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Guy's and St Thomas' NHS
NHS Foundation Trust

Guy's and St Thomas' NHS Foundation Trust

Findings and Recommendations from the 2014/15 NHS Quality Report External Assurance Review

Final report to the Governors, 28 May 2015

Contents

This report sets out the findings from our work on the 2014/15 Quality Accounts.

We would like to take this opportunity to thank the management team for their assistance and co-operation during the course of our review

Executive Summary

Our work is complete

Status of our work

- We have now received the final quality report and the letter of representation, and our work is complete.
- 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 2014/15".
- We have issued a modified opinion with an "except for" conclusion in relation to date accuracy for the "18 Week Referral to Treatment - Incomplete Pathways indicator". This is included in your 2014/15 Annual Report and further details are shown in the appendix.

Key Metrics

Q3 Governance Risk Rating: **Green**

	2014/15	2013/14
Length of Quality Report	29 pages	30 pages
Quality Priorities	11	11
Future year Quality Priorities	10	11

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 is required this year to have 18 week referral to treatment ("RTT") waiting times as a publically reported indicator, and has also selected 62 day cancer referral to treatment waiting times – the alternative was emergency re-admissions with 28 days of discharge from hospital.
  - For 2014/15, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected the Patients' Friends and Family Test.
  - 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 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 18 week RTT and 62-day cancer 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: 18 Week Referral to Treatment (Incomplete), 62-Day cancer wait and Patients' Friends and Family Test.

Executive Summary (continued)

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 2015, the Quality Report will not be 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)?	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 three mandated indicators. 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 2015, 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 2014/15 except that we have qualified our conclusion on the Quality Report in respect of the 18 Week RTT – Incomplete Pathways indicator".

	18 Week RTT – Incomplete	62 Day Cancer Wait	Friends & Family Test
Accuracy Is data recorded correctly and is it in line with the methodology.	R	G	A
Validity Has the data been produced in compliance with relevant requirements.	B	G	A
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	G	G	G
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	B	G	A
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	B	G	A
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	G	G	B
Recommendations identified?	✓	✓	✓
Overall Conclusion	R Qualified Opinion (see Appendix)	G Unmodified Opinion	A No opinion required

G No issues noted B Satisfactory – minor issues only A Requires improvement R Significant improvement required

Content and consistency review findings

The Quality Report has been reviewed

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.

The summary below is based on our review of the most current draft report reviewed on 21 May 2015.

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?	G	Length: 29 pages
• Is there an introduction to the Quality Report that provides context?	G	
• Is there a glossary to the Quality Report?	G	
• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	G	Patient Safety: 4 Clinical Effectiveness: 3 Patient Experience: 4
• Has the Trust set itself SMART objectives which can be clearly assessed?	A	
• Does the Quality Report clearly present whether there has been improvement on selected priorities?	G	
• Is there appropriate use of graphics to clarify messages?	G	
• 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	

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

Deloitte view

We reviewed a draft version of the Quality Report in early May and identified a number of areas for improvement to make the Report more useful for the reader and to make it compliant with Quality Accounts Regulations and Monitor Guidance.

Below is a summary of some of the areas we identified for improvement:

- Rewording the Chief Executive's statement to make reference to findings in the annual governance statement and findings from our Quality Report audit, and consideration of the impact on the statement of assurance.
- Reporting additional quality indicators, including the six week diagnostic wait target that was the locally selected indicator for audit testing.

There have been improvements in these areas since we issued our report to the audit committee. However there remain a number of objectives which do not fully meet SMART criteria.

Content and consistency review findings

Further improvements can be made to improve compliance with Monitor Guidance

Deloitte view

- Making commentary relating to 2015/16 quality priorities and progress against 2014/15 priorities clearer for the reader and making the priorities more measurable.
- Defining all medical-related abbreviations and adding further context to parts of the report to make the Quality Account more understandable for the reader.
- A number of typographical errors which were in many cases impacting the utility of the report for an average reader.

In addition to the above, we assessed the report against Monitor Guidance and made recommendations which included matters relating to the following:

- There was limited commentary covering areas required to be reported by Monitor guidance, such as the patient and staff surveys, national clinical audits, confidential enquiries and investigations;
- We identified instances where there were minor departures from the form of wording prescribed in the Quality Accounts Regulations; and
- Some comparative figures for 2013/14 included in the draft 2014/15 report did not match the figures reported in the 2013/14 quality accounts.

All of the above were fed back to management and our comments were considered during subsequent stages of the quality report preparation.

We reviewed an improved, revised draft on 21st May 2015 and found that most of the significant points from our initial review had been addressed. However, further improvements could be made as follows:

- Updating, and in some cases including for the first time, performance against core indicators with the most recent nationally and locally available data
- Ensuring the accuracy of the national comparative data included in the report
- Ensuring the 2013/14 Trust performance stated in the draft report is the same as the 2013/14 performance reported in the 2013/14 Final Quality Accounts.
- Further amendments to improve clarity of the report.

Further improvements were made in the above matters for the final issue of the report, particularly around inclusion of the national comparative data.

Performance Indicator: 18 week referral-to-treatment waiting times

The Trust has reported that the Target has been met

	Trust reported performance	Target	Overall evaluation
2014/15	92.7%	>92%	R
2013/14	93.5%	>92%	Not tested

Indicator definition

Definition: "The percentage of patients on an incomplete pathway who have been waiting no more than 18 weeks, as a proportion of the total number of patients on incomplete pathways," reported as the average of each month end position through the year.

The NHS Constitution gives patients a legal right to start NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate to do so. This right is about improving patients' experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

There are three 18 week Referral-To-Treatment (RTT) metrics:

- Admitted: The pathway ends (first definitive treatment) with the patient being admitted e.g. for surgery;
- Non-admitted: The pathway ends (first definitive treatment) with the patient not being admitted e.g. an outpatient attendance OR no treatment required; and
- Incomplete: The pathway has not ended and the patient is still waiting for treatment.

