360 ASSURANCE

CQC Internal Assurance Processes: Benchmarking

2013 Refresh

Executive Summary

Information and Background

In the summer of 2011, 360 Assurance (formerly emias) undertook a benchmarking exercise across 18 NHS providers in the East Midlands, examining trusts' internal assurance mechanisms in relation to compliance with the CQC Essential Standards. The report was published in September 2011.

Subsequently a Quality Assurance Forum was established. This provides an opportunity for the Quality/ Assurance/ Compliance leads from each of the NHS provider trusts across the East Midlands and South Yorkshire to meet and discuss their experiences and share best practice. This forum, held bi-monthly since February 2012, is considered invaluable for networking and information sharing.

At a recent meeting of the forum we re-ran the CQC benchmarking survey conducted in 2011 (supplementing it with some additional questions), in order to understand better the progress and changes that had been made within provider trusts over the 2 years. 13 NHS provider organisations completed the re-run survey and this report identifies their responses as well as comparing these to the results obtained in 2011.

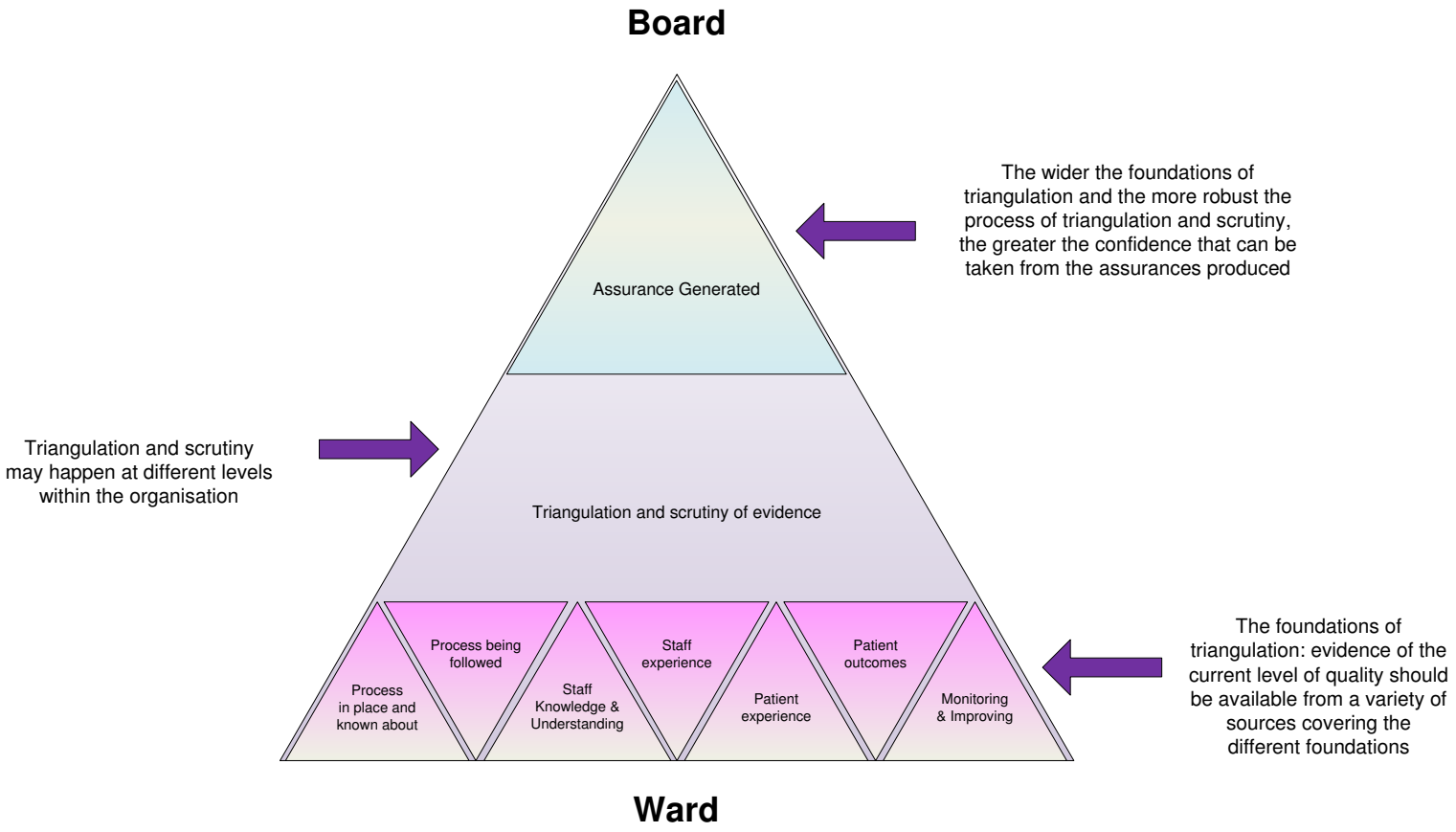
In 2011 we identified that the internal assurance processes around CQC compliance had evolved organically within organisations and were not the result of a conscious design process. Most trusts at the time were about to embark on a redesign of their mechanisms in response to their initial CQC inspections and the learning they had undergone.

The CQC are in the process of changing their inspection methodology, currently undertaking the pilot round of inspections using the new approach.

Robust overall quality monitoring and assurance mechanisms which are developed with the aim of continually improving the quality of services and care will provide the most reliable method of achieving ongoing CQC compliance and allow for the most reliable ongoing assessment of risks to CQC compliance. Therefore, the theoretical process of internal assessment and assurance in relation to CQC compliance will not be affected by the change in inspection methodology, even if some of the practicalities will.

With the continuing drive for efficiency in the NHS, trusts will need to ensure that the quality monitoring and assurance is happening in a co-ordinated manner and that silo-ed mechanisms are not developing in order to tick different boxes.

Below is the model propounded by 360 Assurance for monitoring and assuring on quality (and therefore CQC compliance).



Key Findings

Regulated Activities:

- There remains some discrepancies in the regulated activities that similar trusts have registered to provide and further guidance and clarity may be required from the CQC.

Roles and Responsibilities:

- 100% of trusts now identify an Executive Director(s) as the nominated individual. This demonstrates an increased focus on and prioritisation of the CQC regulatory requirements.
- The majority of trusts have decided that all the NEDs need to take responsibility for monitoring and assuring themselves of compliance with CQC requirements. Therefore they have opted not to have a NED lead for CQC to ensure that it is not viewed as being one NED's role.
- Progress has been made with defining the roles and responsibilities of 'CQC leads' but this could be enhanced further through formalisation and by ensuring there is sufficient skill and capacity to robustly triangulate and scrutinise the information relating to compliance.

- Further training and engagement is required (particularly with medics and Governors) on CQC requirements and how compliance will be assessed.

Governance:

- Overarching responsibility for monitoring CQC compliance is now more likely to be retained at a sub-committee of the Board level rather than an Executive Committee level.
- There has been an increase in the % of trusts who reference compliance with CQC requirements on their Board Assurance Framework.
- The frequency of compliance assessment reporting to this committee has increased from quarterly to monthly. These shifts highlight the significance of this agenda and the priority it is given.
- From a range of common components of these assurance reports, respondents identified that they took the least assurance from the CQC produced QRP. The QRP is being replaced by Intelligent Monitoring reports which, it is hoped, will be more up to date.
- When asked what would benefit them most in improving their process for assessing compliance, trusts have shifted from saying 'audit of evidence available' or 'written guidance' to 'greater use of quality monitoring evidence already in existence' and 'enhanced training for those undertaking assessments', demonstrating a shift in understanding towards seeing CQC compliance as a by-product of effective and efficient quality monitoring and quality assurance processes.

Quality Risk Profile:

- There were significant concerns about the usefulness of the Quality Risk Profile (QRP) produced by the CQC. Review of the QRP became an industry in itself within many organisations. The first batch of the QRP's successor document, 'Intelligent Monitoring' reports, has been publicly published by the CQC and at **Appendix A** to this report we have included a summary of the recurrent risks emerging. Organisations will need to consider how they utilise the information provided by the Intelligent Monitoring Report and how they might pre-empt concerns through internal review of the Tier 1 indicators.

Internal Sources of Compliance Evidence:

- 100% of trusts have developed their own internal tool for assessing compliance with CQC requirements.
- 69% of trusts have mapped documents and evidence already being produced across to the Essential Standards.
- Given efficiency requirements, further developments need to consider the quality monitoring and assurance arrangements already in operation across the trust as part of its governance framework and determine how assessment of compliance

with CQC requirements can utilise the work already being undertaken and rectify any gaps or deficiencies, rather than establish a distinct and separate process.
- Trusts identified that the 'foundations of triangulation' they felt they had least evidence of were patient outcomes and staff knowledge and understanding.

Third Party Review:
- Although more trusts are now using their internal audit service to provide them with independent assurance about their compliance with CQC requirements, overall trusts still need to engage more with third parties, such as patient representative groups, to improve their own assessment of compliance.

Provision of Information to Commissioners
- The % of commissioners now requesting information about providers' CQC compliance assessments has risen from 12% to 46%.

