audited before. The audit results were significantly better than the Skin Breakdown indicator which has never been audited.

Disappointingly, I found issues reported and recommended in 2009/10 were still only partly implemented.

Recommendations

R11 Report progress on previous recommendations, and new recommendations in this report, to the Audit Committee

R12 Spread the learning from the performance indicator audits, by including the key findings and recommendations in data quality framework for creating and monitoring all performance indicators or measures.

Appendix 1 – The scope of my work

Monitor's NHS Foundation Trust Annual Reporting Manual (ARM) sets out your responsibilities in respect of the Quality Report. Its Audit Code for NHS Foundation Trusts sets out my responsibilities, which are to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM;
- the Quality Report is not consistent in all material respects with the sources specified in the ARM; 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 ARM and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

I have met these responsibilities by:

- reviewing the content of the Quality Report to consider whether it has been prepared in line with the requirements set out in the ARM and whether it is consistent with the other information sources as set out in that guidance;
- substantively sample testing the performance indicators mandated by Monitor to consider whether they are reasonably stated in all material respects in line with the requirements set out in the ARM; and
- substantively testing another indicator from the quality report selected by Governors.

Appendix 2 – Limited assurance report

Independent Auditor's Report to the Board of Governors of Oxford Health NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Board 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 2012 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

Mandatory Indicator:

- Care Programme Approach (CPA); and
- Transfer of care.

I 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 the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

- the 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 Monitor's Detailed Guidance for External Assurance on Quality Reports 2011/12; 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.

I read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for my report if I became aware of any material omissions.

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

- Board minutes for the period April 2011 to May 2012;
- Papers relating to quality reported to the Board over the period April 2011 to March 2012;
- Feedback from Buckinghamshire Health Overview and Scrutiny Committee 18 May 2012;
- Feedback from the Commissioners dated 30/05/2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16/04/2012;
- The latest national patient survey dated August 2011;
- The latest national staff survey issued March 2012;
- Care Quality Commission quality and risk profiles dated 02/04/2012;
- The Head of Internal Audit's annual opinion over the trust's control environment dated 11/04/2012; and
- Any other information included in our review.

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

I am in compliance with the applicable independence and competency requirements of the Chartered Institute of Public Finance and Accountancy (CIPFA) Standard of Professional Practice and Ethics. My team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Governors of Oxford Health NHS Foundation Trust as a body, to assist the Board of Governors in reporting Oxford Health NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Board of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Board of Governors as a body and Oxford Health NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

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

- 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 listed above under the respective responsibilities of the Directors and auditors.

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

Limitations

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 impact 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 thereof, 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 nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Oxford Health NHS Foundation Trust.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- 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 Monitor's Detailed Guidance for External Assurance on Quality Reports 2011/12; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

Kevin Suter

Officer of the Audit Commission
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Hampshire
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30 May 2012

Appendix 3 – Follow up of previous recommendations

Recommendations from External Assurance report 2010/11

Recommendations	Auditor assessment
R1 Strengthen current, historical and benchmarking data sources n respect of improvement priorities and performance indicators. **R2** Ensure data sources are made explicit for all reported performance indicators.	There is no structured framework in place when establishing a performance indicator. The framework would establish data sources and compilation processes, reporting and target setting responsibilities as well as definitions and guidance.
R3 Align the timetable for annual reporting of complaints with drafting of the Quality Report to promote efficient and consistent reporting.	Achieved.
R4 Agree an appropriate timetable with stakeholders to ensure that their feedback on next year's Quality Report is received prior to the start of the audit.	Not achieved. I acknowledge this is difficult to do with tight timetable but the process could still be improved.
R5 Address issues arising from detailed testing of indicators. ■ Undertake regular data quality audits and ensure that recommended actions are implemented and progress monitored. ■ Ensure performance information presented in Board papers is up to date and reconciles to Quality Reporting data. ■ Ensure that data is recorded within the required timeframes, and that data reporting is available for use within a reasonable time	■ Performance indicators are now subject to quality audits. However I found that not all these reviews were being documented. ■ Achieved. ■ Achieved.