Our work has focused on the **incomplete 18 week RTT metric.**

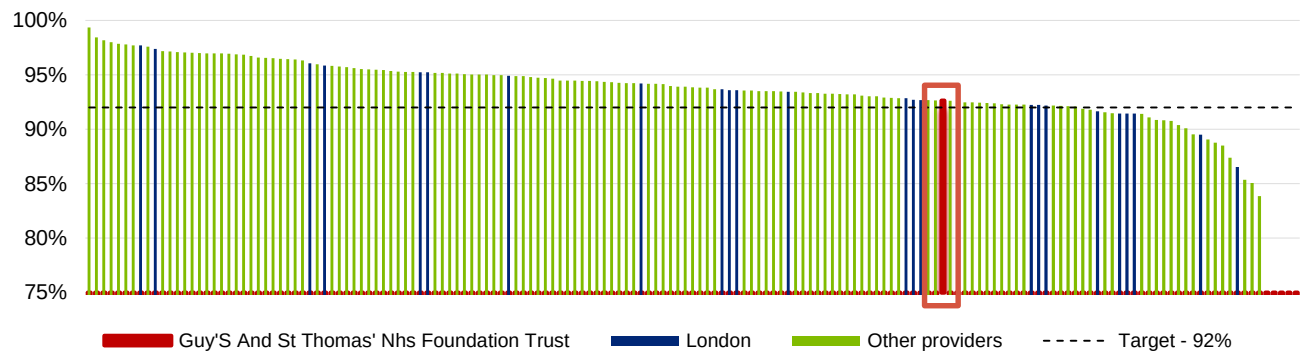
The national performance standard for the incomplete RTT metric (92%) was introduced in 2012.

For the first time, this year Monitor has specified that the 18 week RTT incomplete metric should be subject to substantive testing as part of the Quality Report external assurance process for all acute FTs.

National context

The chart below shows how the Trust compares to other organisations nationally for the first eleven months of 2014/15, the latest national data available.

18 week Referral to Treatment incomplete pathway - 11 months to February 2015 (tested indicator)

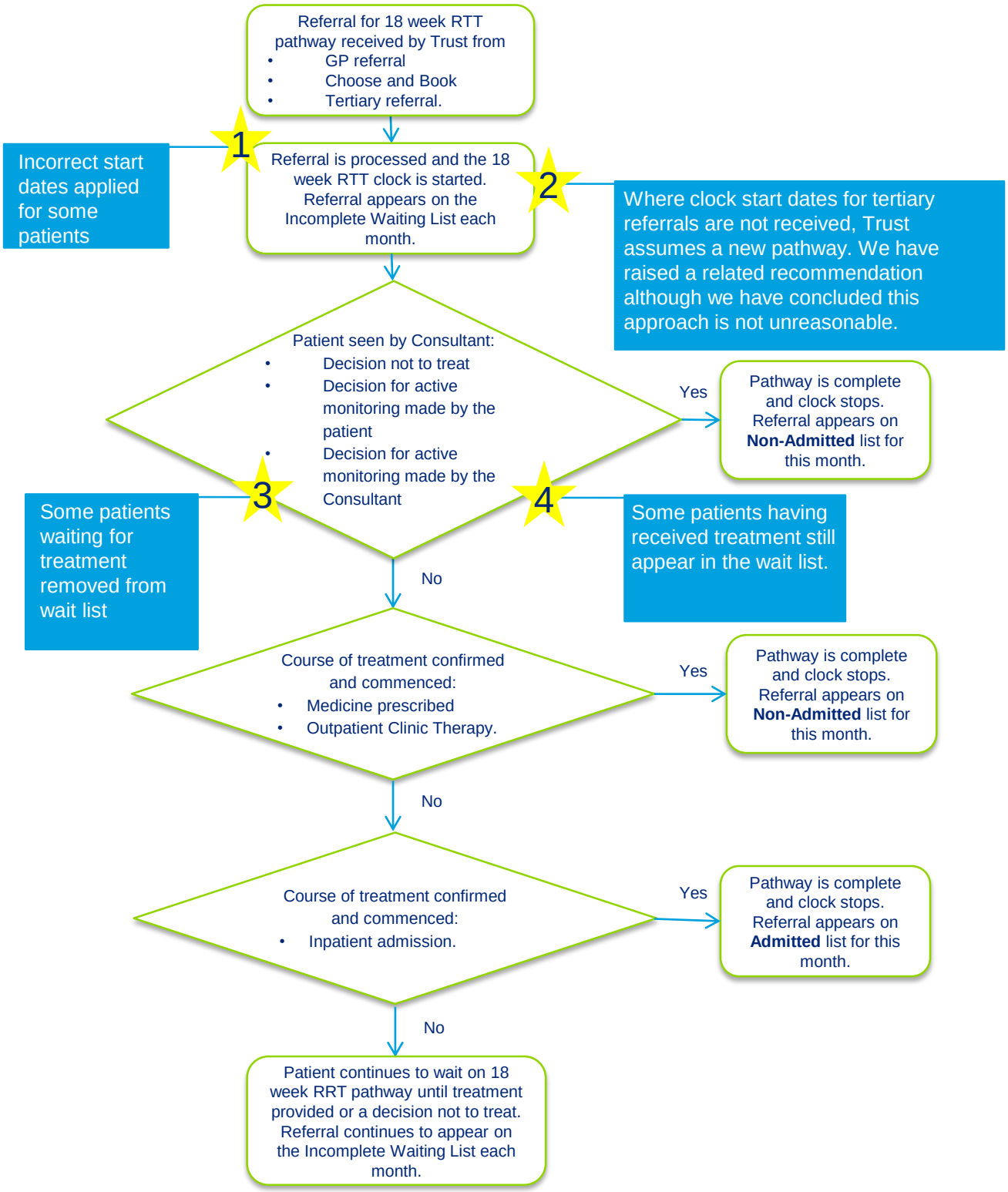


Source: Deloitte analysis of Health and Social Care Information Centre data

Performance Indicator: 18 week referral-to-treatment waiting times (continued)

We have identified issues relating to this indicator

Indicator process



Performance Indicator: 18 week referral-to-treatment waiting times (continued)

The Trust's performance has historically been very close to the 92% target for this indicator

Approach

- We met with the Health Informatics and Elective Assurance Teams to understand the process from patient referral to the result being included in the Quality Report.
- We evaluated the design and implementation of controls through the process. In addition, we discussed with management and used analytical procedures to identify whether there were any periods during the year or divisions within the Trust representing a greater risk that we should focus sample testing on.
- We selected a risk-based sample of 40 patients appearing on the waiting list from 1 April 2014 to 31 March 2015, following patient records through until treatment. We focussed our sample towards patients who were reported as being close to the 18 week deadline or were very long waiters (> 40 weeks), and months where the Trust's reported indicator was very close to the 92% target.
- We agreed our sample of 40 patients to supporting documentation.

Findings

- We identified nine cases with incorrect start dates. In two cases, we could not locate any document to corroborate the start date used. However, in all the remaining cases, the errors were due to mistakes by administration or clinical staff inputting data into PIMS (the patient administration system).

