# NHS Quality Accounts

**Auditor guidance 2014-15**

# Contents

# Introduction

**1** For 2014-15, there is no significant change in the arrangements for producing quality accounts. NHS England, NHS Trust Development Agency (TDA) and Monitor wrote to all trust chief executives in March 2015 to confirm this.

**2** DH recommend that NHS acute and mental health trusts gain external audit assurance on their quality accounts.

**3** DH has confirmed that, for trusts that achieved foundation status between April 2014 and March 2015, there is no requirement to produce a 'part-year' quality account. These new foundation trusts (FTs) will produce one quality account covering the whole year and will gain external assurance on their quality report in line with Monitor's requirements.

**4** This document sets out guidance for auditors providing external assurance on the 2014-15 quality account at NHS trusts.

# Background

## Requirements for NHS trusts

**5** The Health Act 2009 and associated Regulations require all providers of NHS healthcare services in England to publish a quality account each year about the quality of NHS services they deliver.

**6** From 2011-12, DH introduced a requirement for external assurance on the quality accounts for acute and mental health NHS trusts in the Quality Accounts 2011-12 Audit Guidance. It has been agreed that ambulance and community trusts that have yet to achieve FT status will not be required to seek external assurance on their quality accounts in 2014-15

**7** In 2014-15, trusts will produce a quality account following the requirements set out in the Regulations made by the Secretary of State for Health. The Regulations remain unchanged for 2014-15.

**8** The 'Dear Colleague' letter of 9 January 2014 requests that the staff and patient element of the FFT be included in the quality account for acute trusts. Auditors should note the staff element of the FFT is already included*. In the list of mandatory information set out in the *National Health Service (Quality Accounts) Amendment Regulations 2012* this becomes item 21 in the part 2 list in Appendix 1 of this guidance. As such, acute NHS trusts should have reported on this information in 2013-14.

*The patient element of the FFT is not mandated for inclusion for Foundation Trusts Quality Reports as the requirement is not supported by legislation

**9** Auditors should also be aware that this item was removed from the list of requirements in Annex 2 of the 'Dear Colleague' letter and replaced with a reworded indicator based on the FFT survey question. This change does not affect the data to be reported in the quality account as the same information answers both indicators.

**10** As in previous years the DH's Quality Accounts Toolkit 2010-11 will not be updated and is still applicable for 2014-15.

## Summary approach for auditors

### Scope

**11** In 2014-15 auditors will issue a limited assurance report on whether anything has come to their attention that leads them to believe that:

- the quality account has not been prepared in line with the requirements set out in the Regulations;
- the quality account is not consistent with specified documentation detailed in section 3 of this guidance; and
- one or both performance indicators are misstated.

**12** Guidance for auditors on the review approach is set out in sections 3 and 4 of this document.

**13** The review approach is fundamentally unchanged from 2013-14, Changes that were made to the 2012/13 guidance:

- reflect the request from NHS England, the TDA and Monitor for NHS acute trusts to report on the staff and patient* elements of the FFT;
- give auditors greater flexibility in selecting which two indicators to review, by updating the list of indicators that the Audit Commission believed are suitable for substantive testing;
- removed suggested sample sizes for substantive testing, to allow auditors to exercise professional judgement in determining sample sizes for the systems that they are reviewing;
- improved indicator definitions that provide greater clarity in the calculation of the indicator and relevant exclusions.

* not mandated for Foundation Trusts

### Timing

**14** Auditors should aim to complete their work on NHS trusts' quality accounts in time to allow NHS trusts to upload their quality account onto the NHS Choices website by the DH deadline, 30 June. This publication also satisfies the requirement to submit their quality account to the Secretary of State for Health.

**15** Auditors should agree locally with their NHS trusts the detailed timetable for this work,

including when the NHS trust will provide a copy of the draft quality account for review.

**Work performed by another practitioner or an internal auditor**

**16** Auditors should draw on other work where possible, for example relevant internal audit work and the work of other experts, when undertaking their work on the quality account. These sources may support the auditor's review of compliance with Regulations and detailed testing of performance indicators.

**17** Auditors should seek to place reliance on any relevant work by internal audit or other experts where this is an efficient means of gaining the required assurance.

**18** NHS trusts going through Monitor's FT assessment may have evidence that auditors could use to inform work on the quality account.

**19** Although ISAE 3000 (Revised) – *Assurance Engagements Other Than Audits or Reviews of Historical Financial Information*, December 2013, only applies to reports issued on or after 15 December 2015, it provides useful guidance to the use of work by another practitioner, internal auditor or expert."

The following extracts are relevant to the auditor's work on the quality account (paragraphs 53 to 55):

> ***53. When the work of another practitioner or an internal auditor is to be used, the practitioner shall be satisfied that work is adequate for the practitioner's purposes.***
>
> ***54. If information to be used as evidence has been prepared using the work of a responsible party's or a measurer's or evaluator's expert, the practitioner shall, to the extent necessary having regard to the significance of that expert's work for the practitioner's purposes:***
>
> > ***(a) Evaluate the competence, capabilities and objectivity of that expert;***
> > ***(b) Obtain an understanding of the work of that expert; and***
> > ***(c) Evaluate the appropriateness of that expert's work as evidence.***
>
> ***55. If the practitioner plans to use the work of the internal audit function, the practitioner shall evaluate the following:***
>
> > ***(a) The extent to which the internal audit function's organizational status and relevant policies and procedures support the objectivity of the internal auditors;***
> > ***(b) The level of competence of the internal audit function;***
> > ***(c) Whether the internal audit function applies a systematic and disciplined approach, including quality control; and***
> > ***(d) Whether the work of the internal audit function is adequate for the purposes of the engagement.***

**Audit fee**

**20** The recommended audit fee for this work is £10,000 plus VAT based on prior knowledge of fees charged. DH recommends using your existing auditor for this piece for the auditing of Quality Accounts. Where it is felt necessary additional work is required, the fee for this must be negotiated locally.

