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5 Boroughs Partnership NHS Foundation Trust

Quality Report 2012/13

May 2013

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Contents

Audit Code and scope of this work

We have performed this work in accordance with Monitor's Audit Code for NHS Foundation Trusts ("the Code"), which was issued in March 2011 and the *Detailed guidance for external assurance on quality reports 2012/13* which was issued in March 2013 and revised by Monitor on 26 April 2013. This is available from the Chief Executive of the NHS Foundation Trust. Our reports and audit letters are prepared in accordance with the Code.

Reports and letters prepared by external auditors and addressed to governors, directors or officers are prepared for the sole use of the NHS Foundation Trust, and no responsibility is taken by auditors to any governor, director or officer in their individual capacity, or to any third party. The matters raised in this report are only those which have come to our attention arising from or relevant to our work that we believe need to be brought to your attention. They are not a comprehensive record of all the matters arising, and in particular we cannot be held responsible for reporting all risks in your business or all internal control weaknesses. This report has been prepared solely for your use in accordance with the terms of our engagement letter dated 19th April 2013 and for no other purpose and should not be quoted in whole or in part without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose.

A. Background and Scope

Introduction and background

NHS foundation trusts are required to prepare and publish a Quality Report each year. The Quality Report has to be prepared in accordance with the NHS foundation trust Annual Reporting Manual ('the FT ARM').

As your auditors, we are required to undertake work on your Quality Report under Monitor's Audit Code and Monitor's '*Detailed Guidance for External Assurance on the Quality Reports 2012/13'* ('the detailed guidance) which was published in March 2013 and revised by Monitor on 26 April 2013.

The purpose of this report is to provide the Board and Board of Governors of 5 Boroughs Partnership NHS Foundation Trust ("the Trust") with our findings and recommendations for improvements, in accordance with Monitor's requirements. It is referred to by Monitor as the "Governors" report.

Scope of our work

We are required by Monitor to review the content of the 2012/13 Quality Report and three performance indicators and produce two reports:

- Limited assurance report: This report a formal, public document that requires us to conclude whether anything has come to our attention that would lead us to believe that:
    - The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
    - The Quality Report is materially inconsistent with source documents specified by Monitor; and
    - The specified indicators have not been prepared in all material respects in accordance with the Criteria.

  A limited assurance engagement is less in scope than a reasonable assurance engagement (such as the external audit of accounts). The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited compared to a reasonable assurance engagement.

- Governors report: A private report on the outcome of our work that is made available to the Trust's Governors and to Monitor.

Our limited assurance report is restricted, as required by Monitor, to the content and two performance indicators only. The Governors report covers all of our work and, therefore, a third indicator.

Content of the Quality Report

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

- Reviewing the content of the Quality Report against the requirements of Monitor's published guidance, as specified in Annex 2 to Chapter 7 of the FT ARM; and
- Reviewing the content of the Quality Report for consistency with the source documents specified by Monitor in the detailed guidance.

Performance indicators

We are required to issue a limited assurance report in respect of two out of the three indicators included in the Quality Report as follows:

1. 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital;

2. Minimising delayed transfers of care; and

3. Admissions to inpatient services had access to crisis resolution home treatment teams.

The Trust selected the following two indicators for review:

- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital.

- Minimising delayed transfers of care.

Monitor requires we understand the systems used to produce the specified indicators, perform a walkthrough of the system to gain an understanding of the data collection process, and then test the indicators substantively back to supporting documentation.

Performance indicator not included within our limited assurance report

We are also required to undertake substantive sample testing of one further indicator specified by Monitor: Percentage of patient safety incidents resulting in severe harm or death. This indicator is not included in our limited assurance report. Instead, we are required to provide a detailed report on our findings and recommendations for improvements in this, our Governors report.

B. Summary of findings

Content of the Quality Report

No issues have come to our attention that lead us to believe that the Quality Report has not been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2012/13*.

No issues have come to our attention that lead us to believe that the 2012/13 Quality Report is not consistent with the other information sources defined by Monitor.

For further information refer to page 7.

Limited Assurance Report

As a result of our work, we are able to provide an unqualified limited assurance report in respect of the content of the Quality Report.

Performance Indicators

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

Performance indicators included in our limited assurance report	Findings
100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital	Two issues identified; neither impacts on our limited assurance opinion
Minimising delayed transfers of care	One issue identified; no impact on our limited assurance opinion

For further information refer to page 8.

