UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

MONDAY 21 JULY 2014

Title:	**External Assurance on the 2013/14 Quality Report**	
Responsible Director:	David Rosser, Executive Medical Director	
Contact:	Imogen Gray, Head of Quality Development, 13687	

Purpose:	To present the findings from Deloitte's external assurance of the 2013/14 Quality Report and the Trust's response to the recommendations.	
Confidentiality Level & Reason:	N/a	
Annual Plan Ref:	Strategic Aim: To deliver and be recognised for the highest levels of quality of care through the use of technology, information, and benchmarking	
Key Issues Summary:	• The Deloitte report on the external assurance of the 2013/14 Quality Report is provided to the Council of Governors for review (see separate report). • The Trust has been issued with a clean limited assurance opinion on the content of the Quality Report and the two mandated indicators: *C. difficile* infection and 28 day readmissions. • Deloitte made two recommendations for improvement relating to the local indicator which was also audited: Outpatient CT turnaround times. • The Trust implemented both recommendations by 22nd May 2014.	
Recommendations:	The Council of Governors is asked to: **Note** the content of the report.	
Approved by:	Dr David Rosser	Date: 10/07/2014

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS
MONDAY 21 JULY 2014

EXTERNAL ASSURANCE ON THE 2013/14 QUALITY REPORT

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. Introduction

The purpose of this paper is to present the findings from Deloitte's external assurance review of the 2013/14 Quality Report and the Trust's response to the recommendations. The Deloitte report is provided separately for review. The Council of Governors is asked to note the contents of the report.

2. Background

2.1 Monitor published its *2013/14 Detailed Guidance for External Assurance on Quality Reports* in February 2014. During the period February-May 2014, the Trust's external auditor Deloitte carried out an audit of both the content of the Trust's 2013/14 Quality Report and conducted sample testing for three indicators:

5.1.1 *C. difficile* infection;
5.1.2 28 day readmissions; and
5.1.3 Imaging indicator – Outpatient CT (computerised tomography) scan turnaround times

2.2 The Monitor guidance requires Trusts' external auditors to provide a signed limited assurance statement covering whether anything has come to their attention which leads them to believe:

- the Quality Report has not been prepared in line with the Monitor guidance or is not consistent with specified information sources.

- the two mandated indicators – *C. difficile* infection and 28 day readmissions – have not been reasonably stated in all material aspects in accordance with the Monitor guidance.

2.3 The local indicator listed in 5.1.3 above was not subject to a limited assurance opinion in 2013/14. External auditors are required to provide a report to the Council of Governors setting out their findings and recommendations for improvement for all three indicators tested. Please see the separate Deloitte report entitled *University Hospitals Birmingham NHS Foundation Trust: Findings and Recommendations from the 2013/14 NHS Quality Report External Assurance Review*.

3. External Assurance Findings

3.1 Limited Assurance Opinion on Content of the 2013/14 Quality Report and Mandated Indicators

The Trust has been issued with a clean limited assurance opinion on the content and consistency of the Quality Report and the two mandated indicators: *C. difficile* infection and 28 day readmissions.

3.2 Local Indicator – Outpatient CT Turnaround Times

Deloitte identified two recommendations for improvement in relation to the methodology for the Outpatient CT turnaround time indicator which are shown in Appendix A.

4. Trust Response to the Recommendations

The Trust has fully implemented both recommendations as per the action plan shown in Appendix A by 22 May 2014. Progress will continue to be monitored and reported to the Audit Committee during the year.

5. Recommendations

The Council of Governors is asked to:

Note the contents of the report.

Appendix A: Trust Response to Deloitte Recommendations

Indicator	Deloitte Recommendation	Priority	Management Response
CT turnaround times	**Indicator definitions** The Trust should consider whether in light of operational delivery at weekends and in the interests of simplifying calculation, the indicator should be redefined as 7 days rather than 5 working days.	**Low**	The methodology for this indicator and the indicator title have been changed from 5 working days to 7 days to reflect how the Imaging service is now delivered. **Responsible Officer:** Paul Brettle, Deputy Divisional Director of Operations, Division A and Jessica Richardson, Clinical Intelligence Analyst. **Timeline:** Completed 22nd May 2014
CT turnaround times	**Identification of cases for exclusion from performance calculation** The Trust should consider introducing additional filters/criteria into the data extraction methodology that would help ensure that cases allocated to an incorrect folder would be identified.	**Medium**	During indicator testing it was identified that one Imaging (CT) report included within the dataset was an imported one. Imported reports should not be included as they relate to exams performed elsewhere and are generally imported just to complete the full patient history. Imported studies were already excluded based on the room type where the scans took place. An additional exclusion has now been applied to ensure any imported scans are also excluded based on the Referrer field too. **Responsible Officer:** Paul Brettle, Deputy Divisional Director of Operations, Division A and Jessica Richardson, Clinical Intelligence Analyst. **Timeline:** Completed 22nd May 2014

Deloitte.