  We recommend that a programme of mandatory training be rolled out to all administrative and clinical staff. This should include reference to the Monitor Guidance (18 week RTT rules suite), and advise them to contact the Elective Assurance Team where they are unsure of the start date to be used. As part of Elective Assurance's validation work, a record of departments or staff frequently using incorrect start dates should be maintained and those departments or staff prioritised.
- Where a patient is referred to GSTT from another Trust (a tertiary referral), the start date recorded should be the date of referral to the referring trust. In cases where the referring trust does not provide this information, the Trust uses the date the referral is received into the Trust as the start date. Although this is corrected once the information is received, in the meantime, the waiting time is always understated.

  In the absence of further national guidance around the treatment of Unknown Clock starts, we recommend that the Trust consider the best approach to the recording and reporting of unknown clock starts considering the national guidance and aim of improving patient experience as well as consistency in reporting. The approach decided should then be documented within the Trust's access policy and approved by Commissioners and the Governors.
- We identified three cases with incorrect stop dates. In two cases, an input error by the clinician (or their secretary) resulted in the pathway remaining open, although treatment had been provided. In the other case, a wait for diagnostic tests had been incorrectly categorised by the clinician (or their secretary) as "active monitoring" resulting in premature closing of the pathway.

  We recommend that guidance on using the correct stop dates also be included.
- During our work relating to the assessment of controls around the process, we noted that the Elective Assurance team have a process for validating patients appearing on the 18 week RTT – Incomplete pathway on a sample basis. However, the approach to this validation is not documented, and we were informed that historically the validation process has been inconsistently applied.

  We recommend that the validation process be documented, and communicated to all staff involved in the process. The Head of Elective Assurance should monitor the implementation of the process on a monthly basis.

Performance Indicator: 18 week referral-to-treatment waiting times

We expect to provide a qualified opinion for this indicator

Deloitte View:

The 18 week RTT incomplete pathway indicator is being tested nationally for the first time this year. Our experience is that indicators tested for the first time typically show a high error rate, as process issues are identified. This is particularly the case for 18 week RTT, which was selected due to issues identified at a number of trusts and Public Accounts Committee concerns. In particular, the National Audit Office reported in 2014 on waiting times, and found across a sample of trusts only 43% of patient records tested were correct and fully supported by available documentation, with 26% having at least one error. This has been borne out in our work across the sector this year, where we have identified a significant level of issues.

The results at the Trust summarised below, while indicating a need for significant improvement in process and practices, are therefore not out of line with a national picture of weaknesses in 18 week RTT data.

We identified a number of errors through our testing of the 18 week RTT – Incomplete pathway. Some of these errors caused non-breaches to change to breaches and some had no impact on the number of breaches reported. Therefore we consider that whilst there are weaknesses in data quality arrangements that the Trust needs to address, we have not identified evidence of management override of controls or intentional misreporting.

Currently the Trust has reported that it has met the indicator target of 92%, albeit by a narrow margin. However, based on our testing, we have seen that in 7 cases of a sample of 40, tracing back to source documentation identified that waiting time was misstated. There were an additional two cases where supporting documentation to confirm the recorded start date was not available, but other documentation available suggested these to be incorrect. In 3 (7.5%) of these cases, there were errors that, if corrected, would move those cases from non-breaches to breaches. This level of error rate (7.5%), indicates that it is possible that the Trust has not met the Target.

Alternatively, based on our testing, the waiting times for 9 cases from our sample of 40 (22.5%) were understated by an average of 5.63 days. Extrapolating this error, does not indicate that the Trust has not met the target, but it does lead us to consider whether the data quality is sufficiently accurate. However, based on our risk-focussed approach, we have not taken a statistical sample, and therefore whilst this extrapolation can act as a rough guide, it should not be relied upon in order to give further assurance over wider data quality.

Our risk-focussed approach took samples from throughout the year, and does not imply that the error rates detected would be seen throughout the entire population. We note from our discussions on recommendations in relation to this indicator, that the Trust began to implement internal control improvements during December 2014, the benefit of which will not have been fully seen in our testing. Management has also indicated that it will continue to make improvements to their processes following this review.

We have raised some management recommendations to help ensure accurate recording of data relating to this indicator. We have also qualified our limited assurance opinion in respect of the 18 Week Referral to Treatment – Incomplete Pathways quality indicator.

Management has included the following text within the Data Quality section in response to our findings relating to this indicator:

The assurance work carried out by Deloitte LLP in respect of the Quality Report 2014/15 identified some errors in the recording of dates in the 18 week referral to treatment incomplete pathway indicator. We have taken the following action during 2014-15 and continue to deliver this improvement programme to minimise errors made when dates are recorded.

Performance Indicator: 18 week referral-to-treatment waiting times (continued)

We expect to provide a qualified opinion for this indicator

Deloitte View (Continued):

The Elective Assurance Department have developed a suite of six role specific training packages for all administrative staff. This training provides advice and guidance on the internal and external rules in place to deliver robust pathway management. The training also covers the correct administrative processes to be followed when recording data on trust systems. The training programme is underpinned by the Access Policy. The Elective Assurance Department also provide services with access to expert interpretation of the referral to treatment rules and how these should be applied, further work is taking place to ensure that specialty specific local guidelines are agreed and that these are approved by clinicians in the speciality.

As part of 'Fit for the Future' programme, how the Elective Assurance Department supports the trust has been reviewed. As a result of this a rolling trust wide administrative review programme has been put in place. Each review will audit the accuracy of data captured at key milestones along a patient's pathway. These reviews start in late May 2015.