Limited Assurance Report

As a result of our work, we are able to provide an unqualified limited assurance report in respect of the mandated performance indicators.

Performance indicator not included within our limited assurance report	Findings
Percentage of patient safety incidents resulting in severe harm or death	One error identified in the sample tested. One control issue identified.

For further information refer to page 11.

Annual Governance Statement

We identified no issues relevant to the Quality Report.

For further details, see page 13.

C. Detailed findings

Review against the content requirements

We reviewed the content of the 2012/13 Quality Report against the content requirements which are specified in Annex 2 to Chapter 7 of the *FT ARM*.

A number of amendments were made to the draft Quality Report as a result of the work we performed. These are summarised in Appendix A. Once the amendments were made by the Trust, no further issues came to our attention that led us to believe that the Quality Report has not been prepared in line with the *NHS Foundation Trust Annual Reporting Manual 2012/13*.

Review of consistency against specified source documents

We reviewed the content of the 2012/13 Quality Report for consistency against the following source documents specified by Monitor:

- Board minutes for the period April 2012 and up to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period;
- Feedback from the Commissioners – Knowsley Clinical Commissioning Group dated 24/05/2013;
- Feedback from the Council of Members;
- Feedback from local Healthwatch organisations – Healthwatch Knowsley dated 17/05/2013, Healthwatch Warrington dated 16/05/2013 and Halton LINk dated 13/05/2013;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 09/04/2013;
- Feedback from other stakeholders involved in the sign-off of the Quality Report – Warrington Borough Council Scrutiny Committee 14/05/2013; Knowsley Council Health Scrutiny Sub-Committee 20/05/2013;
- The national (Community) patient survey 2012;
- The national staff survey 2012;
- Care Quality Commission quality and risk profiles dated 02/04/2012; 31/05/2012; 31/07/2012; 30/09/2012; 31/10/2012; 30/11/2012; 31/01/2013; 28/02/2013; 31/03/2013;
- The Head of Internal Audit's annual opinion over the trust's control environment dated 28/05/2013.

No issues came to our attention that led us to believe that the Quality Report is not consistent with the other information sources detailed above.

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

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

1. 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital; and

2. Minimising delayed transfers of care.

We are required to evaluate the key processes and controls for managing and reporting the indicators and sample test the data used to calculate the indicator back to supporting documentation. Our work is performed

in accordance with the detailed guidance for external assurance on quality reports 2012/13 which was issued by Monitor in March 2013 and included:

- Identification of the criteria used by the Trust for measuring the indicator;
- Confirmation that the Trust had presented the criteria identified above in the Quality report in sufficient detail that the criteria are readily understandable to users of the Quality Report;
- Obtaining an understanding of the key processes and controls for managing and reporting the indicator through making enquiries of Trust staff and through performing a walkthrough;
- Reconciling the reported performance in the Quality Report to the data used to calculate the indicator from the Trust's underlying systems;
- Testing a sample of relevant data used to calculate the indicator back to supporting documentation; and
- Considering the completeness of the data reported and performing sample testing on this where relevant.

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

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

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

100% enhanced CPA patients receiving follow-up contact within seven days of discharge from hospital	
Reported performance:	
2012/13 Target: >=95%	2012/13 Actual: **96.9%**
Criteria identified:	

We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a the proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within seven days;
- 'Patients discharged' includes patients discharged to their place of residence, care home, residential accommodation, or to non psychiatric care, or to prison;
- The indicator excludes patients who die within seven days of discharge;
- The indicator excludes patients removed from the country as a result of legal precedence within seven days of discharge;
- The indicator excludes patients transferred to NHS psychiatric inpatient ward when discharged from inpatient care;
- The indicator excludes CAMHS (children and adolescent mental health services), i.e. patients aged under 18;
- Those that are recorded as followed up receive face to face contact or a telephone conversation (not text or phone messages); and
- The seven day period should be measured in days not hours and should start on the day after discharge.