University Hospitals Birmingham NHS
NHS Foundation Trust

University Hospitals Birmingham NHS Foundation Trust

Findings and Recommendations from the 2013/14 NHS Quality Report External Assurance Review

the Distinctive audit

Final report: 23rd May 2014

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The Council of Governors,
University Hospitals Birmingham NHS Foundation Trust,
Queen Elizabeth Medical Centre,
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Birmingham,
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23 May 2014

Dear Governors,

We have pleasure in setting out in this document our report to the Council of Governors of Univeristy Hospitals of Birmingham NHS Foundation Trust on our external assurance review of the 2013/14 Quality Report. This report covers the principal matters that have arisen from our review.

We take responsibility for this report which is prepared on the basis of the limitations set out below. The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that may exist or all improvements that might be made. Any recommendations made for improvements should be assessed by you for their full impact before they are implemented.

This report is confidential and prepared solely for the purpose set out in our engagement letter. 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. No other party is entitled to rely on our report for any purpose whatsoever and thus we accept no liability to any other party who is shown or gains access to this report. 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, only on the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Yours faithfully

Gus Miah

Partner

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

The big picture

The big picture

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 selected indicators.We have received the final signed Quality Report and letter of Representation, and can issue our final report to the Governors.
- 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 2013/14".
- In response to the growth of performance indicators across the NHS, we have developed a framework of considerations for evaluating data quality. We have used this framework in evaluating our findings and the recommendations we have raised.
- We are signing an unmodified opinion for inclusion in your 2013/14 Annual Report.

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 Clostridium Difficile (C.Diff) and 28 day readmissions as its publicly reported indicators. The alternative was 62 day cancer waits.
  - For 2013/14, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected turnaround time for outpatient CT scans.
  - 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 C.Diff and 28 day readmissions 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: C.Diff, 28 day readmissions and turnaround time for outpatient CT scans.

The big picture (continued)

We have not identified any significant issues from our work.

Content and consistency review

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 2014 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?	Awaiting stakeholder feedback
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

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 2014, 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 2013/14”.

	28 day readmissions	Clostridium Difficile	Local Indicator
Accuracy Is data recorded correctly and is it in line with the methodology.	G	G	G
Validity Has the data been produced in compliance with relevant requirements.	G	G	G
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.	G	G	G
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	G	G	D
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	G	G	G
Recommendations identified?	✗	✗	✓
Overall Conclusion	G Unmodified Opinion	G Unmodified Opinion	No opinion required

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

Content and consistency findings

Content and consistency review findings

The Quality Report meets regulatory requirements

Content of Quality Report

We reviewed the content of the 2013/14 Quality Report against the content requirements set out in Monitor's 2013/14 Annual Reporting Manual (ARM).

Based on our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014, the content of the Quality Report is not in accordance with the 2013/14 ARM.

Consistency of Quality Report

Monitor require Auditors to undertake a review of the content of the Quality report for consistency with the content of other sources of management information specified by Monitor in its "Detailed Guidance for External Assurance on the Quality Reports".

We reviewed the consistency of the quality report against this supporting information required by Monitor and:-

- We did not identify any significant matters specified in the supporting information which are not specified in the Quality Report.
- We did not identify any significant areas of the Quality Report that could not be confirmed back to supporting evidence.

Statement of Directors Responsibilities

Monitor require NHS FTs to sign a Statement of Directors' Responsibilities in respect of the content of the quality report and the mandated indicators. The guidance requires these to be published in the Quality Report.

We have reviewed the Statement of Directors Responsibilities. The Trust's "Statement of Directors' Responsibilities" is an un-amended version of the pro forma provided by Monitor.

Stakeholder Engagement

Monitor require Auditors to consider the processes which NHS FTs have undergone to engage with stakeholders.

The Trust has circulated the Quality Report to stakeholders and has received feedback from:

- Birmingham Cross City Clinical Commissioning Group
- Healthwatch Birmingham
- Birmingham Health & Social Care Overview and Scrutiny Committee

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Performance indicator testing

28 day emergency re-admissions

	Trust reported performance	Target	Overall evaluation of our work
2013/14	10.18%	No target	G
2012/13	Not audited		
2011/12	Not auditted		

Indicator definition and process

Definition: "Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust."