It is a matter for the auditor to plan the detailed work necessary for the external assurance exercise, based on the guidance set out in this document.

# Limited Assurance Report

## Purpose

**21** Auditors are required to produce a limited assurance report over the NHS trust's quality account. It will cover:

- compliance with the Regulations;
- consistency with specified documentation; and
- two indicators in the quality account.

**22** Appendix 2 provides standard wording for the limited assurance report. Auditors should use this wording for standard reports and amend where necessary for non-standard reports. Where non-standard wording has been used Monitor already asks FT audit firms to notify Monitor of non-standard opinions. Auditors must notify QualityAccounts@dh.gsi.gov.uk providing the non-standard wording that has been used and the reason why it was felt necessary.

**23** The Report of the Mid Staffordshire NHS Foundation Trust public inquiry raises a number of concerns and recommendations about the importance of raising awareness of issues and timely reporting in the NHS. When carrying out their work reviewing quality accounts, where auditors become aware of significant risks, such as evidence of manipulation of performance information, they should report this to QualityAccounts@dh.gsi.gov.uk as well as reporting to the trust.

## Compliance with Regulations

**24** For this work, DH defines 'the Regulations' as those set out in:

- The National Health Service (Quality Accounts) Regulations 2010;
- The National Health Service (Quality Accounts) Amendment Regulations 2011; and
- The National Health Service (Quality Accounts) Amendment Regulations 2012.

**25** The *DH Quality Accounts 2011-12 Audit Guidance* requires trusts to sign a statement of directors' responsibilities and to include the auditors' assurance report within the quality accounts.

**26** To help auditors with this part of their work, DH has provided a checklist of the requirements set out in the Regulations at Appendix 1.

**27** The *DH Quality Accounts toolkit 2010-11* provides support to trusts but there is no requirement for trusts to follow this: Auditors are not required to report on whether bodies have followed this guidance.

## Consistency with specified documentation

**28** The auditor should review the quality account to ensure it is not materially inconsistent with:

- board minutes for the financial year and up to the date of signing the limited assurance

report (the period);

- papers relating to quality reported to the Board over the period;
- feedback from commissioners;
- feedback from Local Healthwatch organisations;
- the NHS trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholder(s) involved in the sign off of the quality account;
- the latest national and local patient survey;
- the latest national and local staff survey;
- the Head of Internal Audit's annual opinion over the NHS trust's control environment;
- the annual governance statement (AGS);
- the Care Quality Commission's quality and risk profiles;
- results of the Payment by Results coding review; and
- other documents, if any are considered relevant, in the auditors' professional judgement, to the quality account.

## Specified indicators

**29** The quality indicators that trusts should include in the 2014-15 quality accounts were detailed in the 'Dear Colleague' letter issued on 4 March 2015, Gateway Reference 03123.

The majority of these are required by the Regulations, although the letter additionally asked trusts to include the staff and patient* (*the patient element is not a mandated field of reporting for Foundation Trusts) elements of the FFT; the staff element being a duplication of one of the indicators specified by the Regulations.

**30** These indicators are often difficult to test substantively because they are processed or presented by third parties. Auditors of acute and mental health NHS trusts should test two indicators relevant to their audited body from the list provided in Table 1. These are indicators which are considered suitable for substantive testing at most NHS acute or mental health trusts. Auditors should carefully consider, when agreeing which indicators to audit, the nature of the trust's activities and whether there are any issues which would prevent the auditor from reviewing the indicator in accordance with the approach set out in this guidance.

**31** For both acute and mental health NHS trusts, the following indicators required by the Regulations are currently considered suitable for substantive testing for each type of trust:

- Acute NHS trusts: the FFT patient element score is an indicator that is suitable for audit
- Mental health NHS trusts: The delayed transfers of care indicator remains a priority area for mental health NHS trusts. This indicator may only be selected for testing if included in the mental health NHS trust's quality account.

**Table 1: 2014-15 indicators**

| Acute NHS trusts |
|---|
| Two of the following four indicators, for auditors to agree with the NHS trust's management team:<br>▪ Percentage of patients risk-assessed for venous thromboembolism (VTE);<br>▪ Rate of clostridium difficile infections;<br>▪ Percentage of patient safety incidents resulting in severe harm or death;<br>▪ and FFT patient element score. |
| **Mental health NHS trusts** |
| Two of the following four indicators, for auditors to agree with the NHS trust's management team:<br>▪ Percentage of patients on Care Programme Approach (CPA) followed up within seven days of discharge;<br>▪ Percentage of admissions to acute wards gate kept by the Crisis Resolution Home Treatment Team (CRHT);<br>▪ Percentage of patient safety incidents resulting in severe harm or death; and<br>▪ Number of delayed transfers of care. |

*Source: Audit Commission*

**32** Definitions for the indicators are provided in Appendix 5. These come from a variety of sources including the indicator portal maintained by NHS Health and Social Care Information Centre.

**33** NHS trusts are required to publish the data reported by the HSCIC for each indicator for the reporting period, i.e. the 2014-15 financial year. For some indicators, no data or only partial year data is available for 2014-15 the latest data set should be published for last two reporting periods or data covering the minimum of a year.

**34** NHS trusts must provide a narrative commentary in their quality account alongside the reported indicator. Auditors are required review the commentary to ensure that its content is not inconsistent with the auditor's knowledge of the NHS trust.

## Testing strategy

### Approach

**35** To help achieve consistency between auditors' work on the quality account indicators, the following testing strategy has been specified. The testing strategy requires auditors to:

- confirm the definition and guidance used by the NHS trust to calculate the indicator;
- document and walk through the NHS trust's systems used to produce the indicator; and
- undertake substantive testing on the underlying data against six specified data quality dimensions.