Issues identified through work performed:		
No.	**Issue**	**Impact on limited assurance report**
1.	We tested a sample of 20 CPA patient discharges to verify that follow-up had occurred within 7 days. From our sample testing we noted a number of data discrepancies between the weekly ward returns and the supporting patient notes as follows: • We identified one error in relation to the inclusion of a patient who was assessed as non-CPA at the date of discharge. This patient had been assessed as CPA at the time of admission but this was revised prior to the patient being discharged. • We also noted three cases where an incorrect date of follow up had been recorded on the ward returns used to report on this indicator (against the follow up date recorded on the patient notes). However, this did not impact on the indicator result, as each of the follow ups had been completed within 7 days. • Additionally, we found one case where the follow-up date recorded on the ward return was the same as the day of discharge and did not appear to have been checked by the Performance Team as a potential error. On further investigation it was noted that the patient had in fact been discharged from the Trust on an earlier date and thus the follow up was valid; however returns should be checked to ensure that valid follow ups have taken place.	As there is no direct impact of these issues on the performance indicator, we have concluded that there is no impact on our limited assurance report from these matters.
2.	The Trust routinely applies a number of additional exemption criteria to the indicator to also exclude: • patients that are transferred from the Trust to an Acute Hospital but who then return to the Trust within 72 hours; • patients that have been discharged from Marlowe, Chesterton and Tennyson wards (as these patients are typically discharged to other psychiatric care); and • patients who are discharged to Nursing Homes with 24 hour care facilities with a mental health professional on site. It was noted that in relation to the discharges from Marlowe, Tennyson and Chesterton wards in particular, that the Trust should not automatically exempt these, but should instead confirm the discharge destination to ward returns to ensure that valid exemptions have been made on a case by case basis.	As there is no direct impact of these issues on the performance indicator, we have concluded that there is no impact on our limited assurance report from these matters.

Conclusion:
Our substantive testing of the indicator identified two issues, neither of which impact on our limited assurance report, resulting in an unmodified report in respect of this indicator.

Minimising delayed transfers of care	
Reported performance:	
2012/13 Target: < 7.5%	2012/13 Actual: **5.1%**

Criteria identified:

We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a the number of Delayed Transfers of Care per number of patients admitted to the Trust (this is in accordance with Monitor's compliance framework, page 48);
- The indicator (both numerator and denominator) only includes adults aged 18 and over;
- The numerator is the number of non-acute patients (aged 18 and over) whose transfer of care was delayed summed across the quarter;
- The denominator is the number of non-acute patients (aged 18 or over) admitted to the trust, summed across the quarter;
- Delayed transfers of care attributable to social care are excluded;
- A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed; and
- A patient is ready for transfer when:
    - A clinical decision has been made that the patient is ready for transfer; AND
    - A multi-disciplinary team decision has been made that the patient is ready for transfer; AND
    - A decision has been made that the patient is safe to transfer.

Issues identified through work performed:

No.	Issue	Impact on limited assurance report
1.	The outturn figure for this indicator originally reported in the draft 2012/13 quality report (5.7%) had been calculated using data compiled on a weekly basis throughout the year. However, we found from our testing that there were delays in the input of patient discharge dates in the PAS. These were not always taken into account and actual discharges were not appropriately excluded from the numerator. The delayed transfers of care figures are also reported as part of the mandatory monthly SITREP return to the Department of Health. The Trust has a separate monthly reporting routine for uploading this data to Unify, which we found to be more consistent with Monitor's guidance for the calculation of this indicator, and more accurately reflected	Although we have identified issues with the way the indicator is calculated, the final outturn is significantly within the required target, therefore we have considered that there is no impact on our limited assurance report.

	adjustments made using the actual discharge date for calculation of the numerator. We used the SITREP figures as the basis for recalculating the final outturn of the indicator as 5.2%. Through detailed sample testing of the SITREP return back to patient records we identified one instance where a patient had been discharged, but who had not been excluded from the indicator calculation. We adjusted the numerator and confirmed with the Trust that the final outturn for this indicator is 5.1%. This is the result now included in the quality report.
Conclusion:	
Our substantive testing of the indicator identified one issue which did not impact on our limited assurance report resulting in an unmodified report in respect of this indicator.	

Performance indicator not included within our limited assurance report

Monitor also requires us to undertake substantive sample testing of a mandated indicator, the results of which are not included within our limited assurance report. This indicator is the percentage of patient safety incidents that result in severe harm or death.

We are required to evaluate the key processes and controls for managing and reporting the indicator and sample test the data used to calculate the indicator back to supporting documentation.

We only tested a sample, as stated above. Our reported errors below are limited to this sample. We have not tested the underlying systems, for example the patient administration system and the data extraction and recording systems.