The readmission rate can indicate early complications after discharge and how appropriate the original decision made to discharge was. Some readmissions are to be expected from planned care pathways. There is a challenge for many trusts in preparing this data due to historic differing demands for 28 day and 30 day reporting by different organisations.

Process diagram for 28 day readmissions

28 day emergency re-admissions

Approach

- We met with the Trust's informatics lead for emergency readmissions to understand the process of a patient being readmitted to the result being included in the Quality Report.
- We evaluated the design and implementation of controls through the process. We discussed with management whether there were any periods during the year or divisions within the Trust representing a greater risk that we should focus sample testing on and no areas were identified.
- We selected a sample of 25 from 1 April 2013 to 31 January 2014 (this was the fullest period of data available at the time that testing took place).
- The sample included those re-admitted both within and outside 28 days and a number of non-emergency admissions. During our work we found no errors.

Findings

Interviews

- Findings:
  - The governance department has audited how readmissions are reviewed and declared.
  - Monthly audit is performed by the ward clerk support managers who review / validate a sample of data.
  - Cases which raise questions are referred back to the relevant Consultant for further explanation.
  - Data is extracted from the trust system via automated queries and in line with national definitions for the indicator.
- Issues: Not applicable
- Recommendations: Not applicable

Testing

- Findings:
  - There were no errors identified within the sample testing as outlined below:
    - Date of Admission: 0 (0%)
    - Date of Discharge: 0 (0%)
    - Date of Readmission: 0 (0%)
    - Type of Readmission: 0 (0%)
    - Number of Days from Discharge: 0 (0%)
- Issues: Not applicable
- Recommendations: Not applicable

Recalculation

- Findings:
  - Re-calculation of the performance indicator identified 4825 breaches of the 28 day readmission indicator from a total of 47376 completed episodes, resulting in a rate of 10.18%. This reconciles with the figures reported in the annual quality report.
- Issues: Not applicable
- Recommendations: Not applicable

C. difficile

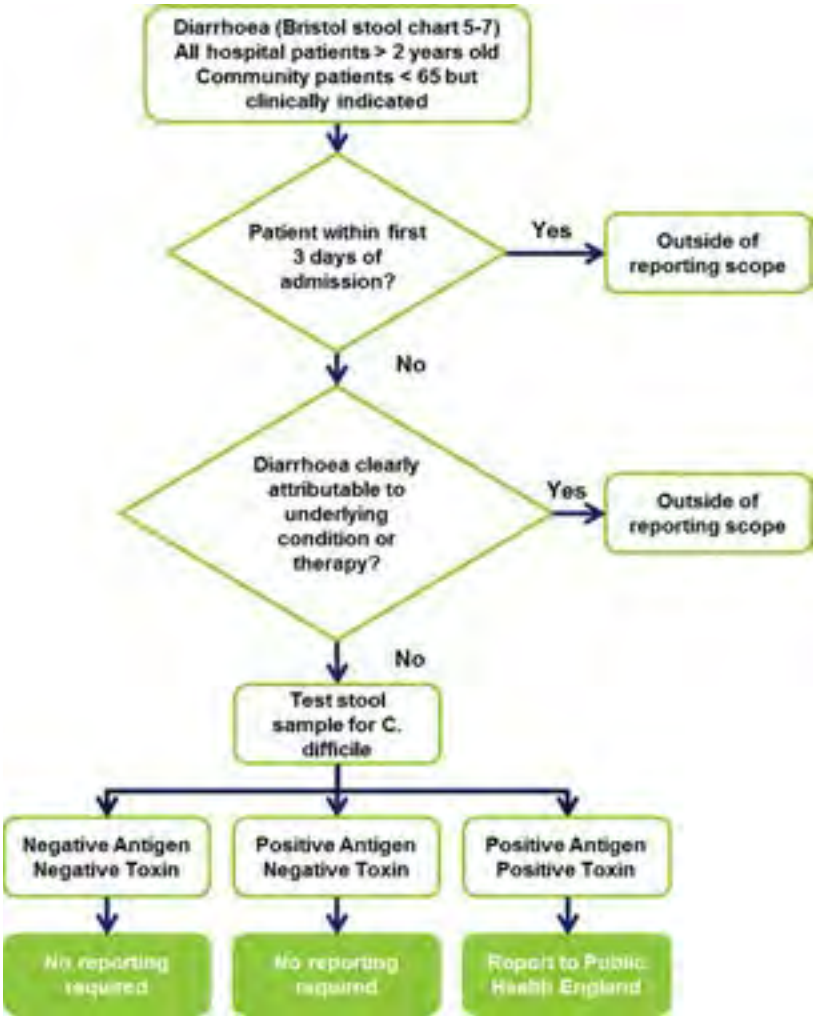
	Trust reported cases	Commissioner agreed tolerance	Overall evaluation of our work
2013/14	80	56	G
2012/13	Not audited		
2011/12	Not audited		