### Confirm definition and guidance used to calculate the indicator

**36** Auditors should confirm the definition and guidance used by the NHS trust to calculate its indicator. Auditors may wish to refer to the definitions in Appendix 5 and to any supplementary guidance produced by the NHS trust.

### Understanding the system

**37** Auditors should gain an understanding of the system used to collect and process the data underlying the indicator. Documentation should include the controls used by the NHS trust to ensure:

- data quality; and
- that it calculates the indicator according to the appropriate national definition and any supplementary local guidance.

**38** Auditors should refresh their understanding and documentation of systems where revisiting an indicator tested in previous years. Issues identified during this process should be considered when determining detailed substantive testing.

### Substantive testing of underlying data

**39** Substantive testing will help inform the auditor's views on data quality, whether the NHS trust has used relevant and reliable data to underpin the quality indicators and has calculated the indicators according to the appropriate definition and guidance.

**40** Auditors will need to design substantive tests for the indicators they select for testing, ensuring the tests cover the six specified data quality dimensions set out in Appendix 4. Auditors should test the indicators to prime documentation, for example to underlying records.

**41** Auditors should follow the substantive testing strategy set out at Appendix 3. The strategy sets out the basic tests auditors are expected to complete to enable them to report on whether the NHS trust has calculated the indicators in line with the definition and guidance.

**42** Appendix 4 sets out the six data quality dimensions and provides example tests for each

dimension for each of the indicators included in Table 1. However, the tests are not intended to be an exhaustive list. Auditors may need to add to the tests according to local circumstances and risks. This is a matter for local auditor judgement.

**Sample sizes**

**43** When undertaking substantive testing, auditors should use an appropriate sample size. Auditors should select the cases for testing themselves. Where the total population size is small, auditors may consider it appropriate to test 100 per cent of the population. The total population will vary depending on the indicator selected.

**44** It may be necessary for auditors to increase sample sizes according to risk and local circumstances, for example where an NHS trust operates across multiple locations or uses multiple systems. Auditors will need to use their professional judgement when deciding whether it is appropriate to increase sample sizes, and by how much they should be increased to reach a meaningful conclusion.

**Evaluating errors**

**45** Where auditors identify errors through their substantive testing, they need to understand how the error has occurred, for example does the error relate to a particular site or an individual member of staff. This is necessary to determine the scale of the error in the remaining population. Auditors may need to undertake additional work if the cause of the error is not clear from their initial testing.

**46** Auditors should base decisions on the extent and focus of any additional testing on the nature of, and the risks attached to, the errors identified.

**47** When reaching a conclusion to inform their opinion, auditors may wish to consider:

- reasons for the error;
- what the error tells them about the reported indicator and the NHS trust's data quality arrangements;
- whether it is a systematic or an isolated error; and
- whether there are any patterns in the errors.

**48** Auditors should discuss with management whether amendments are required to ensure the quality account reflects any significant issues identified, for example to disclose systematic weaknesses in calculating an indicator.

## Directors' statement disclosures

**49** The *DH Quality Accounts 2011-12 Audit Guidance* requires NHS trusts to sign a statement of directors' responsibilities in respect of the content of their quality account. NHS trusts are required to include this statement within the 2014-15 quality account.

**50** The statement includes assertions that there are proper internal controls over the collection

and reporting of indicators, and that the data underpinning the indicators is robust and reliable. The auditor should consider the implications for their limited assurance report if internal control and data quality issues reported in the Annual Governance Statement (AGS) are not reflected in the statement of responsibilities.

### Data protection requirements

**51** As part of their work on the performance indicators, auditors may need to collect, record or transfer personal data about individuals' patient records. This data falls under the jurisdiction of the Data Protection Act 1998, which means that auditors must:

- only collect what they need for their testing;
- not record or retain personal data in a form that is identifiable to the individual;
- protect the contents;
- only keep it for as long as is necessary;
- only use it for the purpose it was collected; and
- destroy it when no longer needed.

**52** Due to some high-profile cases of lost USB memory sticks and laptops in the UK, the Cabinet Office has issued instructions across government departments, including DH. These increase the minimum standards for handling sensitive and personal information.

## Auditor Reporting

**53** In 2014-15, auditors will give a formal limited assurance opinion on;

- the compliance of the NHS trust's quality accounts with the Regulations;
- the consistency of the NHS trust's quality account with the specified documentation; and
- two indicators included in the NHS trust's quality account (see section 3).

**54** The NHS trust will need to include this signed assurance report in their final quality account. DH requires that NHS trusts submit their final quality account to the Secretary of State by uploading it to the NHS Choices website by 30 June each year.

**55** Auditors should raise any significant findings from either part of the review as they arise with management. This will allow the NHS trust to address any issues before it produces its final quality account. Auditors must plan their work to allow sufficient time for NHS trusts to respond to auditor findings before the 30 June deadline.

**56** Standard wording for the limited assurance report, including a section for a non-standard report, is provided at Appendix 2

## Links to VFM conclusion and opinion work

## Reference Material

- National Health Service (Quality Accounts) Regulations 2010
- National Health Service (Quality Accounts) Amendment Regulations 2011
- National Health Service (Quality Accounts) Amendment Regulations 2012
- NHS Outcomes Framework 2014 to 2015
- DH Quality Accounts 2011-12 Audit Guidance
- Technical Guidance for the 2011-12 Operating Framework
- DH Quality Accounts Toolkit 2010-11

# Appendix 1: Quality account compliance checklist

This checklist may help auditors consider whether a trust has compiled its quality account in accordance with relevant DH requirements.

The checklist is based on requirements of the National Health Service (Quality Accounts) Regulations 2010 as amended. More detailed guidance is also given in the DH's Quality Accounts Toolkit 2010-11. However this does not reflect amendments made to the Regulations in 2012.