Our findings are detailed as follows:

Percentage of patient safety incidents that result in severe harm or death
Reported performance:
2012/13 Actual: 0.28%
Criteria identified:
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is expressed as a percentage of patient safety incidents reported to the National Reporting and Learning Service (NRLS) that have resulted in severe harm or death; • A patient safety incident is defined as 'any unintended or unexpected incident(s) that could or did lead to harm for one of more person(s) receiving NHS funded healthcare'; and • The 'degree of harm' for patient safety incidents is defined as follows: 'severe' – the patient has been permanently harmed as a result of the incident; and 'death' – the incident has resulted in the death of the patient.

Issues identified through work performed:		
No.	**Issue**	**Impact**
1.	As part of our testing we validated the data uploaded to the NPSA as part of mandatory patient incident reporting. (Only the first six months of the 2012/13 period is available from the NPSA for comparison purposes.) Between 1 April 2012 and 30 September 2012, 968 incidents were reported to NPSA of which three resulted in death, and none were classified as severe harm. We compared these figures to data extracted from the Trust's DATIX system, which showed 2,581 incidents reported in the same period, 11 of which resulted in death and none that resulted in severe harm. The NPSA report to 30 September 2012 showed that returns had been submitted in three of the six months from April to September 2012. Further we noted in our walkthrough a death which occurred on 26/09/2012 that had not been uploaded onto NPSA. Whilst we were satisfied that incidents are being reported and acted upon internally, this suggests a fundamental flaw in the way the national reporting arrangements are being handled by the Trust. However, proportionately, the percentage of incidents which resulted in severe harm and death reported nationally remains aligned with Trust internal data, being 0.3% from NPSA data to September 2012, against 0.28% calculated from full year internal Trust data.	As this indicator is reported as a percentage, the data reported in the Quality Report is not materially inconsistent with reperformance of the calculation from underlying trust data. Therefore we do not consider there to be an impact on the Quality Report as a result of this issue. Similarly, if this was a mandated indicator, it is unlikely to have affected our limited assurance opinion in this respect.
2.	We tested a sample of 25 incidents from the population taken from across the year, and which represented each classification of incident type to ensure that the rationale for the classification was reasonable, as follows: four deaths, three low harm incidents, one no harm incident and 12 moderate harm incidents. In our sample testing we noted one incident which had been inappropriately classified as moderate harm when the resulting harm actually appeared to be low. We considered the 'moderate harm' group to represent the highest area of risk for potential misstatement, which is why our sample focused mostly in this category. However, we found that in this case the level of harm had been overstated, and we were	There is a risk of misstatement of the indicator if an inappropriate classification is selected. However, we have concluded from our testing that there is no impact on the results reported in the quality report, and similarly would not affect the opinion in our limited assurance report had it been reported upon.

	satisfied that there are appropriate governance and approval procedures in place to review each incident.
Conclusion:	
Our substantive testing of the indicator identified two issues.	

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

Annual Governance Statement

In their *Detailed Guidance for External Assurance on Quality Reports 2012/13* Monitor requires FTs to include a brief description of the key controls in place to prepare and publish a Quality Report as part of the Annual Governance Statement in the 2012/13 published accounts.

The Annual Governance Statement, within the Trust's 2012/13 Annual Report, includes the following statement specific to the Quality Report:

ANNUAL QUALITY REPORTING

Governance and Leadership

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual**.**

The Trust Priorities for quality improvement (safety, experience and effectiveness indicators) for 2012/13 have been monitored monthly by the Trust Board throughout the year. The Quality Accounts Priorities and other quality measures are included in the Trust's Performance Report. :

The Quality Priorities and Quality Measures were agreed in consultation with clinical staff, service users, and partner organisations. These measures cover inpatient and community mental health and learning disabilities and community health services across our business streams (below) and are aligned to the domains of patient safety, patient experience and clinical effectiveness:

- Later Life and Memory Services
- Adult Services
- Children & young people's services
- Forensic services
- Learning disability services
- Targeted, acute and rehab services
- Community Children's and Localities services

Performance with the Quality Priorities and Quality measures for 2012/13 and the agreed priorities and measures for 2013/14 are published in the Trust Quality Report.

Data Quality Policies

The Trust has an approved Data Quality strategy and policy. These documents provide guidance for staff. The documents were jointly developed and agreed by the Trust's Leadership Forum. The Trust produces monthly reports at Executive, management, and operational level to enable the continued improvement of data quality.