Performance Indicator: 62 day cancer waiting times

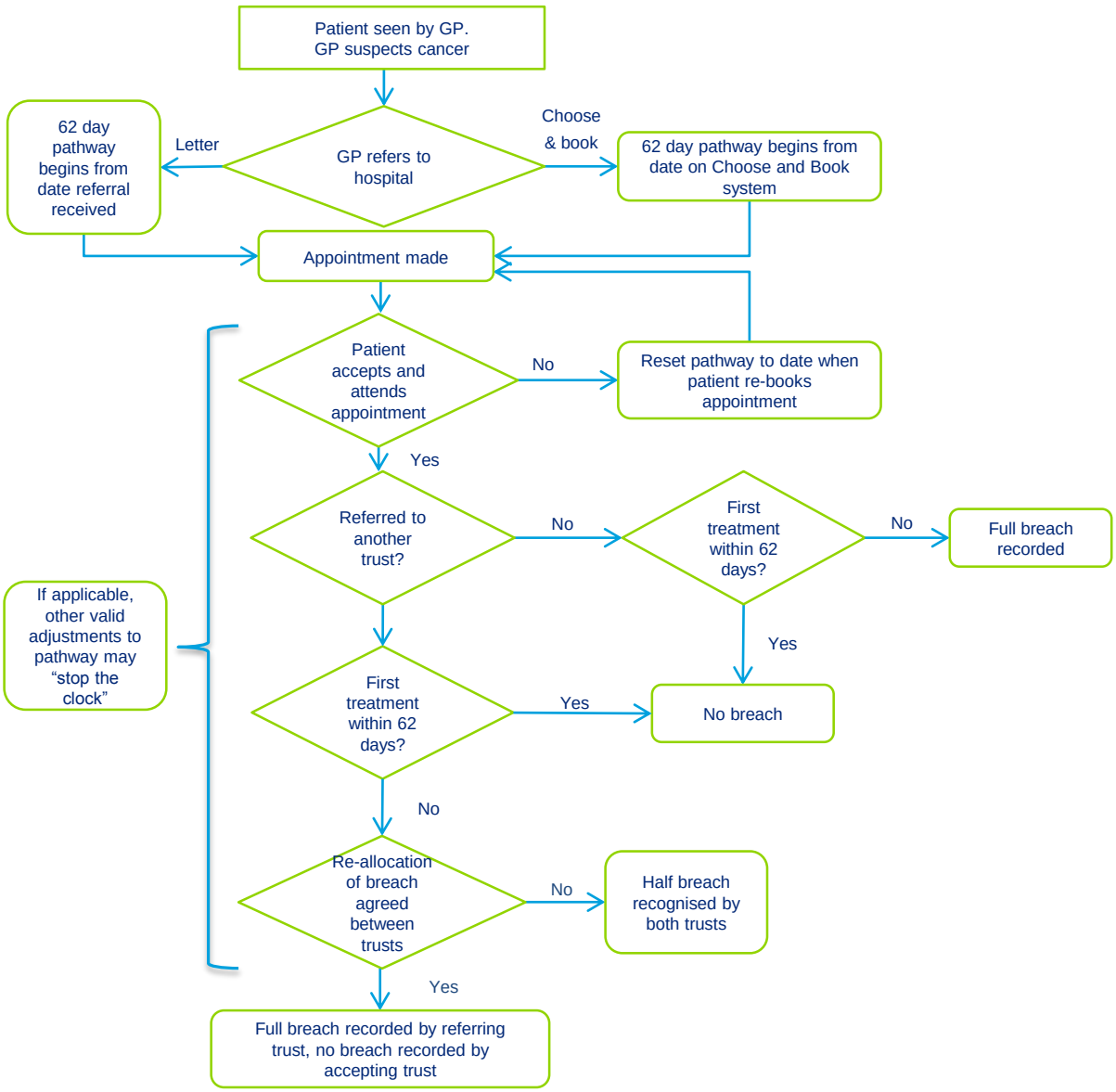
The Trust has reported that the Target has not been met

	Trust reported performance	Target	Overall evaluation
2014/15	75.0%	>85%	G
2013/14	76.2%	>85%	G
2012/13	82%	> 85%	G

Indicator definition and process

Definition: "Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer."

The NHS Cancer Plan set the goal that no patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to the beginning of treatment, except for good clinical reasons.

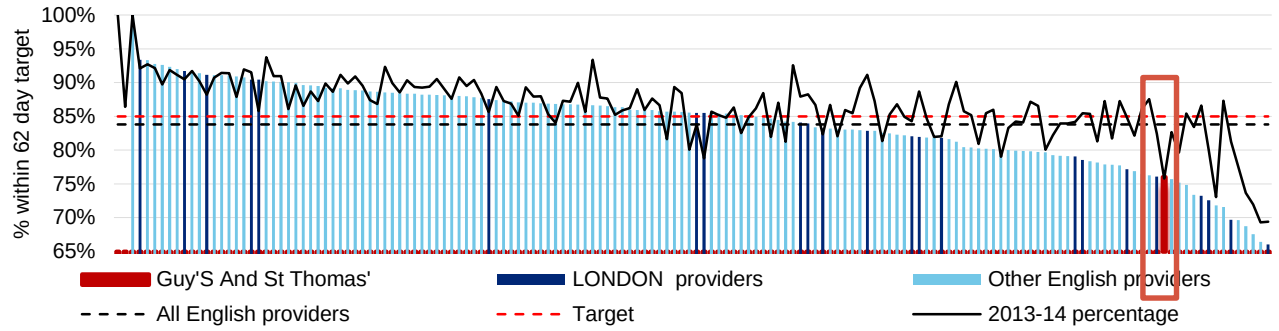


Performance Indicator: 62 day cancer waiting times (continued)

National context

The chart below shows how the Trust compares to other organisations nationally for 2014/15, the latest national data available.

National 62 day cancer wait performance - Q1-3 2014-15



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

Approach

- We met with the Trust's lead for 62 day cancer waits to understand the process from an urgent referral to the Trust to the result being included in the Quality Report. There were no recommendations from the last year to follow up.
- We evaluated the design and implementation of controls through the process. In addition, we discussed with management and used analytical procedures to focus on pathways which appear to be most at risk of error e.g. patients with manual adjustments and pathways close to the 62 day breach date.
- We selected a sample of 24 from 1 April 2014 to 31 March 2015 including in our sample a mixture of cases in breach and not in breach of the target.
- We agreed our sample of 24 to supporting documentation and national Open Exeter records where appropriate.

Findings

- During our testing we identified that in the case of tertiary referrals, the start date for a referred patient is taken from Open Exeter, the national database for the recording of cancer patients. This date is entered into the system by the referring provider. However, using this date increases the risk that an error in recording of the start date on the part of the referring provider could result in the error being carried forward to Guy's and St Thomas's system.

  We recommend that Guy's and St Thomas' refer to supporting documentation (such as inter-provider referral forms, or original GP referrals to the referring trust). Where this information is not provided to the Trust, a process should be introduced for chasing the referring trust for this information, and then retaining it on file under the patient record.

Deloitte View:

We did not identify any errors from our testing, but have made one recommendation for the current year to bring the process in line with good practice.

Based on the testing performed, nothing has come to our attention that causes us to believe that this indicator has not been reasonably stated in all material cases within the Quality Report.

Performance Indicator: Patients' Friends and Family Test

We have identified areas for improvement

	Inpatient	A&E	Overall evaluation
% Recommend	96.9%	83.7%	A
% Not Recommend	0.9%	8.6%	

Indicator definition and process

Definition: Patients are asked to respond to the question "How likely are you to recommend our <ward / A&E department> to friends and family if they needed similar care or treatment?"