## Requirements of National Health Service (Quality Accounts) Regulations 2010 as amended

| Regulations | Requirement |
|---|---|
| **Regulation 1 – Citation, commencement and interpretation** | no audit requirement |
| **Regulation 2 – Exemptions**<br>The quality account regulations do not apply to primary care and continuing healthcare providers | no audit requirement |
| **Regulation 3 – Exemption for small providers**<br>The quality account regulations do not apply to providers with fewer than 50 employees and whose total income for the provision of relevant health services is lower than £130,000. | no audit requirement |
| **Regulation 4 – Prescribed information, content and form of document**<br>The Quality Account must include the following sections:<br><br>Part 1 – a written statement summarising the trust's view of the quality of relevant healthcare services it has provided.<br><br>Part 2 – the mandatory information set out in the schedule attached to the regulations (covers priorities for improvement and statements relating to the quality of relevant healthcare services provided).<br>(See detailed list below)<br><br>Part 3 – information chosen by the provider to demonstrate the quality of relevant healthcare services it has provided.<br><br>An annex containing the statements or copies of the statements referred to in Regulation 5. | |
| **Regulation 5 – written statements by other bodies**<br><br>The quality account must include any written statements from the following external bodies about their view of the provider's quality account:<br>▪ the appropriate Local Healthwatch organisation; and<br>▪ the appropriate Overview and Scrutiny Committee (OSC) about their view of the trust's quality account. | |

| Regulations | Requirement |
|---|---|
| The quality account must also include an explanation of any changes made to the final quality account after receipt of these statements. | |
| **Regulation 6 – signature by senior employee**<br><br>A senior employee (usually the Chief Executive) of the provider must sign Part 1 of the quality account stating that to the best of that person's knowledge, the information in the document is accurate. | |
| **Regulation 7 – priorities for improvement**<br><br>The quality account includes a section confirming the trust has identified key areas for improvement and has in place plans to monitor and report on progress. The section must include:<br><br>▪ at least three priorities for improvement indicating the relationship, if any, between the identification of these priorities and reviews of data quality referred to in item 1.1 of Part 2 of the report (see list below)<br>▪ progress made since the last quality account (if one has been published before);<br>▪ how progress to achieve these priorities will be monitored and measured by the provider; and<br>▪ how progress to achieve these priorities will be reported.<br>▪ the NHS England or relevant CCG;<br>▪ the appropriate Local Healthwatch organisation; and<br>▪ the appropriate OSC.<br>▪ | |
| **Regulations 8 to 10 – documentation assurance by NHS England, relevant CCG, appropriate Local Healthwatch organisation and OSC**<br><br>The provider must send a copy of its quality account to the following organisations by 30 April 2013 for their comments:<br><br>▪ the NHS England or relevant CCG;<br>▪ the appropriate Local Healthwatch organisation; and<br>▪ the appropriate OSC.<br><br>A statement from each, if offered, must be presented in the quality account (see Regulation 4). | |
| **Regulation 11 – publication and provision of copies**<br><br>The trust must make arrangements for uploading its quality account to the NHS Choices website and sending a copy to the Secretary of State by 30 2015. | |

| Regulations | Requirement |
|---|---|
| **Regulation 12 – guidance**<br><br>The trust must have a mechanism to identify any guidance issued by the Secretary of State which relates to chapter 2 of the Health Act 2009, and act upon it appropriately. | |

**i** Where 50 per cent or more of the relevant health services that he trust provides are provided under agreements with the NHS England , the trust should send its quality account to NHS England (England.qualityaccounts@nhs.net), otherwise to the relevant CCG.

**Auditor's overall conclusion**

Have all requirements of the quality accounts regulations been complied with? (Yes / No)

## List of mandatory information to be provided in Part 2 of the quality account

| Prescribed Information | Included (Yes/ No) |
|---|---|
| 1. The number of different types of relevant health services provided or sub-contracted by the provider during the reporting period, as determined in accordance with the categorisation of services—<br>a) specified under the contracts, agreements or arrangements under which those services are provided; or<br>b) In the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider. | |
| 1.1 The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to them on the quality of care provided during the reporting period. | |
| 1.2 The percentage of the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or sub-contracting of, NHS services. | |
| 2. The number of national clinical audits and national confidential enquiries which collected data during the reporting period and which covered the relevant health services that the provider provides or sub-contracts. | |
| 2.1 The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period. | |
| 2.2 A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in. | |
| 2.3 list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in. | |

| Prescribed Information | Included (Yes/ No) |
|---|---|
| 2.4 A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed for during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry. | |
| 2.5 The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period. | |
| 2.6 A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5. | |
| 2.7 The number of local clinical audit reports that were reviewed by the provider during the reporting period. | |
| 2.8 A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7. | |
| 3. The number of patients receiving relevant health services provided or sub-contracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service. | |
| 4. Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of NHS services. | |
| 4.1 If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework the reason for this. | |
| 4.2 If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework, where further details of the agreed goals for the reporting period and the following 12 month period can be obtained. | |
| 5. Whether or not the provider is required to register with the Care Quality Commission ("CQC") under section 10 of the Health and Social Care Act 2008. | |
| 5.1 If the provider is required to register with the CQC<br><br>(a) whether at end of the reporting period the provider is<br><br>(i) registered with the CQC with no conditions attached to registration, (ii) registered with the CQC with conditions attached to registration, or (iii) not registered with the CQC; | |