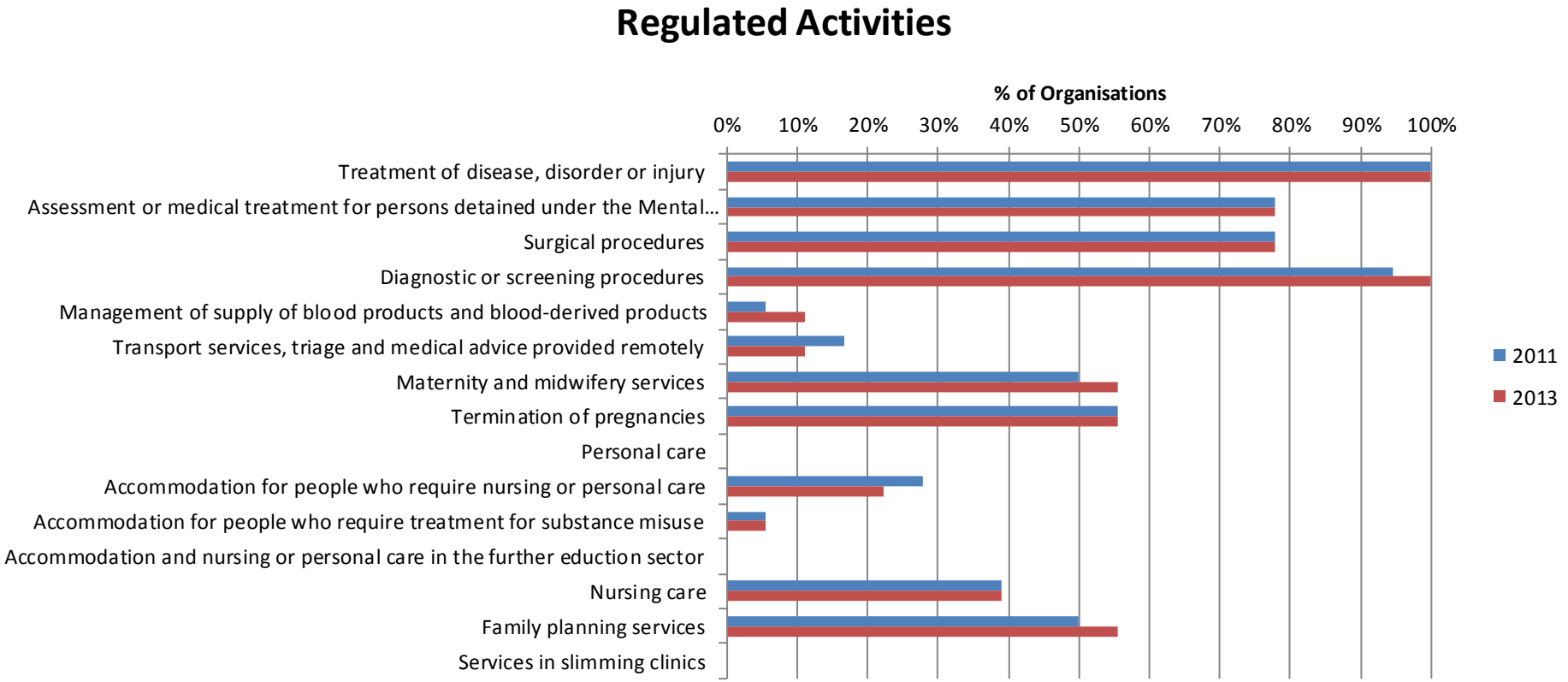
Conclusion & Recommendations

Significant progress has been made by trusts in developing their compliance assessment systems and processes.

As trusts continue to review their methods, particularly in light of the CQC's new inspection regime, they should consider:
- How regular and ongoing assessments of compliance with the CQC requirements can be efficiently and effectively informed by the wider arrangements for quality monitoring and assurance, rather than existing as a separate process;
- The most effective methods for engaging all staff in quality monitoring and assurance arrangements and making them aware of how this relates to CQC compliance;
- How they make efficient use of the Intelligent Monitoring reports produced by the CQC;
- How they can obtain and/or utilise more evidence which is demonstrative of patient outcomes and staff knowledge and understanding in their quality monitoring and assurance processes (and therefore their CQC compliance assessments);
- How they incorporate more third party and independent assessments of quality (e.g. patient groups, internal audit) into their triangulation and scrutiny of evidence when forming overall assessments; and
- How they pro-actively share the assessments produced with commissioners and regulators in keeping with the principle of transparency.

1. Regulated Activities

In the 2011 survey we identified some anomalies with the regulated activities trusts had registered to undertake, due to confusion and apparent changes in the guidance issued by the CQC. This led, in our first report, to the recommendation: 'Review the registered activities for which the trust is licensed in light of the available guidance from the CQC'. We examined the current CQC registration details for the same 18 trusts who took part in the 2011 survey to identify any changes:



This still shows some anomalies, such as 2 trusts registered for the 'management and supply of blood products', which was originally designed to apply only to NHS Blood and Transport. Also, trusts offering the same services have determined differently as to whether to register to undertake 'nursing care' or 'accommodation for people who require nursing or personal care' and some trusts responsible for out of hours care have not registered for 'transport, triage and medical advice provided remotely' whilst others have. Only 1 trust with inpatients has not registered for 'assessment and treatment of patients detained under the Mental Health Act'.

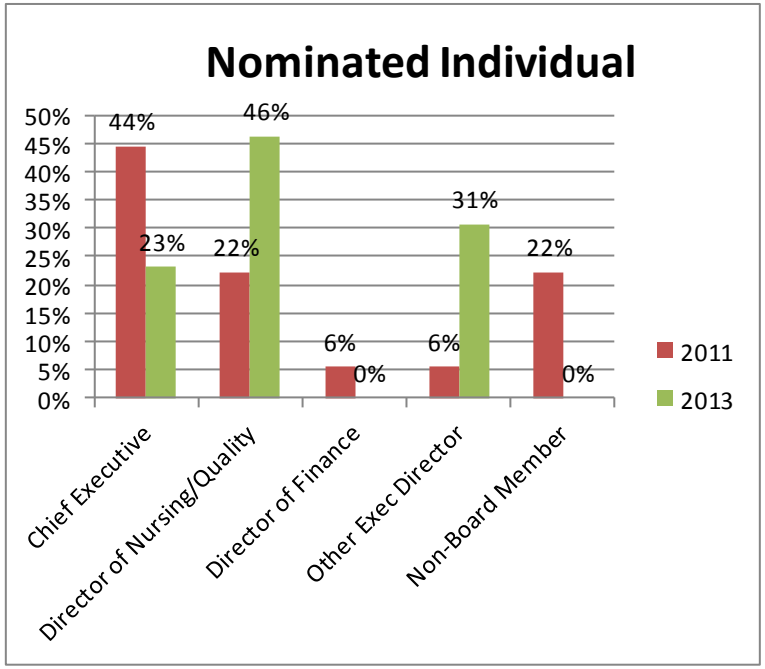
2. Roles and Responsibilities

In 2011, we recommended that trusts "consider whether the most appropriate 'nominated individual' has been identified". The difference between the two years is shown below:

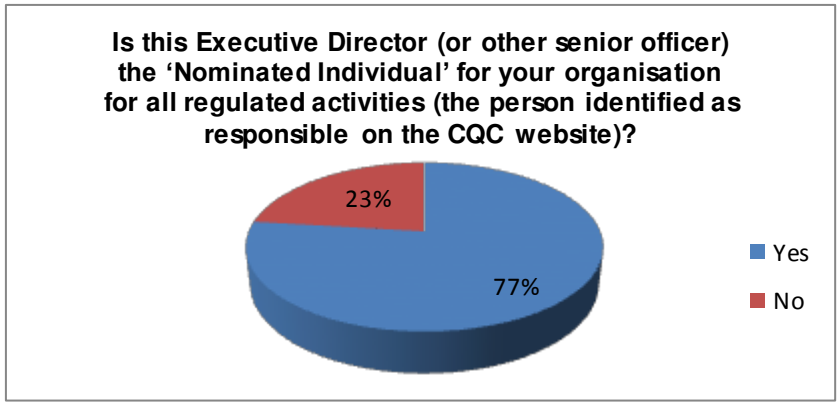
There have been several significant changes to the 'nominated individual' over the course of the two years:

- No trust completing the survey in 2013 had a non-board member as their nominated individual – instead we saw a large increase in the % of 'other exec director' responses.
- Shift away from the 'Chief Executive' – down from 44% to 23%
- Increase in the 'Director of Nursing' as the 'nominated individual', which has risen from 22% to 46%.

The shift towards appointing the Director of Nursing as the nominated individual has the potential for further increasing the emphasis on the role of nursing staff in demonstrating ongoing compliance with the standards. Many trusts report difficulties in engaging medics with ongoing CQC compliance. However, of those trusts providing 'other exec director' as a response, none had identified their medical director as the 'nominated individual'.



We have noticed over the last 2 years that some organisations are identifying different 'Nominated Individuals' for different services, so in the 2013 refresh survey we asked:



In the 2011 report we recommended that organisations should "consider whether formally assigning a Non-Executive Director to lead on CQC assurance will raise the profile and status of the systems and processes within the organisation. Alternatively, if it is considered to be the responsibility of all of the Non-Executive Directors then it should be ensured that this is reflected in the Non-Executive Director job descriptions". Our 2013 survey refresh indicated that the percentage of organisations that have assigned Non-Executive Directors as leads for the ongoing CQC assurance process has increased by 3%.