Respondents are provided with six standard responses ranging from Extremely Likely to Extremely Unlikely, or Don't Know.

The indicator score is then calculated as the proportion of respondents who would be 'extremely likely' and 'likely' to recommend. 'Don't know' answers are excluded from the calculation.

Inpatient Responses

Patients are asked to complete a survey on paper, through a tablet device or they are given a weblink to complete a survey online at their convenience. Paper surveys are input by the Ward into the Meridian system manually, whilst electronic responses automatically populate within Meridian.

A&E Responses

Patients can complete a response card at A&E, or complete a feedback survey online. A third party provider has been contracted to contact patients after A&E discharge and obtain responses by way of an SMS or automated telephone call response. Until December 2014, feedback by way of token collections (patients asked to drop a token in boxes placed at various entry points, indicating their feedback) also took place but this collection method has now ceased.

Response Cards and Token Collection responses are manually input into Meridian, whilst web responses automatically populate within Meridian. SMS / Automated telephone call responses are extracted from a system (Envoy) hosted by the third party provider

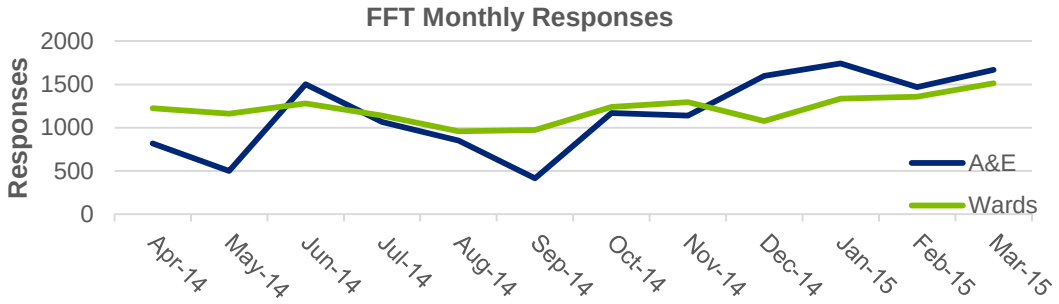
Approach

- We met with the Trust's leads to understand the process for collecting and collating patient responses to reporting the results to Monitor and in the Quality Accounts.
- There were no recommendations from last year's Quality Report as this indicator was not part of the external assurance work.
- In the case of token collection, or response card based responses, we selected a sample of 5 weeks of token collections, and 20 response cards received by the trust from 1 April 2014 to 31 March 2015. We agreed the sample to the paper-based records available.
- In the case of electronic (Web / Tablet) or SMS responses, it has not been possible to confirm that the data within the systems (Meridian and Envoy) against source documentation, due to the electronic nature of recording. We have therefore been limited to performing an analysis on the data reported from source systems.

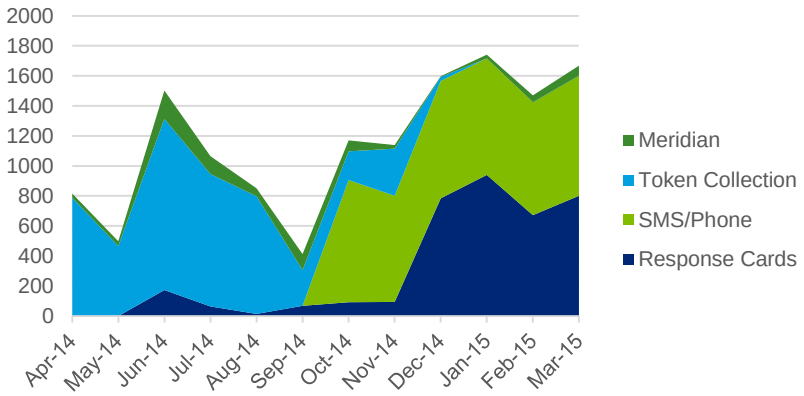
Performance Indicator: Patients' Friends and Family Test

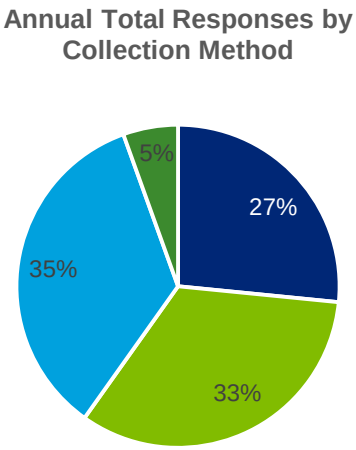
Findings

The analysis of monthly response below, shows that since the roll-out of SMS / telephone surveys in October 2014, there has been an increase in the response rate.



Our findings relating to Accident & Emergency, should be read in conjunction with the analysis below which sets out the different data collection methods employed by the Trust throughout the year





- In the cases of SMS / Telephone responses, the Health Informatics team performs an analysis of data extracted from the source system (Envoy) to produce an eligible population. We noted that as part of this process, any responses received up to 72 hours after discharge were being included in the calculation of the indicator. However, per national guidance, "patients should have an opportunity to provide feedback within 48 hours of discharge. As a result, since October 2014 when the Envoy method was introduced, this has resulted in an additional 722 surveys being reported which should not have been included within the indicator.

  We recommend that the Trust's process be amended so as to only include responses where contact has been initiated (i.e. Time that the SMS has been sent or telephone call made) with the patient within 48 hours of discharge.

- From our sample of twenty A&E response cards to confirm to source documentation, we identified that three cards (relating to June and July) could not be obtained to confirm accuracy, in two cases the incorrect date had been entered and in one case, a date had been entered although the response card was undated. We were informed that response cards for June and July had not been retained by the Trust.

  We recommend that the Trust implement spot-checks on a sample basis to confirm the accuracy of response cards being entered in Meridian.

Performance Indicator: Patients' Friends and Family Test (continued)

Findings

- On a weekly basis, staff collect tokens from collection boxes placed in A&E and record the total number of response for each "satisfaction rating" on a paper chart. The responses are then manually input into Meridian. We found that from our sample of five weekly token collection sheets, in one case, the number of responses recorded in Meridian to be overstated by 31 responses (40% of the week's actual total)

  No recommendation has been raised as token collections is no longer used as a method of feedback collection.

- Inpatient feedback completed on paper forms at wards is not routinely retained and we were therefore unable to confirm the accuracy of inpatient responses.

  We recommend that the Trust retain paper based responses for a period that allows for the checking and follow up of inpatient responses. The Trust has indicated that a three month period may be appropriate and practical.