| Prescribed Information | Included (Yes/ No) |
|---|---|
| (b) if the provider's registration with the CQC is subject to conditions what those conditions are; and<br><br>(c) whether the Care Quality Commission has taken enforcement action against the provider during the reporting period. | |
| Note that 6 and 6.1 were deleted by the 2011 Regulations | |
| 7. Whether or not the provider has taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during the reporting period. | |
| 7.1 If the provider has participated in a special review or investigation by the CQC<br><br>(a) the subject matter of any review or investigation,<br><br>(b) the conclusions or requirements reported by the CQC following any review or investigation,<br><br>(c) the action the provider intends to take to address the conclusions or requirements reported by the CQC, and<br><br>(d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period. | |
| 8. Whether or not during the reporting period the provider submitted records to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest version of those Statistics published prior to publication of the relevant document by the provider. | |
| 8.1 If the provider submitted records to the Secondary Uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data:<br><br>a) the percentage of records relating to admitted patient care which include the patient's<br>(i) valid NHS number; and<br>(ii) General Medical Practice Code;<br><br>(b) the percentage of records relating to outpatient care which included the patient's<br>(i) valid NHS number; and<br>(ii) General Medical Practice Code;<br>(c) the percentage of records relating to accident and emergency care which included the patient's<br>(i) valid NHS number; and<br>(ii) General Medical Practice Code. | |
| 9. The provider's Information Governance Assessment Report overall score for the reporting period, as a percentage and as a colour according to the IGT Grading scheme. | |

| Prescribed Information | Included (Yes/ No) |
|---|---|
| 10. This item has been removed for 2014/15 | |
| 11. The action taken by the provider to improve data quality. | |
| 12. The data made available to the trust by the Information Centre with regard to<br><br>(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and<br>(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | |
| 13. The data made available to the trust by the Information Centre with regard to<br><br>(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and<br>(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | |
| 14. The data made available to the trust by the Information Centre with regard to the percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period. | |
| 14.1 The data made available to the trust by the Information Centre with regard to the percentage of Category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period. | |
| 15. The data made available to the trust by the Information Centre with regard to the percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period. | |
| 16. The data made available to the trust by the Information Centre with regard to the percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period. | |
| 17. The data made available to the trust by the Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period. | |
| 18. The data made available to the trust by the Information Centre with regard to the trust's patient reported outcome measures scores for<br>(i) groin hernia surgery, (ii) varicose vein surgery,<br>(iii) hip replacement surgery, and<br>(iv) knee replacement surgery, during the reporting period. | |

| Prescribed Information | Included (Yes/ No) |
|---|---|
| 19. The data made available to the trust by the Information Centre with regard to the percentage of patients aged<br><br>(i) 0 to 14; and<br>(ii) 15 or over,<br><br>readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. | |
| 20. The data made available to the trust by the Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period. | |
| 21. The data made available to the trust by the Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. | |
| 22. The data made available to the trust by the Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period. | |
| 23. The data made available to the trust by the Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. | |
| 24. The data made available to the trust by the Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period. | |
| 25. The data made available to the trust by the Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. | |
| 26. Where the necessary data is made available to the trust by the Information Centre, a comparison of the numbers, percentages, values, scores or rates of the trust (as applicable) in items 12 to 25 with<br><br>(a) the national average for the same; and<br>(b) with those trusts with the highest and lowest of the same, for the reporting period. | |

*Source: Schedule One to the National Health Service (Quality Accounts) Regulations 2010 as amended.*

# Appendix 2: Form of limited assurance report

**INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF [NAME OF TRUST] ON THE ANNUAL QUALITY ACCOUNT**

We are required to perform an independent assurance engagement in respect of [NAME OF TRUST]'s Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

**Scope and subject matter**

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- [first indicator selected from Table 1 of the guidance, include page number or reference if necessary]
- [second indicator selected from Table 1 of the guidance, include page number or reference if necessary]

We refer to these two indicators collectively as "the indicators".

**Respective responsibilities of Directors and auditors**

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH on insert date ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated XX/XX/20XX;
- feedback from Local Healthwatch dated XX/XX/20XX;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated XX/XX/20XX;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated XX/XX/20XX;
- the latest national staff survey dated XX/XX/20XX;
- the Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX;
- the annual governance statement dated XX/XX/20XX;
- the Care Quality Commission's quality and risk profiles dated XX/XX/20XX;
- the results of the Payment by Results coding review dated XX/XX/20XX; and
- [any other relevant information included in our review.]

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

This report, including the conclusion, is made solely to the Board of Directors of [NAME OF TRUST].

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and [NAME OF TRUST] for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- [analytical procedures];
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

**Limitations**

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by [NAME OF TRUST].

**[Conclusion]**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.]

**[Basis for qualified conclusion]**

[Insert description of the matter that prevents the auditor giving an unqualified conclusion. If the qualification relates to the calculation of one or both indicators subject to the limited assurance review, include the details
as to which of the six dimensions of data quality has led to the qualification.]

**Qualified conclusion**

Based on the results of our procedures, with the exception of the matter(s) reported 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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.]

*[Audit Firm]*
*[Address]*
*[[Date]*

# Appendix 3: Generic testing strategy

The following testing strategy sets out the basic tests expected of auditors to undertake as part of their work on indicators. The tests are not exhaustive and should not replace the auditor's own judgement in undertaking sufficient appropriate work to obtain the level of evidence required to issue their limited assurance report. As such, auditors may need to add to or otherwise adapt the tests according to local risks and circumstance.

## 1. Confirm definition and guidance

Confirm the definition and guidance followed by the NHS trust to calculate the indicator selected for testing.

Confirm that the definition and guidance used are appropriate.

## 2. Document and walkthrough the system

Gain an understanding of the system used to collect and process the data underlying the indicator.

Document the key controls used to ensure data quality and that the indicator is calculated in accordance with the appropriate definition and guidance. Consider the impact of any issues identified on the testing strategy.

## 3. Check calculations

Refer to the indicator definition and guidance and confirm correct numerator and denominator have been used.

Check the figure back to systems reports or compilation documents and re-perform the calculation. Compare outturn to previous year and confirm reasons for any significant differences. Note that comparison may be difficult if the definition used for the indicator has changed.