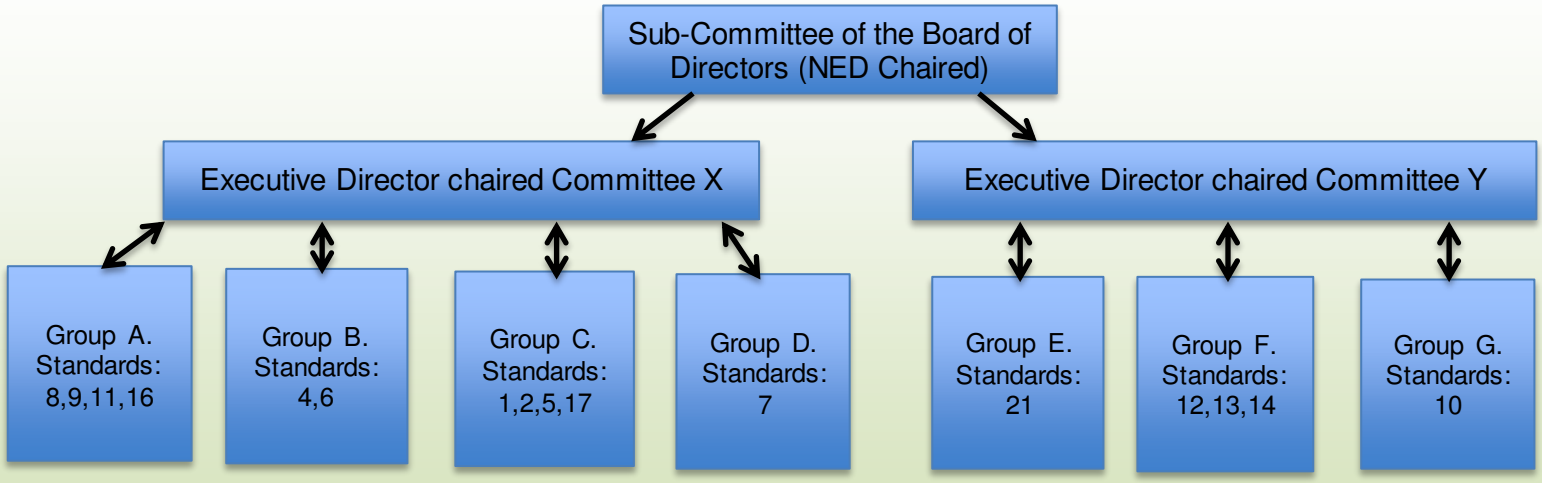
Our survey responses received in both years, however, suggest that the majority of provider organisations have not identified a Non-Executive Director to lead on CQC assurance. In conversation with NHS organisations we further identified that many trusts had considered whether to formally assign a lead Non-Executive Director and had decided that it was such an important area that they did not want to run the risk of it being viewed as one person's responsibility.

The 2013 refresh survey confirmed that 'CQC leads' continue to be identified by: standard; by clinical division/directorate; or by standard *and* division. As an addition to our 2013 survey refresh, we asked whether an Executive Director had been assigned responsibility for each

individual CQC Essential Standard: 77% of responses received indicated that an 'Executive Sponsor' has been identified for each CQC standard.

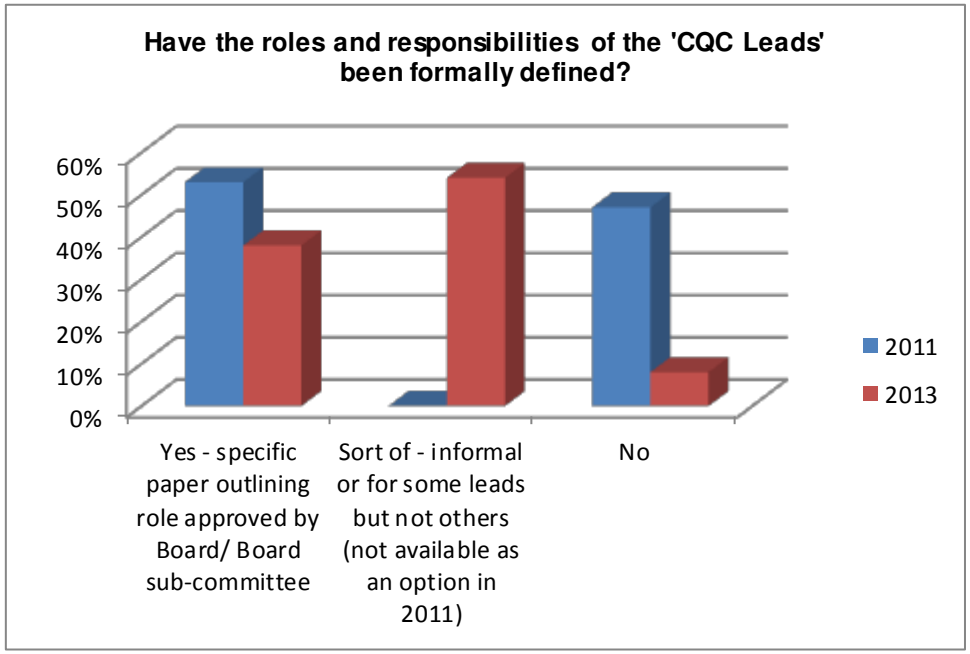
In our 2011 report, we included the following case study as one method for delegating the responsibility for scrutinising the evidence of compliance and providing assurance up through the organisation:

This trust has assigned each CQC standard to a trust group and this is documented within each group's terms of reference and was approved in a paper to the Board of Directors. The chair of each group therefore has overarching responsibility for ensuring compliance and reporting up. The structure of the assurance process is outlined below:



Each of the groups A-G has responsibility for assessing, monitoring and improving compliance with their assigned standards across the trust. This is included in the workplan and forward agendas for the groups. They are held to account by Committees X & Y, who in turn are held to account by the Board level committee with delegated responsibility from the Board of Directors.

This methodology ensures that a broad range of evidence (i.e. all the papers, audit results, visit reports etc that are normally presented to a committee) is scrutinised by several individuals with specialist knowledge before an assessment of compliance (or risks of non-compliance) is made. The majority of trusts still identify individuals to be responsible for assessing compliance with a particular standard across the trust. This presents a risk that they will not have available to them all of the relevant evidence and also that they will not, single-handedly, have the capacity or expertise to apply sufficient scrutiny to the available evidence to form a judgement.



In 2011 only 50% of respondent trusts confirmed that the role of the CQC leads/committees had been formally documented. Formal documentation supports consistent responsibilities across all of the standards/divisions. Therefore, we recommended that roles and responsibilities of the leads be formally documented in job descriptions, work plans or procedural documents.

Following on from our conversations with client trusts, we included in the 2013 survey an option about the documentation of roles and responsibilities of CQC leads that reflected the position of a significant number of trusts – 'informal or partial'. 54% of respondent organisations in 2013 selected this new option. Although the % of 'yes's fell (as some organisations assessed 'informal or partial' as being a more accurate reflection of their position), the % of 'no's fell significantly from 47% to 8%, indicating that progress has been made in this area, although there is still work to be done.

During the 2011 survey, one trust stated that the knowledge and understanding of their clinical staff around the CQC standards was 'poor', whilst three trusts thought the knowledge and understanding of 'other staff' was 'poor'. The knowledge and understanding of all specified staff groups (governors, NEDs, Executive Directors, Operational CQC leads, Clinical staff, other staff) was considered only 'satisfactory' in at least one trust ('clinical staff' in three trusts and 'other staff' in nine trusts). As a result of this we recommended that "a plan for improving knowledge and understanding around the CQC Essential Standards and the assurance mechanisms should be developed, which covers all staff groups".

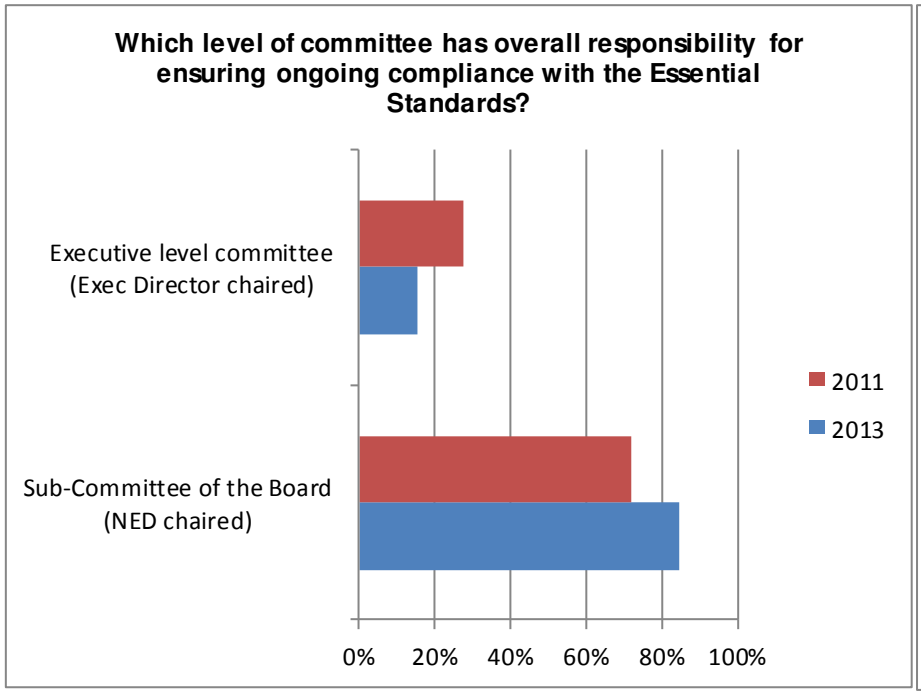
The results of the 2013 survey refresh revealed that Corporate CQC Leads were ranked the highest in terms of their level of knowledge and understanding of what CQC compliance entails, with Operational CQC Leads in second place and Nurses in third place. Medics, Allied Health Professionals (AHPs) and Governors (for FTs only) were identified as having the least amount of knowledge and understanding of what CQC compliance entails.