  In addition, spot-checks should be carried out on a sample-basis for inpatient responses to confirm accuracy of responses being entered into Meridian

- The Trust excludes responses from patients who do not need to be included in the indicator calculation per the guidance (e.g. day-cases and children). However, we noted that some patients who should be included in the indicator calculation were being excluded (Sleep Studies and Somerset Wards).

  We were informed that both wards had a mix of day-case and inpatient admissions and therefore had been excluded.

  Guidance has been revised as of 1st April 2015 to include additional categories of patients (such as children and daycases) when calculating the indicator. We therefore recommend that the Trust review the current data collection and reporting process (including the wards being excluded) against the new guidance.

- We noted that all A&E patients are sent a text message, or an automated phone call, inviting them for feedback. There is currently no process in place to check whether the respondent may already have completed a response card / token collection, and therefore to exclude the duplicate response from the indicator calculation.

  We recommend that the Trust implement a process for identifying duplicate responses and remove these patients from the indicator calculation

Deloitte View:

We are not required to provide an opinion on this indicator.

However, it should be noted that our findings above should be read taking into consideration the limited scope of our work due to the reliance on automated data collection processes, as described in the Approach section.

In addition, although we identified the mis-recording of token collection results, we have not raised a recommendation in respect of this collection method, as this method is no longer used by the Trust in line with national guidance.

Recommendations for improvement

18 Week Referral to Treatment – Incomplete Pathways

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
18 Week RTT – Incomplete Pathways	**Staff Guidance and Training** Our testing identified cases of errors in the recording of clock start and stop dates by administrative, clinical and clinical support staff. We recommend that a programme of mandatory training be rolled out to all staff involved in the recording of patient referrals and clock stops. This should include reference to the Monitor Guidance (18 week RTT rules suite), and advise them to contact the Elective Assurance Team where they are unsure of the start date to be used. As part of Elective Assurance's validation work, a record of departments or staff frequently using incorrect start dates should be maintained and those departments or staff prioritised for training and guidance.	Role specific training is available for staff. This training provides advice and guidance on how to correctly administer patient pathways. With effect from June 15, Elective Assurance training is being incorporated into Trust induction. Thus ensuring all new starters receive relevant training and are given clear advice and guidance on the RTT rules and how these should be applied within their role. Work is also underway to ensure annual EA refresher training is mandated for existing staff. **Responsible Officer:** Head of Elective Assurance **Timeline:** June 2015 **Process for updating Council of Governors:** Briefing to next meeting	High
18 Week RTT – Incomplete Pathways	**Documentation and implementation of data validation** The Elective Assurance team carried out sample-based validation checks on the 18 week RTT data. However, this process is not documented, and we were informed that it is inconsistently applied. We recommend that the validation process be documented, and communicated to all staff involved in the process. The Head of Elective Assurance should monitor the implementation of the process on a monthly basis.	Service/milestone specific validation reviews are carried out by the Elective Assurance Department. However currently this process is not formally documented. With effect from the end of May 15 a rolling Elective Assurance administrative review programme is being rolled out. Each speciality specific review will audit the accuracy of data captured at key milestones along a patients pathway. The outcome of these reviews will be documented and fed back to the Directorate Management and COO team **Responsible Officer**: Head of Elective Assurance **Timeline:** June 2015 **Process for updating Council of Governors:** Briefing to next meeting	Medium

Recommendations for improvement

RTT and 62 day cancer waits

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
18 Week RTT – Incomplete Pathways	**Treatment of Unknown Clock Starts for tertiary referrals** In the case of tertiary referrals, where a clock start date is not provided by the referring trust, GSTT's approach assumes the clock to start on the date the referral is received by GSTT. We have noted this to be a national issue. However, the national guidance required that a "not unreasonable" approach be taken when start dates are not known. Therefore, in the absence of further national guidance around the treatment of Unknown Clock starts, we recommend that the current approach be documented within the Trust's access policy and approved by Commissioners and the Governors.	The Trust aims to ensure that the start date of the pathways of all patients is reliably known. A dedicated team chases any referring organisations that have not provided complete information on referral. Typically this is established within 2-3 weeks of receipt of referral, so the 'default' date is only used temporarily. Less than 0.1% of total completed pathways have an unknown start date and are excluded from the measurement of waiting times. Formal documentation of this process will be included in the next iteration of the Trust's access policy due in August. The Trust would not wish to change its approach, which has the merit of simplicity and being understandable. **Responsible Officer:** Director of Health Informatics / Head of Elective Assurance **Timeline:** August 2015 **Process for updating Council of Governors:** Briefing to next meeting	Low
62 Day Cancer Waits	**Recording of start dates for tertiary referrals** We identified that in the case of tertiary referrals, the start date for a referred patient is taken from Open Exeter, the national database for the recording of cancer patients. This date is entered into the system by the referring provider. However, using this date increases the risk that an error in recording of the start date on the part of the referring provider could result in the error being carried forward to Guy's and St Thomas's systems. We recommend that Guy's and St Thomas' refer to supporting documentation (such as inter-provider referral forms, or original GP referrals to the referring trust). Where this information is not provided to the Trust, a process should be introduced for chasing the referring trust for this information, and then retaining it on file under the patient record.	We agree in principle with the recommendation to help further assure our Cancer Wait Times performance. The Cancer Data Team will request referral letters sent from GP to referring trusts as part of the Inter Trust Transfer process. We will initially attempt enforcement within South East London as they make up 80% of our external referrals as a trial. The trial will be formalised at a trust level and have set review dates This will be audited by Cancer Informatics regularly to check coverage on content. **Responsible Officer:** Cancer Information Manager **Timeline:** Process and Enforcement to commence in June 2015, with ongoing implementation throughout 2015/16 **Process for updating Council of Governors:** Briefing to next meeting	Low

Recommendations for improvement (continued)