## 4. Test numerator and denominator

Check supporting figures and totals back to source, for example through system audit trails, system reports or control totals.

Where intermediate calculations or adjustments have been performed to arrive at the required figure, check the arithmetic and review for reasonableness and accordance with the indicator definition and guidance.

Check a sample of items in total back to prime documentation and ensure the data is:

- complete for the whole reporting period;
- complete and relevant for all methods of collection (for example where data is collected from different sites); and
- recorded accurately, timely and in accordance with the required definition and guidance;
- and valid and relevant, for example the correct data has been included or excluded.

## 5. Review indicator and commentary

Read the commentary provided by the NHS trust in the quality account relating to the indicator.

Compare the commentary with the information reported in the indicator, and the specified documentation, to ensure that the commentary is not inconsistent with these other data sources.

# Appendix 4: Six data quality dimensions

The tables below set out the six data quality dimensions and provides example tests for each dimension for each of the indicators that DH has identified as being suitable for substantive testing. However, the tests are not intended to be an exhaustive list. Auditors may need to add to the tests according to local circumstances and risks; this is a matter for local auditor judgement.

**Table 2: Six data quality dimensions – acute NHS trusts**

| Data quality dimension | Description | Example tests (based on the VTW risk-assessment indicator) | Example tests (based on the C.Diff indicator) | Example tests (based on patient safety indicator) | Example tests (based on the FFT patient element indicator) |
|---|---|---|---|---|---|
| Accuracy | Is the data sufficiently accurate for the intended purposes? | Recalculate indicator and confirm correct numerator and denominator have been used. | Recalculate indicator and confirm correct data source has been used. | Recalculate indicator and confirm correct numerator and denominator have been used. | Recalculate indicator and confirm correct data source has been used. |
| Validity | Is the data recorded and used in compliance with relevant requirements? | Agree details of a sample of risk-assessments to admission records and source documents. Agree the number of inpatient admissions to source documents. | Agree details of a sample of positive and negative test results to patient records. Check that any exclusions from the | Agree details of a sample of reported incidents to source records. Check that incident severity has been classified in line with the | Agree details of a sample of completed patient surveys to the survey form. |

| Data quality dimension | Description | Example tests (based on the VTW risk-assessment indicator) | Example tests (based on the C.Diff indicator) | Example tests (based on patient safety indicator) | Example tests (based on the FFT patient element indicator) |
|---|---|---|---|---|---|
| | | | indicator are in line with the indicator guidance. | indicator guidance. | |
| Reliability | Does the data reflect stable and consistent collection processes across collection points and over time? | Confirm that there have been no significant changes to the system for collecting and processing the data underlying the indicator in year. Where significant changes raise additional risks, auditors may wish to revisit the initial testing strategy. Check that manual adjustments to the indicator data have been approved by an appropriate senior person. | underpinning the indicator is updated from patient risk-assessment forms and admissions data regularly. | Confirm that there have been no significant changes to the system for collecting and processing the data underlying the indicator in year. Where significant changes raise additional risks, auditors may wish to revisit the initial testing strategy. Check that manual adjustments to the indicator data have been approved by an appropriate senior person. | underpinning the indicator is updated from patient notes regularly. |
| Timeliness | Is the data up-to- date and has it been captured as quickly as possible after the event or activity? | Check whether the system used to record the data underpinning the indicator is updated from patient risk-assessment forms and | Check whether the system used to record the data underpinning the indicator is updated from patient notes regularly. | Check whether the system used to record the data underpinning the indicator is updated in a timely manner following a patient | Check whether the system for issuing surveys to patients does so prior to or within 48 hours of discharge as required |

| Data quality dimension | Description | Example tests (based on the VTW risk-assessment indicator) | Example tests (based on the C.Diff indicator) | Example tests (based on patient safety indicator) | Example tests (based on the FFT patient element indicator) |
|---|---|---|---|---|---|
| | | admissions data regularly. | | safety incident. | by the specification of the indicator. |
| Relevance | Is the data captured applicable to the purposes for which it is used? | Reconcile records of all adult inpatient admissions in the year to the number of risk-assessments used in the indicator. | Reconcile records of all tests for C.Diff in the year to number of positives used in indicator. | Reconcile records of all patient safety incidents in the year to the number classified as resulting in severe harm or death used in indicator. | Confirm that the standard wording and responses for the questions have been used in the survey. |
| Completeness | Is all the relevant data included | Check a sample of admissions excluded from the indicator to confirm the exclusion is consistent with the NHS trusts local policy. | Reconcile records of all tests for C. Diff in the year to number of positives used in indicator.<br>Check a sample of items excluded from the indicator to confirm the exclusion is valid. | Check a sample of patient safety incidents excluded from the indicator to confirm the exclusion is valid. | Check that any wards not submitting data for inclusion do not contain accident and emergency or acute beds. |

*Source: Audit Commission*

**Table 3: Six data quality dimensions – mental health NHS trusts**

| Data quality dimension | Description | Example tests (based on CPA follow-up indicator) | Example tests (based on CRHT gatekeeping indicator) | Example tests (based on patient safety indicator) | Example tests (based on delayed transfers of care indicator) |
|---|---|---|---|---|---|
| Accuracy | Is the data sufficiently accurate for the intended purposes? | Recalculate indicator and confirm correct numerator and denominator have been used. | Recalculate indicator and confirm correct data source has been used. | Recalculate indicator and confirm correct numerator and denominator have been used. | Recalculate indicator and confirm correct numerator and denominator have been used. |
| Validity | Is the data recorded and used in compliance with relevant requirements? | Agree details of a sample of follow ups to patient records. Check that any exclusions from the indicator are in line with the indicator guidance. | Agree details of a sample of inpatient admissions to patient records. Check that cases identified as having been gate kept have been recorded correctly | Agree details of a sample of reported incidents to source records. Check that incident severity has been classified in line with indicator guidance. | Agree details of a sample of delayed transfers to patient records. Agree the calculation of occupied beds to source records. |
| Reliability | Does the data reflect stable and consistent collection processes across collection points and over time? | Confirm that there have been no significant changes to the system for collecting and processing the data underlying the indicator in year. Where significant | underpinning the indicator is updated from patient risk-assessment forms and admissions data regularly. | Confirm that there have been no significant changes to the system for collecting and processing the data underlying the indicator in year. Where significant | underpinning the indicator is updated for new admissions on a timely basis. |