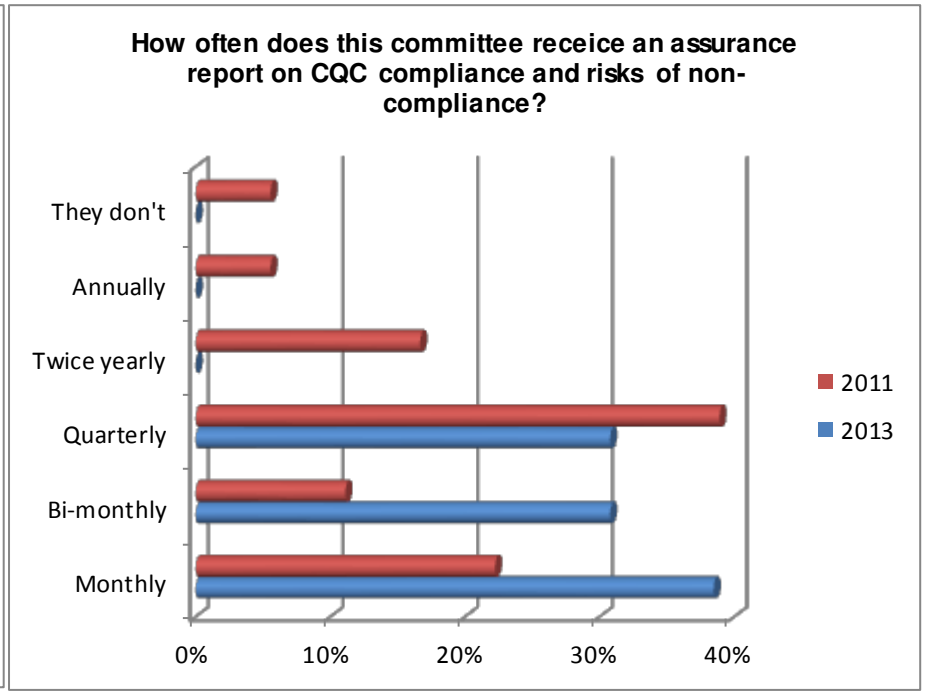
Rank the following groups in terms of their level of knowledge and understanding of what CQC compliance entails (enter highest first)	
Description	**Overall**
Corporate CQC leads (standard leads)	**86**
Operational CQC leads (divisional leads)	**68**
Nurses	**56**
Executive Directors	**54**
Non-Executive Directors	**52**
AHPs	**32**
Medics	**26**
Governors (FTs only)	**14**

3. Governance Structures

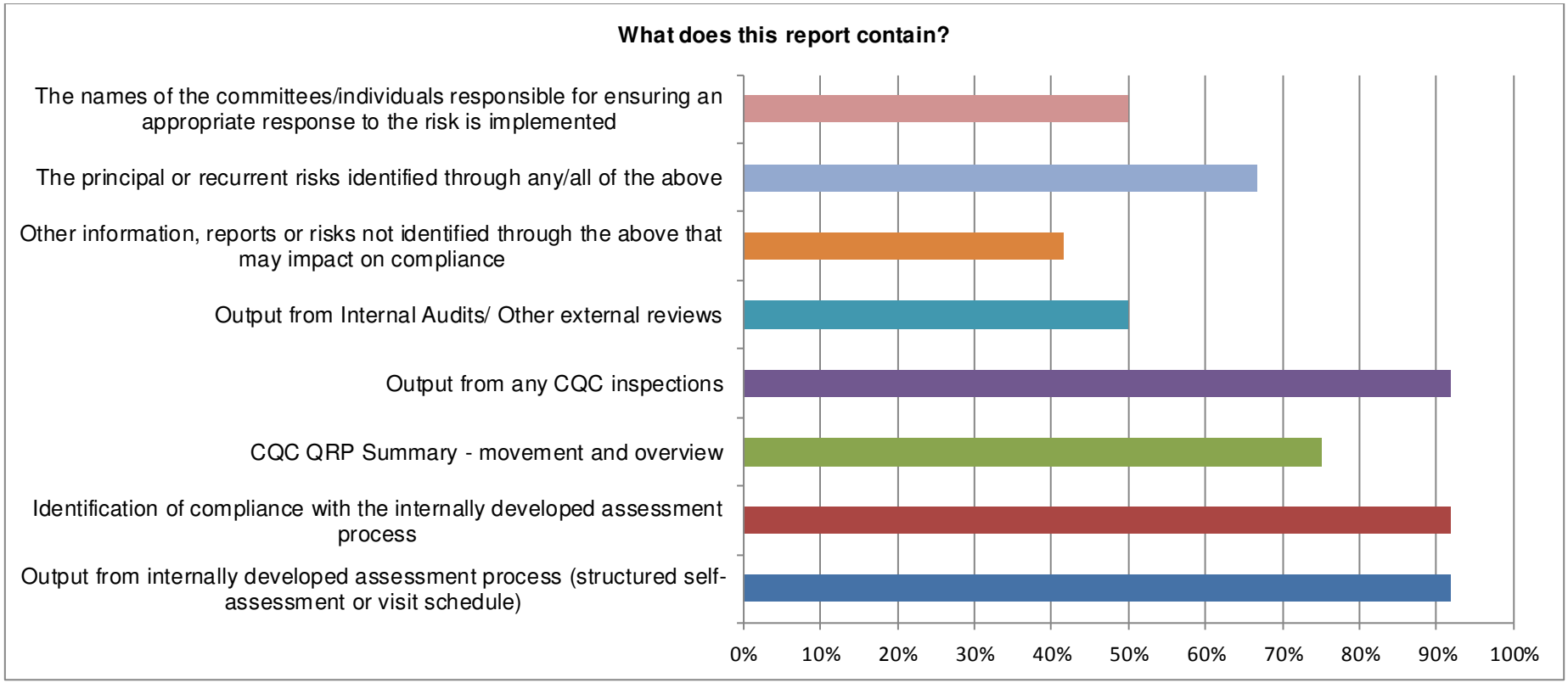
The Board of Directors is ultimately responsible for ensuring that the organisation's registration with the Care Quality Commission is maintained. Organisations therefore need to have structures in place that enable assurance to be provided to the Board that the organisation continues to meet the requirements of registration and any specific conditions placed upon it.

Although the committee with (delegated) overarching responsibility may provide their assurance to the Board purely on a routine annual and by exception basis, the committee with this delegated responsibility should ensure that they are regularly assessing and scrutinising the level of compliance. Our 2013 survey refresh indicates that there has been a small shift in the extent of delegation, from delegation down to Executive level Committees to retaining overarching responsibility at a sub-committee of the Board. The frequency with which the delegated committee receives an assurance report has become more frequent, with a significant increase in bi-monthly and monthly reporting and an elimination of annual and twice-yearly reporting.





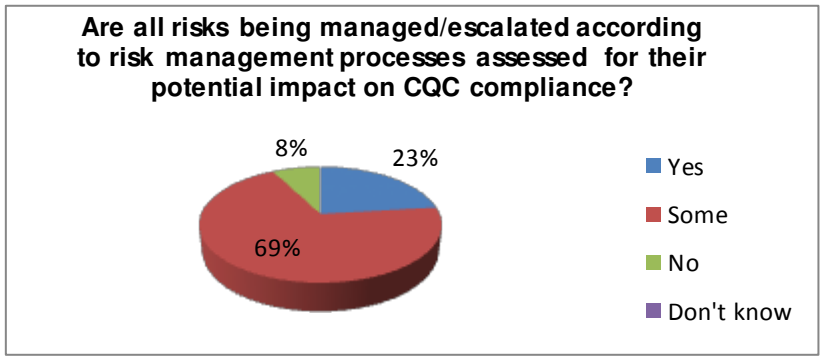
The content of the assurance report submitted to the delegated committee varies but typically includes the output from completed CQC inspections, identification of compliance with the internally developed assessment process and output from the internally developed assessment process.



For the 2013 survey refresh, we asked organisations to:

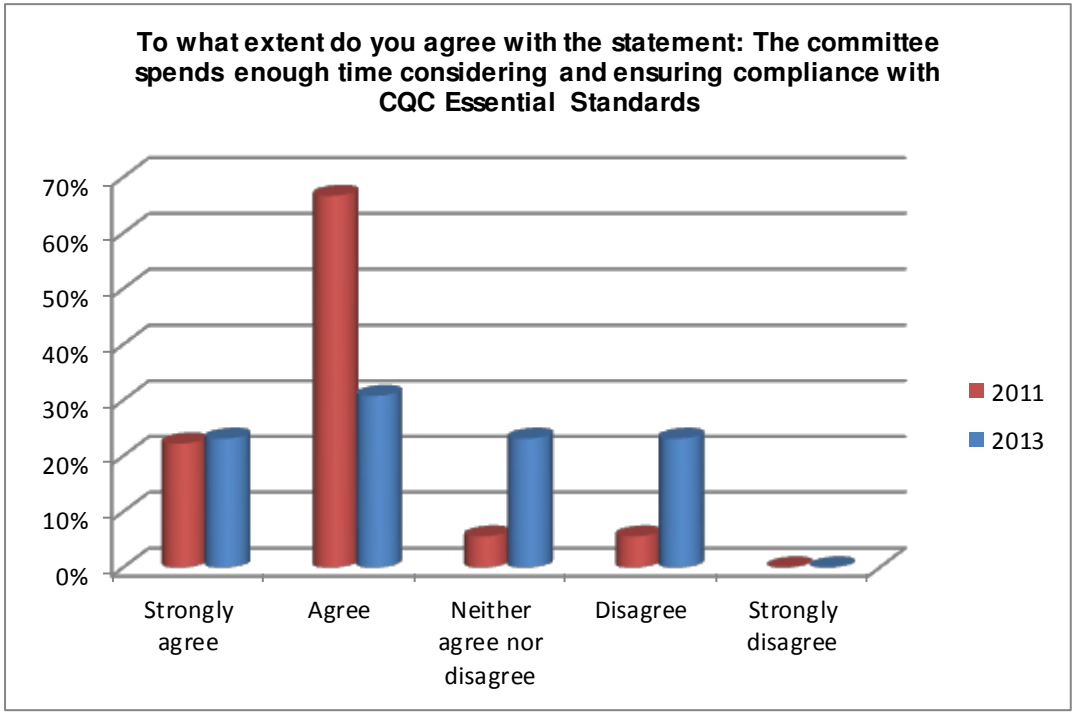
Rank the following in terms of which should be included in the report to the committee to ensure that they are able to take sound assurance about current compliance levels	
Description	**Overall**
Outcome of any CQC inspections	1st
Output from internally developed assessment process	2nd
Information about whether action plans have been developed in response to weaknesses/ risks to compliance identified	3rd
Outcome of an internal audit/ other independent assessments	4th
The main rationale for any assessments identifying weaknesses/risks to compliance	5th
Full description of the assessment process (various components) so that the committee know how the information in their report has been generated	5th
QRP summary	7th

The responses received corroborated the findings in the graph above, indicating that organisations are reporting on those factors they believe their committees will take assurance from. Our survey responses indicate that Quality Risk Profiles (QRPs) and the main rationale for any assessments identifying weaknesses / risks to compliance are not routinely reported to the nominated committee to seek assurance about current compliance levels. Feedback from organisations indicate that there was often a discrepancy between the risks highlighted on the QRP and the actual risks at that point in time, due to the fact that some of the data informing the QRP was out-of-date or limited in its scope. As a result, many organisations do not feel that their committees are able to obtain reliable assurance of potential risks to compliance using this tool.