Indicator definition and process

Definition: "A C. difficile infection is defined as a case where the patient shows clinical symptoms of C. difficile infection, and using the local Trust C. difficile infections diagnostic algorithm (in line with DH guidance) is assessed as a positive case. Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken." The metric is calculated as "The sum of episode durations where the patient was aged 2 or over at the end of the episode from Hospital Episode Statistics."

Clostridium Difficile, often referred to as C. difficile or C-diff, is a bacterium that is present naturally in the gut of around two thirds of children and 3% of adults. C. difficile does not cause any problems in healthy people but some antibiotics that are used to treat other health conditions can interfere and cause the C. difficile bacteria to multiply and produce toxins. At this point, a person is said to be infected with C. difficile.

Process diagram for C.Diff reporting



C. difficile (continued)

Approach

- We met with the Trust's lead for C.difficile to understand the process from the initial symptoms being identified to the result being included in the Quality Report.
- We evaluated the design and implementation of controls through the process. Interviews with the Trust did not expose any particular specialties where issues have been identified.
- The quality report for 2013/14 identifies that there were 80 cases of positive C-Diff recordings that were attributable to the Trust. The target agreed with commissioners for 2013/14 was set at 56 cases. The figure for 2013/14 has been recorded as 80 cases in the Quality Account. This has been validated to the total number of cases reported to Public Health England.
- We selected a sample of 25 cases from 1 April 2013 to 28 February 2014 including in our sample a mixture of cases attributable and not attributable to the Trust.
- We agreed our sample of 25 to supporting documentation.

Findings

Interviews

- Findings:
    - There is robust knowledge of the process in place across the infection control staff interviewed.
    - Performance is reported monthly both internally (Board of Directors, Chief Executive's Advisory Group and Infection Prevention and Control Group meetings) and via external submission to the Public Health England portal.
    - The Trust conducts regular joint review panels with the Clinical Commissioning Group to establish whether cases were avoidable or unavoidable, with the intention on a focus on reducing avoidable cases.
    - The Trust has a number of internal cross checks to further assure that reporting processes and data quality are robust.
    - NHS England has commended the Trust's process and is promoting this a national best practice model.
- Issues: Not applicable
- Recommendations: Not applicable

Testing

- Findings:
    - There were no errors identified within the sample testing undertaken as outlined below:
        - Date of Admission: 0 (0%)
        - Date of Blood Culture Test: 0 (0%)
        - Date of Positive Result: 0 (0%)
        - Attributable to Trust: 0 (0%)
- Issues: Not applicable
- Recommendations: Not applicable

Recalculation

- Findings: Re-calculation of the performance indicator identified 80 positive cases that were attributable to the Trust. This reconciles with the figures reported in the annual quality report.
- Issues: Not applicable
- Recommendations: Not applicable

Turnaround time for outpatient CT scans

	Trust reported performance	Target	Overall evaluation of our work
2013/14	63.7%	85%	G
2012/13	Not audited		
2011/12	Not audited		

Indicator definition and process

Definition: The percentage of outpatient CT scans performed which are reported in 5 working days or less.

The clock commences at the point at which the CT scan is completed and available within the radiology CRIS system. The clock is stopped at which the CT scan is dated as "verified" within the CRIS system.

Numerator	Number of eligible CT scans performed which were reported within 5 working days or less.
Denominator	Total number of eligible CT scans performed

Approach

- We met with the radiology service manager and informatics lead to understand the process from the patient's attendance for scanning through to the reporting of performance against the indicator.
- Walk through of the key systems (PACS and CRIS) were undertaken to understand how information is captured and reported.
- We selected a sample of 45 records for testing, and included a range of cases shown as reported both inside and outside the 5 day target. The sample was biased to include a number of cases taking place within a rnage of dates which included weekend days or bank holidays (see Findings section below for further explanation to support this rationale).