| Data quality dimension | Description | Example tests (based on CPA follow-up indicator) | Example tests (based on CRHT gatekeeping indicator) | Example tests (based on patient safety indicator) | Example tests (based on delayed transfers of care indicator) |
|---|---|---|---|---|---|
| | | changes raise additional risks, auditors may wish to revisit the initial testing strategy. Check that manual adjustments to the indicator data have been approved by an appropriate senior person. | | changes raise additional risks, auditors may wish to revisit the initial testing strategy. Check that manual adjustments to the indicator data have been approved by an appropriate senior person | |
| Timeliness | Is the data up-to- date and has it been captured as quickly as possible after the event or activity? | Check whether the system used to record the data underpinning the indicator is updated for new admissions on a timely basis. | Check whether the system used to record the data underpinning the indicator is updated for new admissions on a timely basis. | Check whether the system used to record the data underpinning the indicator is updated in a timely manner following a patient safety incident | Check whether the data underpinning the indicator is updated from patient notes and ward records. |
| Relevance | Is the data captured applicable to the purposes for which it is used? | Reconcile records of all CPA patient discharges to the number of follow ups used in the indicator. | Reconcile records of all admissions to the number identified as having been gate kept used in the indicator. | Reconcile records of all patient safety incidents in the year to the number classified as resulting in severe harm or death used in the indicator. | Verify that the guidance issued to staff reporting delayed transfers is consistent with the indicator definition used by the NHS Trust. |

| Data quality dimension | Description | Example tests (based on CPA follow-up indicator) | Example tests (based on CRHT gatekeeping indicator) | Example tests (based on patient safety indicator) | Example tests (based on delayed transfers of care indicator) |
|---|---|---|---|---|---|
| Completeness | Is all the relevant data included | Check a sample of CPA patient discharged excluded from the indicator to confirm the exclusion is valid | Check a sample of admissions excluded from the indicator to confirm the exclusion is valid. | Check a sample of patient safety incidents excluded from the indicator to confirm the exclusion is valid. | Check that any wards not submitting data for inclusion do not contain acute, non-acute or mental health beds. |

*Source: Audit Commission*

# Appendix 5: Definitions for individual indicators

DH requires auditors to test two indicators from the list below. At acute NHS trusts, auditors should test the FFT patient element indicator if the trust has included this in their quality account.

**NHS trusts providing relevant acute services**

- Percentage of patients risk-assessed for VTE
- Rate of clostridium difficile infections
- Percentage of patient safety incidents resulting in severe harm or death
- FFT patient element score

**NHS trusts providing relevant mental health services**

- Percentage of patients on CPA followed up within seven days of discharge
- Percentage of admissions gate kept by the CRHT
- Percentage of patient safety incidents resulting in severe harm or death

The tables that follow set out the agreed definitions for each of these indicators with links to sources of more information. Auditors will need to familiarise themselves with the chosen indicators in order to inform their chosen testing strategy.

For indicators taken from the Outcome Framework, DH has mandated specific definitions based on the reporting undertaken by the Information Centre. For the non-mandated indicators available to mental health NHS trust auditors, DH has not mandated specific definitions for quality account reporting in 2014-15. Therefore, it is for these NHS trusts to select the appropriate definition and guidance for the indicators it reports on in its quality account. NHS trusts may choose to include a detailed definition of the indicators in the quality account.

As noted in paragraph 43 auditors will need to confirm the precise definition being used by the NHS trust before commencing any detailed testing. Auditors should consider the implications for their limited assurance opinion if they are unable to agree a precise definition for an indicator which has been included in the quality account.

**This section has not been updated for 2014/15.*

**Percentage of patients on CPA followed up within seven days or discharge**

## Detailed descriptor

The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

## Data definition

- Numerator: The number of people under adult mental illness specialties on CPA who were followed up (either by face to face contact or by phone discussion) within seven days of discharge from psychiatric in-patient care during the reporting period.
- Denominator: The total number of people under adult mental illness specialties on CPA who were discharged from psychiatric in-patient care. All patients discharged from a psychiatric in-patient wards are regarded as being on CPA during the reporting period.

## Details of the indicator

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. The seven day period should be measured in days not hours and should start on the day after the discharge.

Exemptions include patients who are readmitted within seven days of discharge; patients who die within seven days of discharge; patients where legal precedence has forced the removal of the patient from the country; and patients transferred to an NHS psychiatric inpatient ward.

All CAMHS (child and adolescent mental health services) patients are also excluded.

## Timeframe

Data produced quarterly for the 2014-15 financial year.

## Detailed guidance

More detail about this indicator and the data can be found within the Mental Health Community Teams Activity section of the NHS England website.

*Source: NHS England*

**Percentage of admissions gate kept by the CRHT**

## Detailed descriptor

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team, (CRHT) acted as a gatekeeper during the reporting period.

## Data definition

- Numerator: The number of admissions to the trust's acute wards that were gate kept by the CRHT during the reporting period.
- Denominator: The total number of admissions to the trust's acute wards.

## Details of the indicator

An admission has been gate kept by a crisis resolution team if it has assessed the service user before admission and was involved in the decision making-process which resulted in an admission. An assessment should be recorded if there is direct contact between a member of the CRHT team and the referred patient, irrespective of the setting, and an assessment is made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient.