Patients' Friends and Family Test

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
Patients' Friends and Family Test	**Cut-Off applied to Telephone / SMS responses** In the cases of SMS / Telephone responses, the Trust includes any responses received up to 72 hours after discharge in the calculation of the indicator. However, per national guidance, only patients contacted within 48 hours of discharge should be included. We recommend that the Trust's process be amended so as to only include patients who have been sent an SMS or contacted by telephone within 48 hours of discharge	Health Informatics Team will review the process and verify the approach to ensure that responses are included where contact has been initiated with the patient within 48 hours of discharge. **Responsible Officer:** Health Informatics Team **Timeline:** May 2015 **Process for updating Council of Governors**: Briefing to next meeting	High
Patients' Friends and Family Test	**Recording of A&E Response Card feedback** We identified cases where the dates of feedback had been recorded incorrectly by the Trust. We recommend that the Trust implement spot-checks on a sample basis to confirm the accuracy of response cards being entered in Meridian	We suggest a 6 monthly spot check of a sample of records from urgent care centres on each site. **Responsible Officer:** Patient Experience Manager **Timeline:** September 2015 **Process for updating Council of Governors** Briefing to next meeting	Medium
Patients' Friends and Family Test	**Retention of Inpatient Paper-Based feedback** Inpatient feedback completed on paper forms at wards is not routinely retained. We recommend that the Trust retain paper based responses for a period that allows for the checking and follow up of inpatient responses. The Trust has indicated that a three month period may be appropriate and adequate. In addition, spot-checks should be carried out on a sample-basis for inpatient responses to confirm accuracy of responses being entered into Meridian	We agree that three months is a reasonable period for paper records retention and suggest a 6 monthly spot check of a sample of records from 2 wards on each site. **Responsible Officer:** Patient Experience Manager **Timeline:** September 2015 **Process for updating Council of Governors:** Briefing to next meeting	Medium

Recommendations for improvement (continued)

Patients' Friends and Family Test

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
Patients' Friends and Family Test	**Double Counting of A&E Responses** All Patients are sent an SMS or receive an automated telephone call after discharge. Patients can also complete a response card at the A&E department before leaving. Currently, there is no process to identify responses made by an individual patient through both data collection methods We recommend that the Trust implement a process for identifying duplicate responses and remove these patients from the indicator calculation	Experience has shown that capturing responses from A&E patients is particularly challenging and we believe the number of patients who have provided a response to the FFT question more than once for the same visit is likely to be extremely small. Prior to implementing the SMS system we explored the option of including an opt out in the text message for patients who had responded via postcard. Using this option would mean that patients who opted out would be unable to provide responses via SMS following future A&E, day case and outpatient attendances as following opt out the patients phone number is permanently encrypted and messages not sent to this number. In the revised 2014 FFT guidance NHS England has moved away from the principle of asking Trusts to provide a unique identifier when responding to ensuring patients are provided with the opportunity to provide when and as frequently as they wish. Therefore we believe the current approach complies with the spirit of the guidance whilst recognising that there may be a small number of patients who complete a card and reply to a text. **Responsible Officer:** N/A **Timeline:** N/A **Process for updating Council of Governors:** N/A	Medium

Recommendations for improvement (continued)

Patients' Friends and Family Test

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
Patients' Friends and Family Test	**Incorrect exclusion of responses** The Trust excludes responses from patients who do not need to be included in the indicator calculation per the guidance (e.g.. daycases and children). However, we noted that some patients who should be included in the indicator calculation were being excluded (Sleep Studies and Somerset Wards). We were informed that both wards had a mix of day case and inpatient admissions and therefore had been excluded. Guidance has been revised as of 1st April 2015 to include additional categories of patients (such as children and day cases) when calculating the indicator. We therefore recommend that the Trust review the current data collection and reporting process (including the wards being excluded) against the new guidance.	This audit covers the indicators for the year 2014-15 prior to the new areas of care coming being reported upon from 1st April 2015. Health Informatics will review and verify additional categories to ensure that all data is being categorised appropriately in line with NHS England guidance seeking guidance from the national Friends and Family Test Team as required. **Responsible Officer:** Health Informatics Team **Timeline:** May 2014 **Process for updating Council of Governors**: Briefing to next meeting	Medium
Patients' Friends and Family Test	**Recording of Token Collections** We found cases where the number of responses recorded on the paper chart did not match the responses entered into Meridian. No recommendation has been raised as token collections is no longer used as a method of feedback collection.	Not Applicable **Responsible Officer:** N/A **Timeline:** N/A **Process for updating Council of Governors**: N/A	Low

Update on prior year recommendations

Our prior year recommendations have been addressed.

Indicator	Prior year process maturity	Deloitte Recommendation	Current year status
Dementia CQUIN	G	**Consistent wording for Screening Question** The "Find" element requires clinicians to ask a designated question of whether a person has been forgetful within the last 12 months and whether this has significantly affected their and their carers daily life. There is no system or documented prompt to ensure that this exact wording is used on patient contact. We recommend the Trust considers a method of introducing this in order to ensure uniform screening and a standardised approach. **Responsible Officer:** Clinical lead for dementia and delirium **Timeline:** Q1 2014/15	**Completed** There is now a system-generated alert on EPR when recording a dementia assessment or placing an order in EPR.
Dementia CQUIN	G	**Engagement with GPs** Compliance with the CQUIN ends with the Trust making a referral, usually to the GP, for those assessed as likely to have Dementia. GPs are external to the Trust and there is currently no mechanism for the Trust to identify whether the next stage of diagnosis and ensuring an appropriate care package has been put in place, is present. Introducing such a step is not a requirement of the Trust, and is outside of the CQUIN requirement, but with an increased emphasis on the important of joined-up and integrated care, this is an area we recommend the Trust discusses with commissioners and community care providers. **Responsible Officer:** Clinical lead for dementia and delirium **Timeline:** Q1 2014/15	**Substantially Completed** Discussions have been held with commissioners and the outcomes discussed at Dementia and Delirium Committee meetings. It has been noted that the Trust's ability to follow up following discharge is limited due to resourcing constraints.
Dementia CQUIN	G	**Training Attendance** Testing identified that the system generated report of attendance was not properly linked to employee records and suggested non-compliance. Further investigation and a manual reconciliation showed that attendance was compliant. We recommend that this issue is further investigated with an accurate system solution being preferable. **Responsible Officer:** Deputy Chief Nurse **Timeline:** End of Q3 2014/15	**Completed** The Trust has introduced WIRED (Workforce Information Reporting Engine Database), a web-based tool, which interfaces with ESR to help ensure training attendance is now linked to employee records.

Appendices

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, United Kingdom
28 May 2015

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 25 November 2014, only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Qualification to our Opinion

As stated within this report, we have made a qualification to our Opinion on the quality accounts as a result of our findings relating to the “18 week Referral to Treatment – Incomplete Pathways” indicator.

We have provided below, the basis for our qualified opinion and the wording of the opinion.

Basis for qualified conclusion

The “maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway” indicator requires that the Trust accurately record the start and end dates of each patient’s treatment pathway, in accordance with detailed requirements set out in national guidance.

We found that:

- for 22.5% of the sample tested the start date was not accurately recorded, affecting the calculation of the published indicator; and
- for 7.5% of the sample tested, there were errors in the recording of the clock-stop date for the pathway, affecting the calculation of the published indicator.

Our procedures included testing a risk based sample of items from throughout the year, and therefore the error rates identified from that sample should not be directly extrapolated to the population as a whole.