Findings

Interviews

- Findings:
  - The Trust has undergone a PACS system upgrade in Novembr 2013 and a dip in performance was noted in December 2013 which was believed to be a consequence of staff adjusting to the new system. By January 2014 performance had improved again.
  - The performance target has not been achieved at any point during the year and the optimal performance declared by the trust has been 73.28% in May 2013.
  - Performance is monitored and reported on a monthly basis and flags are raised on the basis of performance shifting by an agreed tolerance (statistical exceptions from month to month). Where flags are raised the indicator is then raised to Clinical Quality Monitoring Group and the service is required to provide an action plan.
  - During interviews and testing it was observed that the indicator is currently defined as 5 working days. However around 3% of scans take place on a non-working day but the 0 day for the clock is still the next actual working day (e.g. for a scan performed on a Monday the 0 day would be Monday, however if a scan is performed on a Saturday the 0 day is still Monday). If radiology staff were present and performing the scan at a weekend then the service was operational and this could be deemed a working day.
  - Additionally using a 5 working day (rather than a 7 day) methodology introduces additional complexity into the calculation of performance as the algorithm needs to exclude all working days and Bank Holidays.
- Issues: Definition of the indictor being in working days rather than days.

- Recommendations: The Trust should consider whether in light of operational delivery at weekends and in the interests of simplifying calculation, the indicator should be redefined as 7 days rather than 5 working days.

Testing

- 47 records were tested, of which 2 were ineligible (see below for further explanation). As such the total eligible sample tested was 45 records.
- Findings:
    - There were no errors identified within the sample testing undertaken as outlined below:
        - CT scan date testing: 0 (0%)
        - CT reporting date testing: 0 (0%)
        - Days calculation testing: 0 (0%)
        - Breached / target met designation: 0 (0%)
    - There were two cases included within the data extract which we tested which should not have been included.
        - One was a failed pathway where the clock had been started when the patient had not attended and as such there was no pathway to assess.
        - One was a scan which was performed on behalf of another organisation and as such would not be eligible for inclusion in monitoring of Trust performance. The trust has 'rooms' within the system for allocation of such cases however this case had been allocated to a 'room' from which data would be drawn for performance monitoring.
- Issues: Not applicable
- Recommendations: The Trust should consider introducing additional filters/criteria into the data extraction methodology that would help ensure that cases allocated to an incorrect 'room' would be identified.

Recalculation

- Findings: Re-calculation of the performance indicator identified a performance of 63.7% 2013/14. This reconciles with the figures reported in the annual quality report.
- Issues: Not applicable
- Recommendations: Not applicable

Recommendations

Recommendations for improvement

We have identified two recommendations relating to the local indicator.

Indicator	Deloitte Recommendation	Priority (H/M/L)	Management Response
CT turnaround times	**Indicator definitions** The Trust should consider whether in light of operational delivery at weekends and in the interests of simplifying calculation, the indicator should be redefined as 7 days rather than 5 working days.	Low	The methodology for this indicator and the indicator title will be changed from 5 working days to 7 days to reflect how the Imaging service is now delivered. . **Responsible Officer:** Paul Brettle, Deputy Divisional Director of Operations, Division A and Jessica Richardson, Clinical Intelligence Analyst. **Timeline:** 30th June 2014 **Process for updating Council of Governors:** The Independent Auditor's Report on the Quality Report will be presented to the Council of Governors with the Trust's initial management response. Progress will then be reported to the Audit Committee.
CT turnaround times	**Identification of cases for exclusion from performance calculation** The Trust should consider introducing additional filters/criteria into the data extraction methodology that would help ensure that cases allocated to an incorrect folder would be identified.	Medium	During indicator testing it was identified that some Imaging (CT) reports included within the dataset were imported ones. These should not be included as they are exams performed elsewhere and are generally imported just to complete the full patient history. The imported reports can be identified as 'UHBIMP' in the Referrer field. The methodology for this indicator will therefore be reviewed and amended to exclude imported studies. **Responsible Officer:** Paul Brettle, Deputy Divisional Director of Operations, Division A and Jessica Richardson, Clinical Intelligence Analyst. **Timeline:** 30th June 2014 **Process for updating Council of Governors:** The Independent Auditor's Report on the Quality Report will be presented to the Council of Governors with the Trust's initial management response. Progress will then be reported to the Audit Committee.

Update on prior year recommendations

Recommendations from the previous auditor have been recorded below, together with a progress update provided by the Trust.