Recommendations	Auditor assessment
period. This should be monitored and reported to senior management. ■ Improve audit trails by providing dates at which reports have been run and ensuring that sufficient information is included to track patient activity. ■ Develop a standard approach to documenting processes & controls and to the storing of & reporting on performance data.	■ Achieved on mandatory indicators but not on Skin Breakdown indicator. ■ No evidence of this found.
R6 Accountability for the production of the Quality Report (and the Annual Report) should be clarified and internal processes improved.	Partly achieved. Accountability has been set at Director level. However the process could be sharper to prevent too much work being done in the last few days before submission. In my judgement support to the Director by an operational manager who is knowledgeable about the Trust and its processes would improve the production and coordination.
R7 Provide assurance to the Trust Board that the Quality Report complies with relevant guidance and that processes for the collection and reporting of performance measures are in place.	Done. Quality report information is reported to the Trust Board quarterly.
R8 Ensure all agreed actions from 2009/10 audit are fully implemented: ■ Monthly performance reporting should be fully aligned with Board reporting. ■ Systems reviews should cover the full year and findings should be reviewed and actioned. ■ Internal reviews by senior management or audit should be evidenced.	Partly achieved. Reporting to the Board is much improved but there is still a lack of senior management review in some areas and evidence of audit reviews is not always retained.
R9 Establish a corporate approach to data quality: update data quality policies, processes and controls to reflect the expanded health service responsibilities and reporting requirements.	Partly achieved. A corporate approach is being developed. My work identified that learning from my previous assessments of performance indicators has not been shared or applied across the range of performance indictors.

Appendix 4 – Action Plan

Recommendations	
Recommendation 1	
IT report parameters should be reviewed for accuracy before being used.	
Responsibility	Head of Information
Priority	Medium
Date	October 2012
Comments	Agreed, this assurance will be undertaken
Recommendation 2	
An independent senior manager should review and sign-off each indicator prior to distribution. This will provide some assurance to the Board that the indicators are accurate and complete.	
Responsibility	Head of Performance
Priority	Medium
Date	September 2012
Comments	Agrees this will be undertaken.

Recommendations

Recommendation 3

Performance targets should be clearly set at the appropriate level, documented and then disseminated at the start of the year. Any subsequent changes should be properly recorded and approved.

Responsibility	Head of Performance
Priority	High
Date	July 2012
Comments	Targets have been set for this year, documentary evidence will be established.

Recommendation 4 – Skin breakdown

An appropriate manager should retain lists of audited patients for future audit and review. The manager should retain documents that provide evidence of percentages, numerators and denominators arising from the clinical audits and reported in the Quality Report.

Responsibility	Quality Manager
Priority	Low
Date	July 2012
Comments	Agreed

Recommendation 5 – Skin breakdown

For each audit, an audit workbook should be compiled and sent to the appropriate manager detailing each patient ID reference and the test result, plus a summary numerator and denominator. The manager should then review it and evidence that review.

Responsibility	Quality Manager
Priority	Low
Date	July 2012
Comments	Agreed

Recommendations	
Recommendation 6 – Skin breakdown	
The Trust should calculate the indicator based on the whole population.	
Responsibility	Quality Manager
Priority	Low
Date	July 2012
Comments	Agreed
Recommendation 7	
Select any local indicator is identified as early as possible for 2012/13.	
Responsibility	Director of Nursing
Priority	Medium
Date	January 2013
Comments	Agree
Recommendation 8	
Improve the process for producing the Quality Report, bringing it forward to allow sufficient time for review and consideration both internally and by Stakeholders.	
Responsibility	Director of Nursing
Priority	High
Date	March 2013
Comments	Agree

Recommendations	
Recommendation 9	
Appoint an operational manager, with sufficient knowledge of the Trust, to manage the production of the quality report.	
Responsibility	Director of Nursing
Priority	High
Date	January 2012
Comments	This will be within the Quality and Safety team.
Recommendation 10	
Review Trust policy and staff training to ensure that no personal information is unintentionally distributed.	
Responsibility	Head of Information Governance
Priority	High
Date	September 2012
Comments	Agree
Recommendation 11	
Report progress on previous recommendations, and new recommendations in this report, to the Audit Committee	
Responsibility	Director of Nursing
Priority	Medium
Date	October 2012
Comments	Agree

Recommendations

Recommendation 12

Spread the learning from previous performance indicator audits, by including the key findings and in a data quality framework for creating and monitoring all performance indicators or measures.

Responsibility	Head of Performance
Priority	Medium
Date	October 2012
Comments	Agree

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