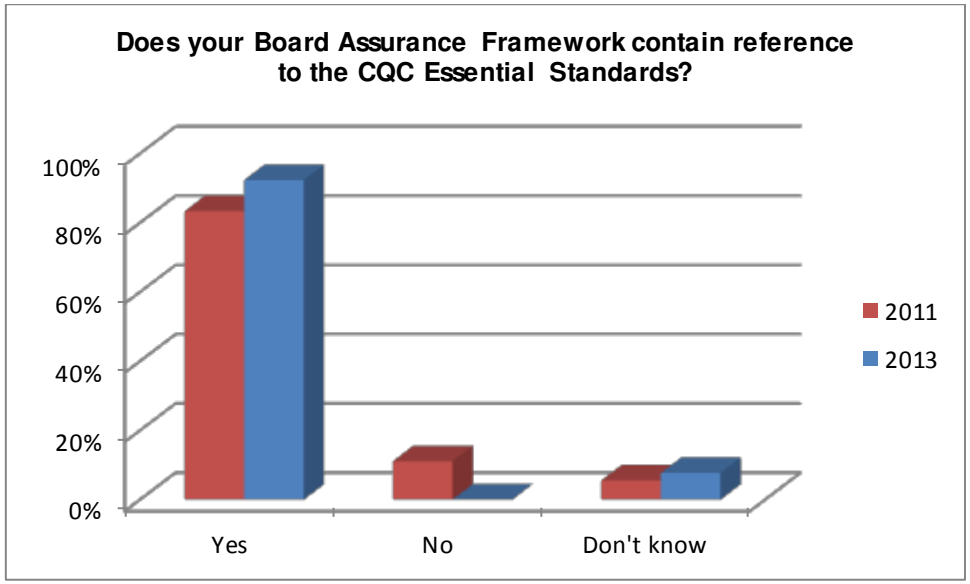
Only 23% of organisations that completed our survey in 2013 felt that all risks which were being managed / escalated according to risk management processes were assessed for their impact on compliance with the Essential Standards. 69% believed that some risks were assessed for their impact and 8% stated no risks were routinely assessed for their impact on CQC compliance. Robust risk management processes should ensure that all risks are assessed against the principal objectives of the organisation, one of which will inevitably be maintaining compliance with regulatory requirements i.e. CQC Essential Standards.

During 2011, it appeared from our survey responses that, overall, trusts in the East Midlands were satisfied that their governance structures were appropriate and fulfilling their necessary functions. For 2013, there appears to be a significant decrease in the number of organisations that consider their committees are spending sufficient time considering and ensuring compliance with the standards. If committees are not spending a sufficient amount of time considering whether the information provided demonstrates compliance with the standards they may not be sufficiently equipped to provide the Board with assurance that the organisation is compliant with the standards.



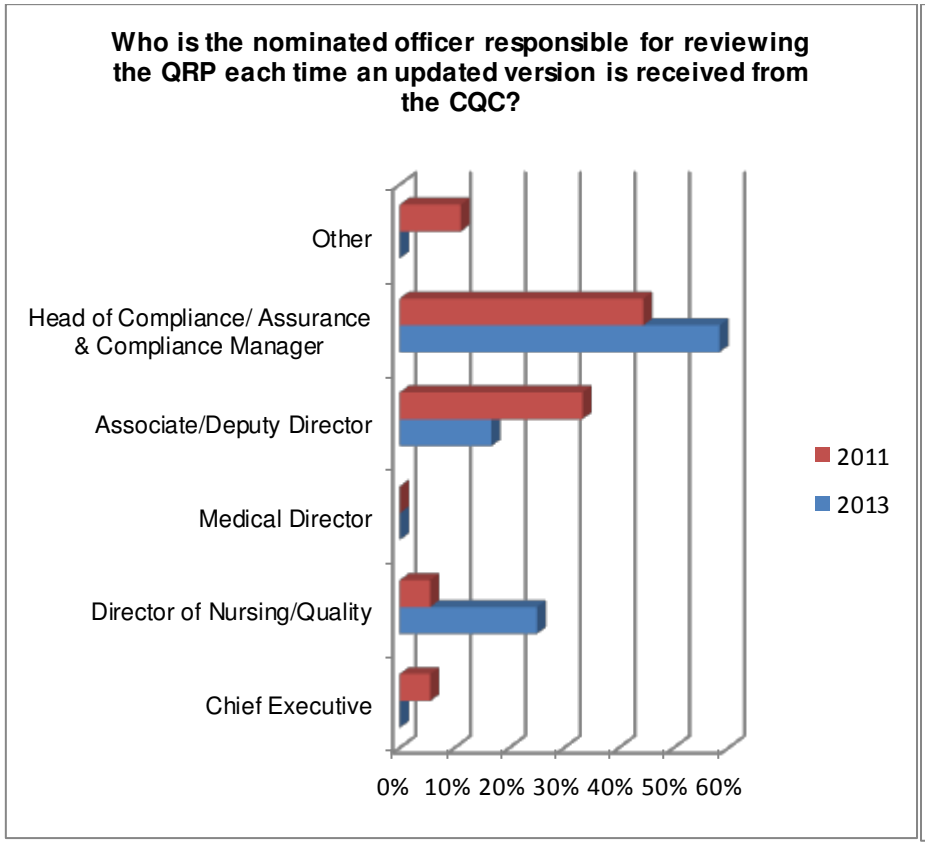
Responses to our survey for 2013 indicated that organisations felt that greater use of quality monitoring evidence that was already being reported, followed by training for those making assessments of compliance would be the most effective ways to improve the assessments of compliance made throughout the organisation. This has shifted over the last 2 years: in 2011 organisations felt that audit of existing evidence and printed guidance providing examples of evidence for each standard were needed to improve confidence in ensuring the organisation can demonstrate compliance with the standards.

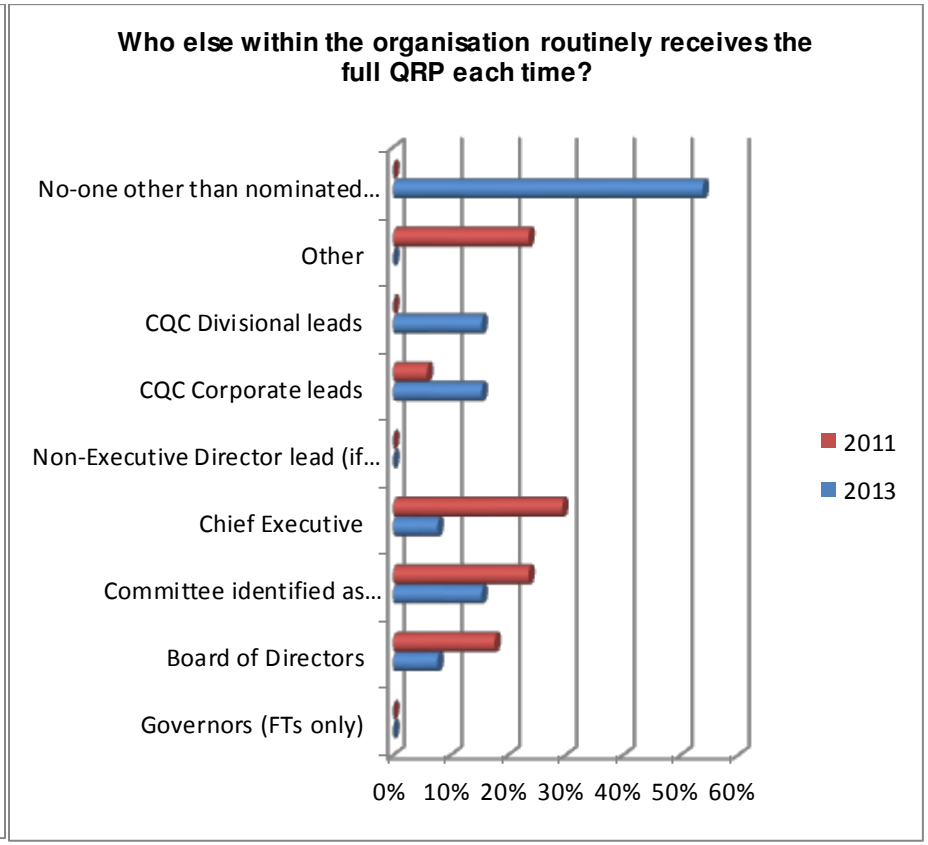
It is assumed that the provision of safe, high quality healthcare is a strategic objective of all NHS trusts. Therefore, it could be expected that compliance with the CQC Essential Standards could be directly mapped to the strategic objectives and therefore risks to CQC compliance would be referenced on the Board Assurance Framework. Indeed, 92% of organisations indicated that their Board Assurance Framework contained reference to the Essential Standards. This has increased slightly from 83% reported in 2011.