The “Our Data Quality” section on page 60 of the Trust’s Quality Report details the actions that the Trust is taking post year end to resolve the issues identified in its processes.

As a result of the issues identified, we have concluded that there are errors in the calculation of the “maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway” indicator for the year ended 31 March 2015. We are unable to quantify the effect of these errors on the reported indicator.

Qualification Wording in the Quality Accounts

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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 in accordance with the ARM and the six dimensions of data quality set out in the “Detailed Guidance for External Assurance on Quality Reports 2014/15; 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’.

Qualification Wording in the Audit Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts except that we have qualified our conclusion on the Quality Report in respect of the ”maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway” indicator.

Data Quality responsibilities

The new False or Misleading Information offence applies to this year's Quality Accounts.

New legal responsibilities over data quality

From 1 April 2015, health providers are subject to the False or Misleading Information ("FOMI") offence, introduced in response to issues over data quality in the NHS. The FOMI offence applies to:

- specified information which trusts already report regularly to the Health and Social Care Information Centre; and
- the contents of the Quality Accounts.

The FOMI offence is a two stage offence:

- firstly, a NHS or private sector provider organisation is guilty of the offence if it provides information that is false or misleading whether intentionally or through negligence i.e. this is a strict liability offence where intent is not relevant to the offence being committed.
- secondly, if a provider has committed and offence, it is possible that a director or other senior manager or other individual playing such a role may be personally guilty of an equivalent of the FOMI offence as well.

The potential penalties for providers include fines, a requirement to take specific action to remedy failures in data reporting, or to publicise that the offences have been committed and corrected data. For an individual, penalties can be an unlimited fine or up to 2 years in jail.

Providers and individuals are able to make a defence that they reported information having taken "took all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information"– however it is currently unclear what would be interpreted as "reasonable" in this context. In practise, there is likely to be significant discretion exercised in determining whether to mount a prosecution.

Deloitte view

Over the course of the year, we have updated the Trust on the potential implications of the offence and have discussed with management the findings from our Quality Accounts work in the context of the offence. We have recommended additional wording that has been included in the Quality Accounts to make clear the inherent limitations of recording and reporting some metrics, which the Trust has included in order to present reported data in the appropriate context.

The scope of the FOMI offence is wide ranging, and covers many more indicators and data sets than are considered in our Quality Accounts data testing of three indicators, or than Internal Audit are able to cover in their data work each year. In order to be able to demonstrate across all reported metrics that they have taken "all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information", providers are ultimately reliant upon the quality of their systems for data recording and information reporting.

However, accurately reported data is not just a compliance requirement – it is perquisite for creating an insight driven organisation. A lack of accurate, complete and timely data can increase operational and financial risk. Failure to govern and use data effectively can lead to poor patient experiences and reputational damage. Data issues can also undermine a Trust's ability to run an efficient service, as key information that should influence decision making is not available or accurate.

To support boards in considering their use of data, our latest NHS Briefing on Data Quality highlights areas of good practice for Trusts to consider in improving how they govern and use data. Key questions for Trust boards to consider include::

- Is there a risk that your reported data is not accurate or that you are making decisions on unreliable data?
- What sources of assurance has the Board sought around the quality of data? Do you place too much reliance on the mandatory external data governance reviews to assure data quality?
- Is there an opportunity to improve patient outcomes, patient experience, operational efficiency and financial performance of your Trust by using data in a more sophisticated way?
- Has your Trust adequately identified the costs and benefits associated with a data governance effort?
- Does your Trust have in place a system of Data Governance designed to address data quality concerns and enable more effective data usage?
- Is your data governance effort owned at a sufficiently senior level and is the Board aware of data governance issues and concerns?
- Has your Trust set out its analytics and information vision and strategy?
- Is your analytics and information strategy aligned to other Trust strategies?
- Does your Trust have the analytics capacity, capability and technology to exploit its data assets effectively?

Events and Publications

Our events and publications to support the Trust.

Governor seminars

We run a regular programme of seminars for Governors of trusts we audit. Recent areas covered have included:

- Themes from our Connected Health study,, led by Karen Taylor, Director of our Centre for Health Solutions, looking at how digital technology is transforming health and social care;
- 2014/15 Reporting Requirements, focusing on areas for Governors to be aware of such as Quality Accounts changes;
- Findings from governance reviews under Monitor's "Well Led" framework; and
- "Hot topics" in the sector ahead of the year-end reporting and audit process.

The sessions provide an opportunity for Governors to share both challenges and examples of successful approaches from across their Trusts. We would welcome suggestions for themes for future sessions.

The Trust has been represented by a Governor at previous events. Our next session will be in the autumn: we will send an invitation via the Lead Governor for the Council of Governors to nominate an attendee.

Deloitte UK Centre for Health Solutions

Deloitte Centre for Health Solutions

The Deloitte Centre for Health Solutions generates insights and thought leadership based on the key trends, challenges and opportunities within the healthcare and life sciences industry. Working closely with other centres in the Deloitte network, including our US centre in Washington, our team of researchers develop ideas, innovations and insights that encourage collaboration across the health value chain, connecting the public and private sectors; health providers and purchasers; and consumers and suppliers.

Recent reports include:

- Connected Health;
- Healthcare and Life Science Predictions 2020;
- Better care for frail older people;
- Guideposts Dementia Information Prescription, in partnership with the Guideposts Trust; and
- Working differently to provide early diagnosis.

Upcoming studies include End of Life Care, and the Cost of Compliance

For access to our latest studies and opinion pieces, please sign up to receive our weekly blog at http://blogs.deloitte.co.uk/health/ or email centreforhealthsolutions@deloitte.co.uk:

NHS Briefings and publications for the Trust

We provide the Trust through the year with publications and access to webinars and information on accounting requirements, including our "Stay Tuned Online" accounting update sessions.

We regularly publish NHS Briefings designed to disseminate our insights on topical issues within the NHS in general, and Foundation Trusts in particular. They focus on current issues facing the sector and ask questions to help readers assess if the issue is being appropriately addressed at their Trust.

Briefings have covered a range of topics including Data Quality, The Dalton Review: Implications for providers, Joined up QIPP, Patient Administration Systems, Effective Boards, the Evolving Role of Governors, Narrative Reporting, Quality Accounts requirements, Human Resources, Mergers & Acquisitions in the NHS, Transforming Community Services, and the challenges of Monitor's Quality Governance framework.

We also run regular NHS Foundation Trust dinners for directors, with speakers from across the sector on key current issues. Recent events have focussed on Quality Governance and on the Dalton Review.