These reports highlight any areas for improvement and provide recommended actions to achieve this.

Further guidance is available to staff regarding the collection, storage, reporting, and disposal of data, with detailed operating procedures for staff use. All policies are stored on the Trust's intranet system and are available to all staff members, with a limited number of hard copies available to each clinical area. All policies are monitored; annual reports on care records, audit of care records, and information governance, are presented to a Trust Board Sub-Committee annually.

Systems and Processes

A range of systems and processes are in place for the collection, recording and analysis of reporting of data and the Trust employs a member of staff to work with clinical staff to assist with understanding/ training and improving data quality. Staff roles and responsibilities with regard to data quality are made clear in policies/ process notes and workbooks. There is a programme of data quality training in place.

People and Skills

The implementation of these measures and the specific training provided to staff ensures that the skills for the effective collection, recording and analysis of data are present for relevant staff; and for the managers driving the data quality improvement plan. Data quality is incorporated into relevant job descriptions throughout the Trust.

Internal Control of Data Quality

- All information systems and processes will have routines developed and designed to systematically identify errors and other aspects of poor data quality.
- Data quality reports will be generated regularly and considered by the appropriate monitoring body which will make recommendations regarding the improvement of data quality.
- Data quality reports will be routinely fed back to operational managers with advice as to corrective action to be taken such as improving processes and systems and staff training and development.

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

- Review whether the Annual Governance Statement reflects compliance with Monitor's guidance; and
- Report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements.

The work we undertook on the Annual Governance Statement as part of our work on the financial statements identified no issues relevant to the Quality Report.

Appendices

Matters arising from our limited assurance review of the Trust's 2012/13 Quality Report: Content review

	Observation	Recommendation
	Review of the content requirements	
1.	We noted a number of non-compliance issues or omissions in the Trust's initial draft Quality Report against the detailed guidance as follows: a) The Chief Executive's statement was very brief and did not adequately summarise the trust's view of the quality of its services during 2013/13 in a balanced manner; b) Priorites for 2012/13 were expected to be presented in Part 2 of the report, but had been included in Part 3; c) A number of sections were not presented in the sequence prescribed by the detailed guidance; d) No data sources were provided for the indicators being reported; e) No rationale was provided for a revised selection of priority indicators from the prior year; f) From 2012/13 all trusts were required to report against a core set of indicators, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012. Whilst most of the relevant indicators had been reported in some form elsewhere in the Quality Report, a specific section using the mandated wording prescribed by Monitor along with national comparative data from the Health and Social Care Information Centre was not included.	Ensure the requirements of the FT ARM and other reporting guidance are reviewed and incorporated into the Quality Report. Where the exact wordings of sentences and/or paragraphs are mandated, ensure that these are appropriately highlighted within the document to avoid inadvertent modification.

	Observation	Recommendation
	This feedback was reported to the Trust and the Quality Report has been updated accordingly in line with guidance requirements. Therefore there was no impact upon our conclusion.	
	Review of the consistency of the report with specified source documents	
1.	Proactive and cooperative approach taken by key personnel to ensuring consistency challenges were responded to promptly.	No recommendations noted.

Matters arising from our limited assurance review of the Trust's 2012/13 Quality Report: Performance indicators

	Observation	Recommendation
	100% enhanced CPA patients receiving follow-up contact within seven days of discharge from hospital	
1.	We tested a sample of 20 CPA patient discharges to verify that follow-up had occurred within 7 days. From our sample testing we noted a number of data discrepancies between the weekly ward returns and the supporting patient notes as follows: • We identified one error in relation to the inclusion of a patient who was assessed as non-CPA at the date of discharge. This patient had been assessed as CPA at the time of admission but this was revised prior to the patient being discharged. • We also noted three cases where an incorrect date of follow up had been recorded on the ward returns used to report on this indicator (against the follow up date recorded on the patient notes). However, this did not impact on the indicator result, as each of the follow ups had been completed within 7 days. • Additionally, we found one case where the follow-up date recorded on the ward return was the same as the day of discharge and did not appear to have been checked by the Performance Team as a potential error. On further investigation it was noted that the patient had in fact been discharged from the Trust on an earlier date and thus the follow up was valid; however returns should be checked to ensure that valid follow ups have taken place.	Whilst none of the specific issues raised from our sample testing are considered to have materially affected the overall performance indicator result, there is a risk that the indicator could be misstated if incorrect data is included in the returns prepared by the wards. Care should be taken to ensure that data is complete and accurate. The Trust may wish to consider implementing an independent review process to spot-check the accuracy of returns to underlying patient records. The criteria stipulates that: • The seven day period … should start on the day **after** discharge, therefore a control check could be applied within the returns spreadsheets to flag up any instances where there is an anomaly between the date of discharge and date of follow-up to ensure that this is checked for validity.
2.	The Trust routinely applies a number of additional exemption criteria to the indicator to also exclude: • patients that are transferred from the Trust to an Acute Hospital but who then return to the Trust within 72 hours; • patients that have been discharged from Marlowe, Chesterton and	Care should be taken to ensure that exclusions are appropriately applied in line with national guidance. There is a risk that routine exemptions based on ward may incorrectly exclude patients from the indicator calculation, if the patient is not discharged to the expected destination.