4. Quality Risk Profile

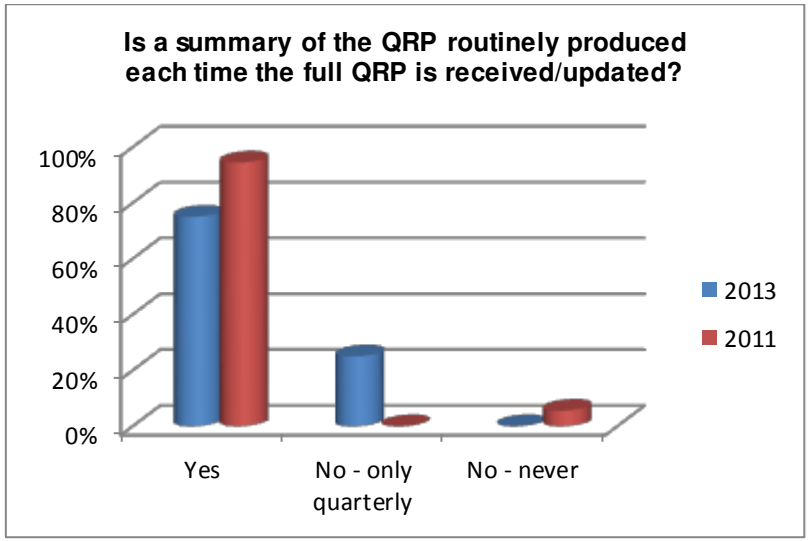
The CQC previously maintained a Quality Risk Profile (QRP) for each of the organisations it has registered to provide health and social care regulated activities. This profile contains information gathered from sources such as commissioners, the NHS Litigation Authority, LiNKs, national patient survey, national staff survey, patient opinion/NHS choices website etc. The CQC aimed to update each QRP on a monthly basis and send it to the relevant organisation.

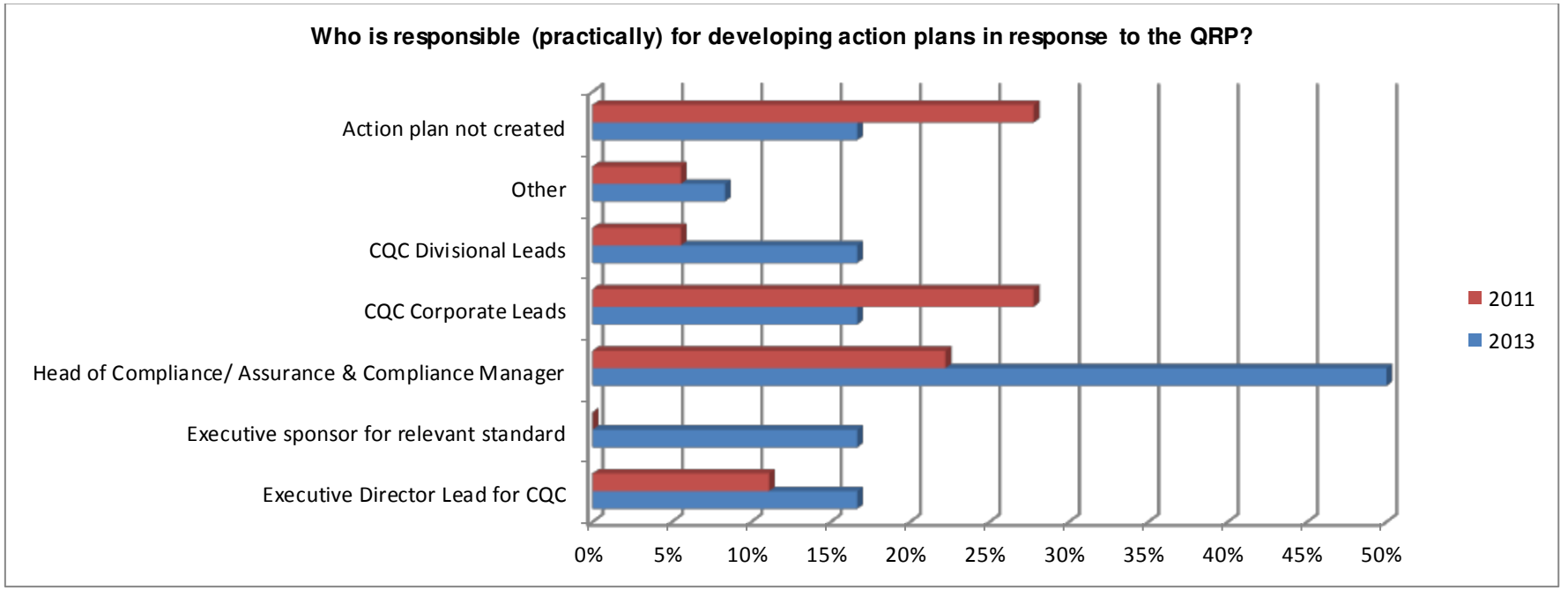




All trusts had assigned a member of staff to review the Quality Risk Profile each time an updated version was received from the CQC. This was typically the Head of Compliance / Assurance followed by the Director / Deputy Director of Nursing. QRPs could run to several hundred pages long. It would not be realistic to expect lots of people within the organisation or whole committees to review the document in its entirety on a regular basis. This was reflected in the decrease from 2011 to 2013 of individuals other than the nominated officer who were sent the full QRP for review.

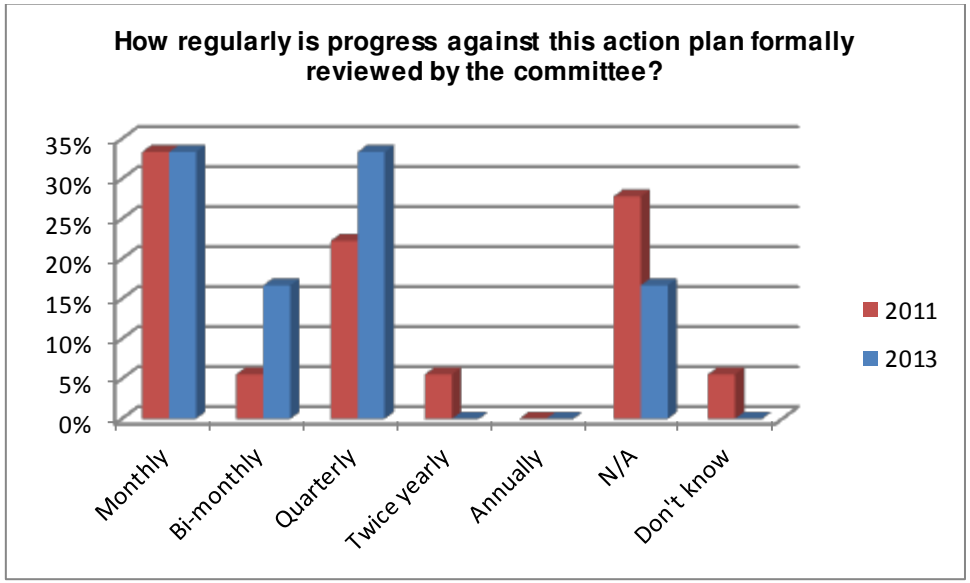
Following the 2011 benchmarking survey, we recommended that organisations ensure that significant information from the QRP is highlighted in a regular report. The results from our 2013 survey refresh indicate that 100% (94% 2011) of trusts produce a monthly/quarterly summary following their review of the QRP. For several trusts this was not necessarily a *formal* report, but simply new areas of concern picked up on an exception basis and the relevant leads / managers contacted (via email) to ascertain the level of risk and any required action.





50% of trusts indicated that the development of the QRP action plans is the responsibility of the 'Head of Compliance/Assurance and Compliance Manager' where weaknesses are identified. The most noticeable difference between the 2013 and 2011 survey results is the completion of an action plan. In 2011 28% of responses received indicated that action plans were not created this is in contrast to 17% reported for 2013. This suggests that more organisations are developing action plans to address weaknesses / risks identified in the QRP.

The reported regularity of action plan monitoring is shown in the graph below. Overall, the 2013 survey refresh indicated that the regularity of reporting progress against QRP action plans is monthly and quarterly.

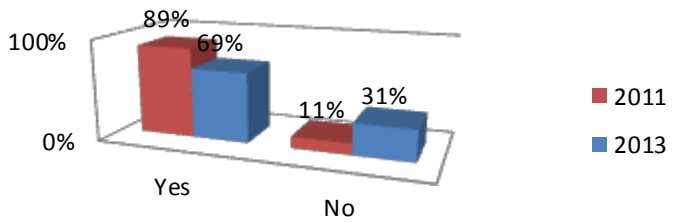


Organisations will need to be mindful that the CQC will, as part of their new inspection regime, be replacing QRPs with intelligence monitoring data based upon a number of key indicators. This new approach was first introduced by the CQC in their consultation document: *A new start: Consultation on changes to the way CQC regulates, inspects and monitors care* (June 2013). The first batch of 'Intelligent Monitoring' reports has been publicly published by the CQC and at **Appendix A** to this report we have included a summary of the recurrent risks emerging.

Organisations will need to consider if and how they are currently capturing this information to identify any weaknesses / risks emerging and ensure action is taken to address this.