Indicator	Priority rating	KPMG Recommendations	Current year status
Incidents resulting in severe harm/ death	Medium	**Concluding outcomes on SIRI and RCA forms** Where the Trust undertakes a SIRI or RCA investigation, a clear conclusion of the severity of harm should be recorded within the report, along with a supporting rationale detailing the clinical judgement made in arriving at this conclusion. This will ensure that a full audit trail is in place that supports the level of severity reported in the incident report form and to the National Reporting Lines Service (NRLS). **Responsible Officer:** Bob Hibberd, Head of Governance **Timeline:** Implement from July 2013	A section has been added to all Serious Incident Requiring Investigation (SIRI) reports where the severity of harm can be recorded. All SIRI reports from 2013-14 have the severity of harm included or a comment to state this is not possible where it is not known if the harm caused was a direct result of the incident or not. Implemented from 1 July 2013
Incidents resulting in severe harm/ death	Low	**Clear description of permanent harm in IRFs and Datix** The Trust should incorporate a control check to ensure that for incidents resulting in severe harm, the outcome of “permanent harm” is clearly documented within the IRF and Datix. **Responsible Officer:** Bob Hibberd, Head of Governance **Timeline:** Implement from July 2013	Incidents resulting in severe harm are subject to SIRI investigation. Upon confirmation of a SIRI investigation, the electronic incident report form is checked to ensure the injury has been stated in the relevant section. Pressure ulcers are detailed in the extra fields section where the site, grade and type are recorded. Monthly checks are also undertaken to ensure the injury section has been fully completed. Implemented from 1 July 2013

Data Quality Framework

Data Quality Framework

For evaluating the findings from our testing

Overview

The volume and importance of non-financial performance information across the NHS has grown significantly in recent years. Performance reporting has emerged as a key tool used both internally and externally. Managers use information to monitor performance, regulators use it to gauge risk, commissioners use it to ensure their priorities are met, and governors, patients and the public use it to gain more information about their trust and to hold them to account.

Whilst the availability and use of non-financial performance information has developed quickly, the control frameworks used to produce and control such information has not been subject to the same level of rigour as that of financial information. On average a trust will receive information on 61 performance indicators on a monthly basis, but very few will be subject to independent review. This can result in a potential assurance gap.

In the table below we have prepared a summary of key considerations that each trust should be able to answer regarding their performance information. It can be used as an assurance tool to gauge the risk around accuracy and completeness of performance information.

Area	Overview	Key considerations
System	The accuracy of an indicator is influenced by the level of automated vs manual controls. In general, an automated system requiring minimal manual adjustment has a lower risk of error. However, this assumes that the system controls are operating as they are intended.	• Is the indicator generated from one system or the interaction of different systems? • How often are system controls reviewed to ensure they are appropriate and meet indicator definitions? • How quickly is data produced after the event? • Does data require manual adjustment prior to being reported as a performance indicator?
Governance	Accuracy and completeness of indicators are influenced by the 'tone at the top'. Good performance would mean clarity of responsibility for performance metrics, clear processes and procedures in place for each metric which are regularly updated, and quick and comprehensive action where concerns have been raised.	• Who is responsible for the quality and completeness of performance information at Board level? • If different individuals are responsible for different indicators, is it clear who is responsible for each? • Are there documented procedures and processes for each indicator and is this regularly updated? • If data quality concerns have been raised have they been addressed quickly and comprehensively?
Inputs	Some performance indicators rely on a wide variety of sources to produce the end metric. In general, the greater the number of separate sources of information, and the higher the volume of data, the greater the likelihood of error.	• What is the volume of inputs of each indicator on a daily / weekly / monthly basis? • How many different sources of data are there, and how do you know they all apply consistent? methodology in collecting and reporting the data? • What checks are in place to ensure the consistency and completeness of input data?
Complexity and skill	Some indicators require specific skills to identify, analyse and report performance. Some indicators have complex rules, which requires specialist consideration. If the complexity of these rules is not understood and applied correctly, there is a risk that indicators contain errors or are reporting incomplete information.	• If performance indicators have specific rules, is there regular training to ensure that all individuals involved understand these rules and apply them correctly? • Does the Trust have its own assurance systems in place to test compliance with such rules? • Has the Trust got the appropriate skill and level of resources to identify, analyse and report performance for complex indicators? • If national guidance is not clear, does the Trust have local guidance regarding process and procedures and is this shared with appropriate individuals?

Responsibility statement

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.

The scope of our work

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

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

[Signature]

Deloitte LLP
Chartered Accountants

Xx May 2014