Exemptions include patients recalled on Community Treatment Order; patients transferred from another NHS hospital for psychiatric treatment; internal transfers of service users between wards in the trust for psychiatry treatment; patients on leave under Section 17 of the Mental Health Act; and planned admissions for psychiatric care from specialist units such as eating disorder units.

Partial exemption for admissions from out of the trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local area. Crisis resolution team should assure themselves that gatekeeping was carried out. This can be recorded as gate kept by crisis resolution teams.

## Timeframe

Data produced quarterly for the 2014-15 financial year.

## Detailed guidance

More detail about this indicator and the data can be found within the Mental Health Community Teams Activity section of the NHS England website.

*Source: NHS England*

**Percentage of patients risk-assessed for venous thromboembolism (VTE)**

## Detailed descriptor

The percentage of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period.

## Data definition

- Numerator: Number of adults admitted to hospital as inpatients in the reporting who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool during the reporting period.
- Denominator: Total number of adults admitted to hospital in the reporting period.

## Details of the indicator

The scope of the indicator includes all adults (those aged 18 at the time of admission) who are admitted to hospital as inpatients including:

- surgical inpatients;
- in-patients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease); trauma inpatients;
- patients admitted to intensive care units;
- cancer inpatients;
- people undergoing long-term rehabilitation in hospital;
- patients admitted to a hospital bed for day-case medical or surgical procedures; and
- private patients attending an NHS hospital.

The following patients are excluded from the indicator:

- people under the age of 18 at the time of admission;
- people attending hospital as outpatients;
- people attending emergency departments who are not admitted to hospital; and
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

## Timeframe

Data produced monthly for the 2014-15 financial year.

## Detailed guidance

More detail about this indicator can be found on the NHS England website. The data collection standard specification can be found here.

*Source: NHS England*

**Rate of clostridium difficile infections**

## Detailed descriptor

Rate of *Clostridium difficile* infections ("CDIs") per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period.

## Data definition

- Numerator: The number of CDIs identified within a trust during the reporting period.
- Denominator: The number of bed days (divided by 100,000) reported by a trust during the reporting period.

## Details of the indicator

The scope of the indicator includes all cases where the patient shows clinical symptoms of clostridium difficile infection, and has a positive laboratory test result for CDI recognised as a case according to the trust's diagnostic algorithm. A CDI episode lasts for 28 days, with day one being the date the first positive specimen was collected. A second positive result for the same patient, if collected more than 28 days after the first positive specimen, should be reported as a separate case, irrespective of the number of specimens taken in the intervening period, or where they were taken. Specimens taken from deceased patients are to be included.

The following cases are excluded from the indicator:

- people under the age of two at the date the sample of taken; and
- where the sample was taken before the fourth day of an admission to the trust (where the day of admission is day one).

## Timeframe

Thirteen month data on the number of CDI cases per trust is produced on a monthly basis. Annual reporting on the number and rates of CDI cases per trust for the financial year.

## Detailed guidance

More detail about CDIs can be found on the Public Health England website.

The latest published 13 month data for CDI cases for each trust and the latest published annual data for the number and rate of CDI cases can be found here.

*Source: Public Health England*

**Percentage of reported patient safety incidents resulting in severe harm or death**

## Detailed descriptor

Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period.

## Data definition

- Numerator: Number of reported patient safety incidents resulting in severe harm or death at a trust reported through the National Reporting and Learning Service (NRLS) during the reporting period.
- Denominator: Number of reported patient safety incidents at a trust reported through the NRLS during the reporting period.

## Details of the indicator

The scope of the indicator includes all patient safety incidents reported through the NRLS. This includes reports made by the trust, staff, patients and the public. From April 2010 it became mandatory for trusts in England to report all serious patient safety incidents to the Care Quality Commission. Trusts do this by reporting incidents on the NRLS.

A case of severe harm is defined in Seven steps to patient safety: a full reference guide, published by the National Patient Safety Agency in 2004, as "(a)ny patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care." "Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage."

This indicator does not capture any information about incidents that remain unreported. Incidents with a degree of harm of 'severe' and 'death' are now a mandatory reporting requirement by CQC, via the NRLS, but the indicator's quality statement states that underreporting is still likely to occur.

## Timeframe

Six-monthly data produced for April to September and October to March of each financial year.

## Detailed guidance

More detail about this indicator and the data can be found on the Patient Safety section of the NHS England website and on the HSCIC website in NHS Outcomes Framework > Domain 5 – Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm > Overarching indicators > 5b Severity of harm.

*Source: NHS England*

**FTE patient element score**

## Detailed descriptor

The friends and family test (patient element) score for the reporting period.

## Data definition

At acute trusts, all inpatients and patients discharged from A&E should be asked to complete the friends and family survey. For the standard question, “How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?” One of six standard responses can be selected:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don’t know

The indicator score is calculated as the proportion of respondents who would be extremely likely to recommend (response category: “extremely likely”) minus the proportion of respondents who would not recommend (response categories: “neither likely nor unlikely”, “unlikely” and “extremely unlikely”) during the reporting period.

## Details of the indicator

All inpatients and patients discharged from A&E should be asked to complete the survey on the day or within 48 hours of discharge, with the exception of patients under 16 years of age and maternity service users.
While “likely” responses are not included in the indicator’s calculation, they can significantly impact the score as they reduce the number of responses in the “extremely likely to recommend” or the “would not recommend” elements of the calculation.

## Timeframe

Data produced monthly for the 2015-16 financial year.

## Changes

Its inclusion in the quality account is not mandated by Regulation, but NHS England, the TDA and Monitor have requested that acute NHS trusts include it in their quality account.

More detail about this indicator and the data can be found on the NHS England website.

*Source: NHS England*