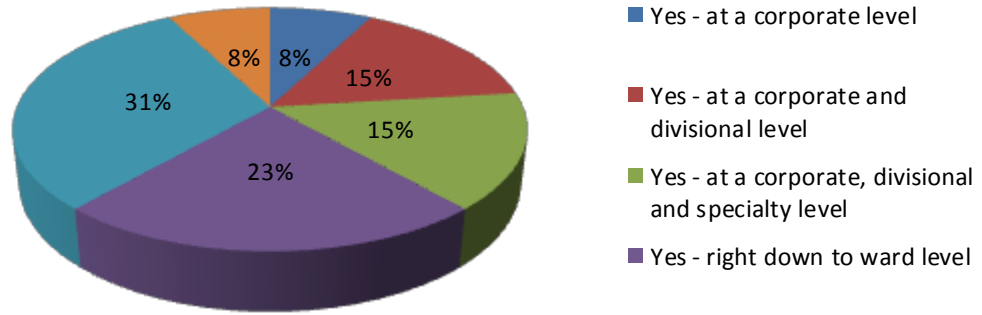
5. Internal Sources of Compliance Evidence

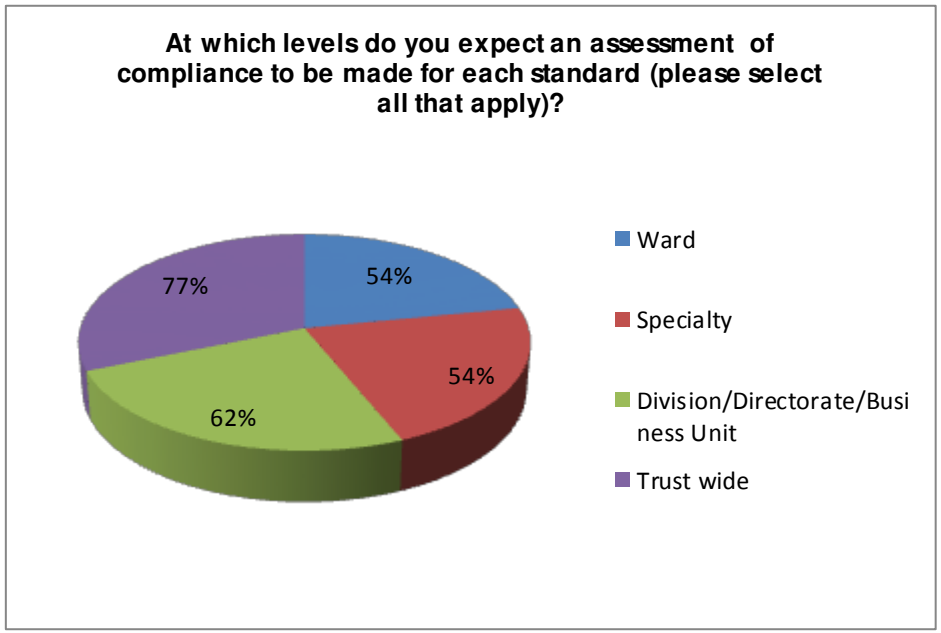
For the 2013 survey refresh, 100% of responses to our survey indicated that their organisation had developed a specific CQC assessment tool for internal completion.

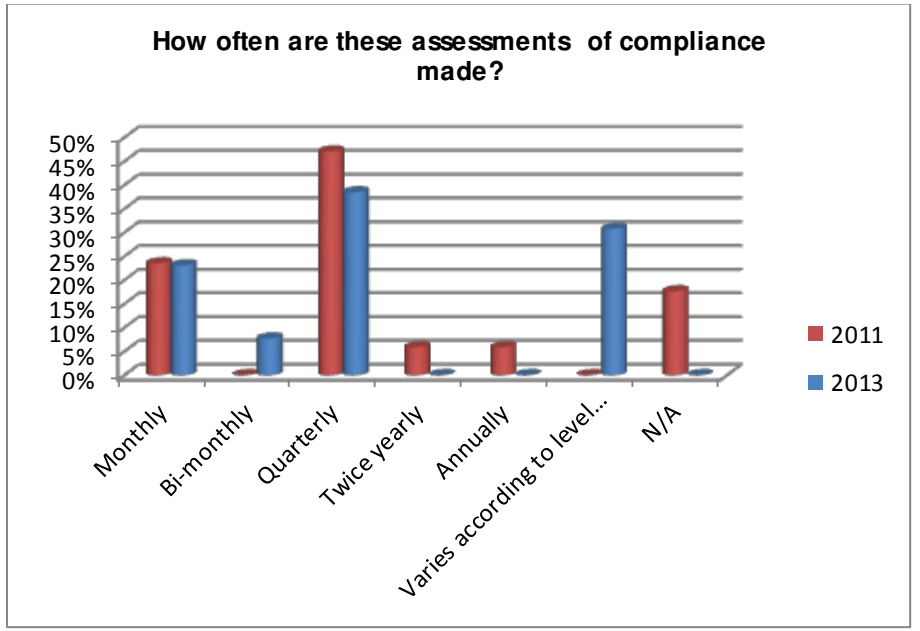


69% of trusts said that they had undertaken a systematic assessment of the evidence that was available in the trust and how this maps across to the CQC Essential Standards. However, this is down 20% from 89% obtained from our 2011 survey. The percentage of trust's that have not undertaken a mapping exercise to establish how all of the current / previous quality monitoring evidence collected and scrutinised relates to the CQC standards has risen from 11% in 2011 to 31% in 2013.

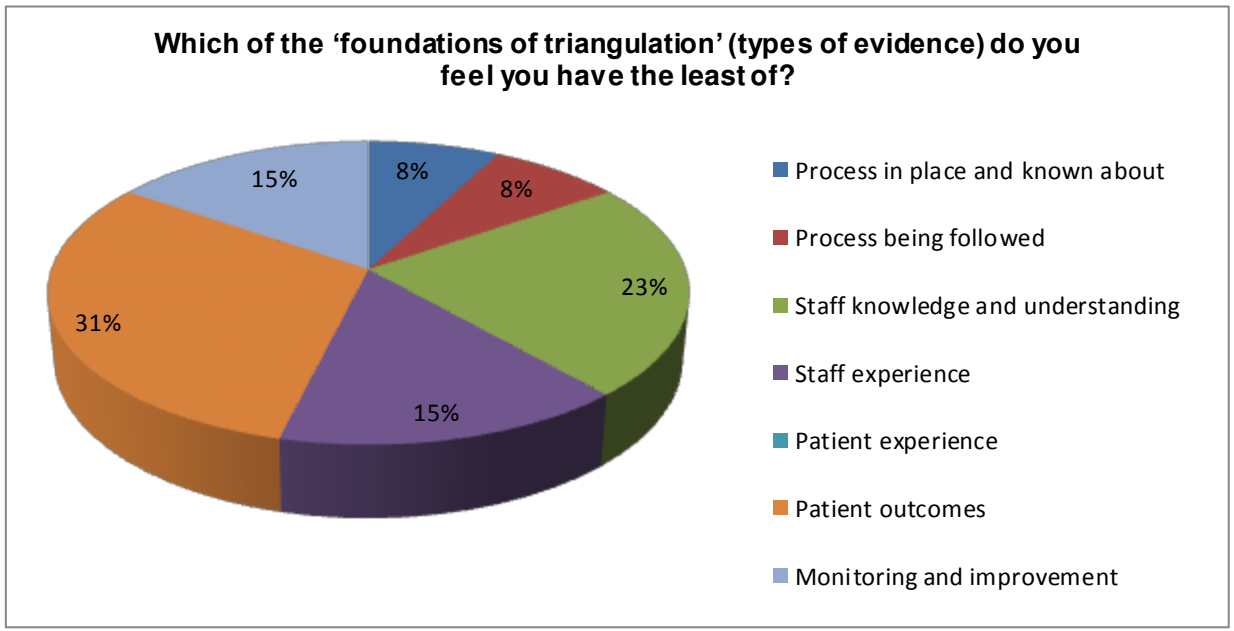
31% of survey responses for 2013 indicated that lists of evidence to assess/make a judgement about compliance had commenced. A further 23% stated that lists had been made right down to ward level, with 15% identifying that lists had been developed at a corporate, divisional and specialty level.







The frequency with which these assessments are made varied has become increasingly dependent on the level (trust-wide, divisional, specialty, ward) at which the assessment takes place. This means that assessments of compliance can be tailored to the level of risk associated with that particular level be it ward / specialty / divisional to enable it to respond to weaknesses / risks identified in a more timely manner. On the whole though 38% stated quarterly.



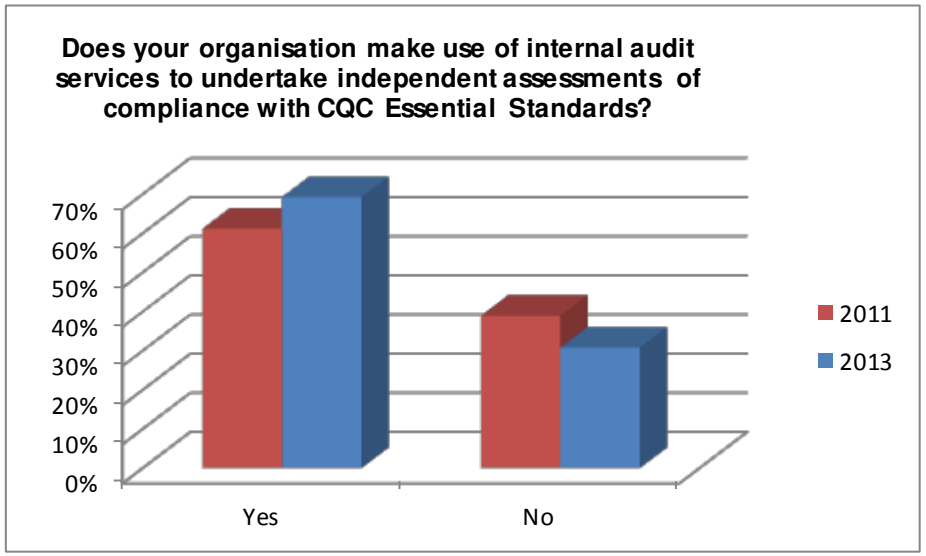
For the 2013 survey refresh, we identified that 31% of trust's felt they had the least amount of evidence to support patient outcomes. A further 23% identified staff knowledge and understanding the evidence they had the least of to support their assessment of compliance with the CQC standards.