	Observation	Recommendation
	Tennyson wards (as these patients are typically discharged to other psychiatric care); and • patients who are discharged to Nursing Homes with 24 hour care facilities with a mental health professional on site.	Actual discharge destinations should be recorded on ward returns to ensure that valid exemptions have been made on a case by case basis.
	Minimising delayed transfers of care	
3.	The outturn figure for this indicator originally reported in the draft 2012/13 quality report (5.7%) had been calculated using data compiled on a weekly basis throughout the year. However, we found from our testing that there were delays in the input of patient discharge dates in the PAS. These were not always taken into account and actual discharges were not appropriately excluded from the numerator. The process for collating delayed discharge information from wards and departments is manually intensive, and therefore is at risk of producing incomplete and/or inaccurate data. The delayed transfers of care figures are also reported as part of the mandatory monthly SITREP return to the Department of Health. The Trust has a separate monthly reporting routine for uploading this data to Unify, which we found to be more consistent with Monitor's guidance for the calculation of this indicator, and more accurately reflected adjustments made using the actual discharge date for calculation of the numerator. We used the SITREP figures as the basis for recalculating the final outturn of the indicator as 5.2%. Through detailed sample testing of the SITREP return back to patient records we identified one instance where a patient had been discharged, but who had not been excluded from the indicator calculation. We adjusted the numerator and confirmed with the trust that the final outturn for this indicator is 5.1%; this is the result now included in the 2012/13 quality report.	The internal monitoring and reporting system for the management of delayed discharges should be reviewed to ensure it meets regulatory guidance and reporting requirements. Discharges should be input onto the PAS promptly to ensure that delayed transfers of care are not inaccurately reported. Monthly returns should be checked to ensure that no discharges have been missed so that the SITREP reflects accurate trust data.

	Observation	Recommendation
	Percentage of patient safety incidents resulting in severe harm or death	
4.	As part of our testing we validated the data uploaded to the NPSA as part of mandatory patient incident reporting. (Only the first six months of the 2012/13 period is available from the NPSA for comparison purposes.) Between 1 April 2012 and 30 September 2012, 968 incidents were reported to NPSA of which three resulted in death, and none were classified as severe harm. We compared these figures to data extracted from the trust's DATIX system, which showed 2,581 incidents reported in the same period, 11 of which resulted in death and none that resulted in severe harm. The NPSA report to 30 September 2012 showed that returns had been submitted in 3 of the 6 months from April to September 2012. Further we noted in our walkthrough a death which occurred on 26/09/2012 that had not been uploaded onto NPSA. Whilst we were satisfied that incidents are being reported and acted upon internally, this suggests a fundamental flaw in the way the national reporting arrangements are being handled at the Trust.	Incident reports should be submitted to the NPSA at least monthly. The trust should review its reporting arrangements to ensure that complete and accurate data is uploaded on a monthly basis.
5.	We tested a sample of 25 incidents from the population taken from across the year, and which represented each classification of incident type to ensure that the rationale for the classification was reasonable, as follows: four deaths, three low harm incidents, one no harm incident and 12 moderate harm incidents. In our sample testing we noted in one instance an incident which had been inappropriately classified as moderate harm when the resulting harm actually appeared to be low.	Whilst Trust procedures do include a management review and approval of reported incidents, care should be taken to appropriately categorise each incident in line with guidance, and according to the actual level of resulting harm.

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