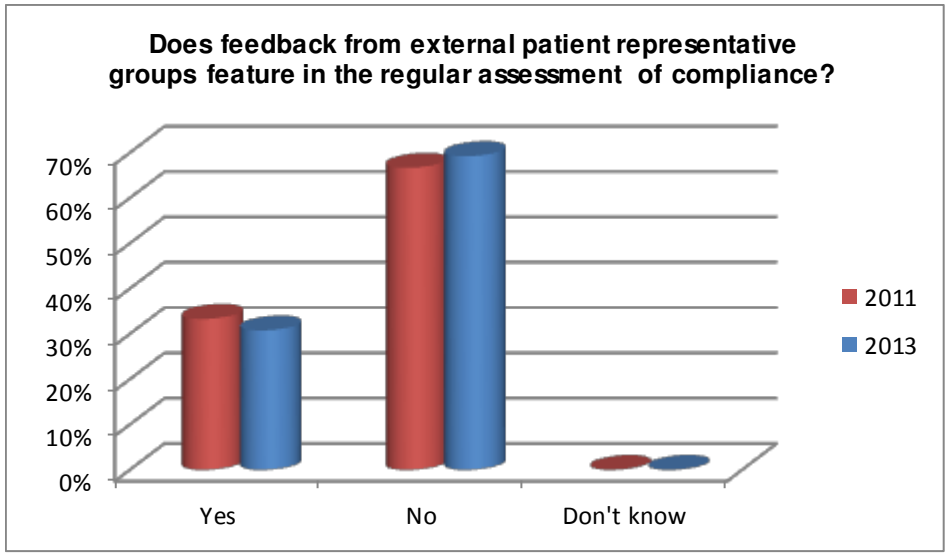
For the 2013 survey refresh we asked whether 'CQC Leads' are expected to summarise and/or upload their evidence onto a central electronic database and if so which system is routinely used. 27% indicated that there was no expectation to use an electronic system as a central depository to store sources of evidence used to assess compliance with the standards. Several trusts have specific electronic systems for managing documents which are considered to be evidence of compliance (e.g. Performance Accelerator/Health Assure). There is a risk that this becomes used simply as a place to deposit documents, without identification and extraction of the information from each document that provides the actual evidence about the safety and quality of care being delivered. There also does not appear to be a simple method of eliminating the risk that multiple electronic versions of documents are stored on the system.

6.Third Party Reviews

69% of the trusts in the East Midlands are using their Internal Audit function in respect of CQC compliance assurance. This has increased slightly from 61% reported in 2011. However, 31% of trust's still do not appear to be utilising external independent sources of assurance such as internal audit to undertake assessments of compliance against the CQC standards.

In 2011, some of these reviews appear to focus primarily on the corporate assurance processes. At emias we have developed and undertaken a series of operational compliance reviews which function in the same way as CQC compliance review visits, preparing staff and providing an objective opinion of where a location or a service has weaknesses.

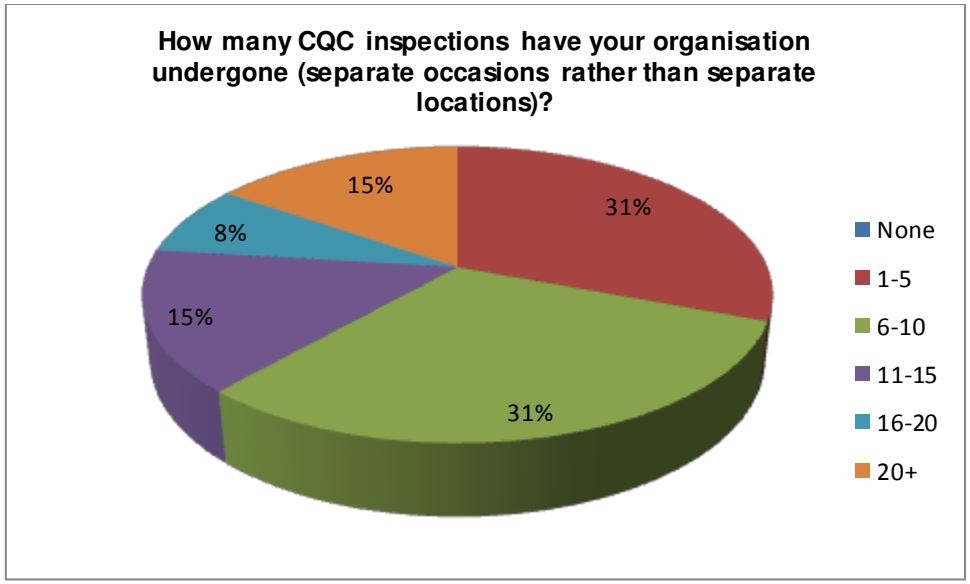




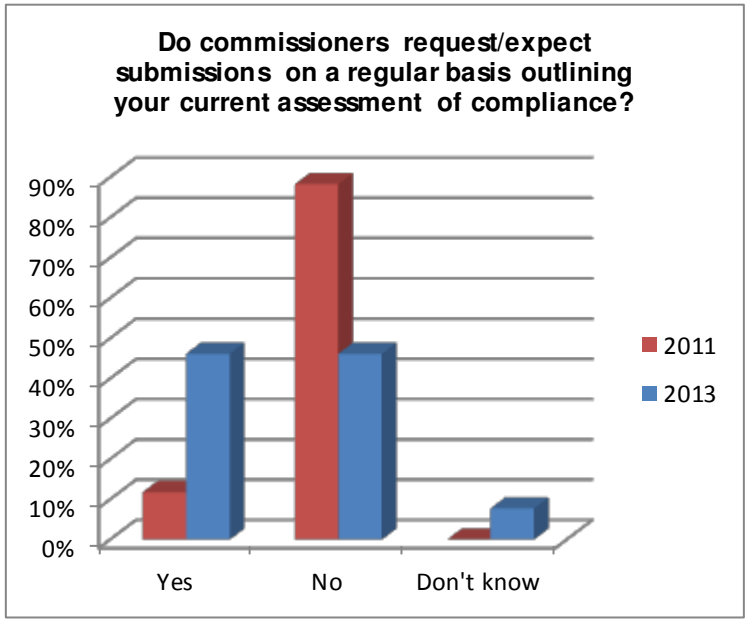
An overwhelming 69% of responses to our survey indicated that feedback from external patient representative groups do not feature in regular assessments of compliance undertaken. These survey results mirror those obtained during 2011.

The CQC will place particular weight on evidence that is service user focused. However, apart from the national patient survey results there is little service-user-focused evidence put forward by trusts.

31% of trusts reported that they have had between 6-10 visits from the CQC since registration, either as part of a review of compliance or as part of the specific Dignity and Nutrition and Learning Disability reviews. 15% of trusts commented that they had received 20+ visits from the CQC since registration. Only 8% reported that they had not yet had a visit from the CQC since registration.

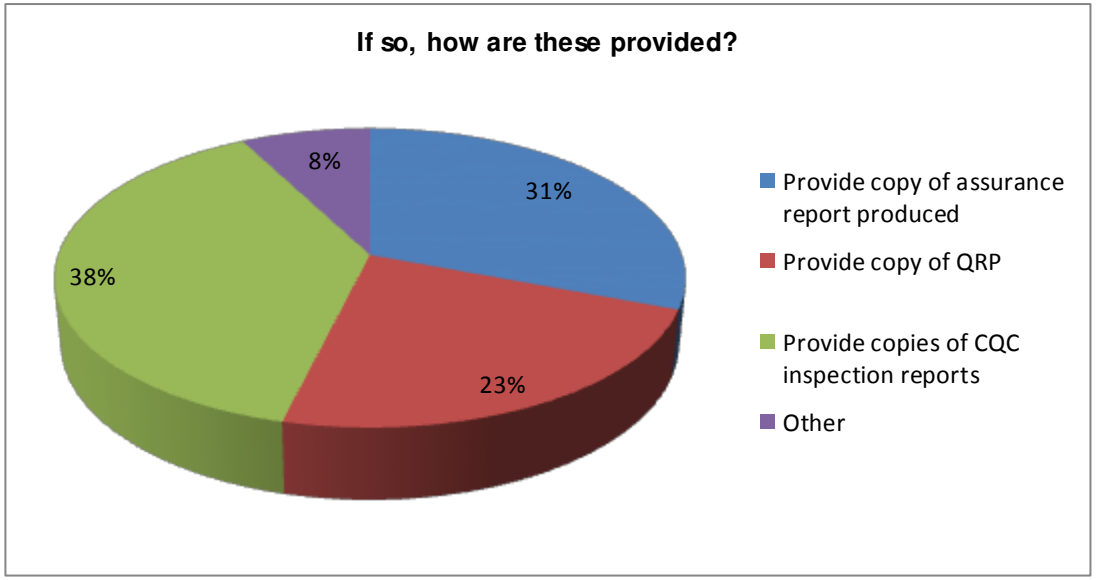


7. Provision of information to commissioners



The percentage of responses for whether commissioners request / expect submissions on a regular basis of the organisations assessment of compliance against the standards was evenly split between yes and no for 2013 (46% each). This is in contrast to the 2011 survey responses, when 88% of trusts stated that commissioners did not expect assessments of compliance to be submitted as part of the contractual arrangements in place.

Of the trusts that responded yes to the question above, 38% stated that this assessment was provided through copies of CQC inspection reports, 31% through submitting a copy of the assurance report produced for the delegated committee and 23% by way of a copy of the QRP.



Intelligent Monitoring

Introduction

The CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions they will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care.

The indicators have been developed following the Francis Report and the learning from the Keogh reviews. Over 160 indicators have been selected. These include multiple mortality indicators, indicators around patient safety incidents, reporting culture, patient experience, staff experience and staffing.

The CQC has used the following datasets to develop the indicators:

- Hospital Episode Statistics (HES);
- Incidents reported to the National Reporting and Learning System (NLRS);
- Never Events reported to the Strategic Executive Information System (STEIS);
- National Inpatient Surveys;
- Experience information reported on NHS Choices, Patient Opinion, and to CQC;
- NHS Staff Survey;
- Junior Doctor Survey;
- Electronic Staff Record (ESR) system; and
- Staff concerns reported to CQC (whistleblowing information).

The indicators were first introduced in the CQC's consultation *A new start: Consultation on changes to the way CQC regulates, inspects and monitors care* (June 2013).

To promote a risk-based approach to inspections, the indicators have been analysed by the CQC to identify one of the following levels of risk for each Trust:

- No evidence of risk.
- Risk.
- Elevated risks.

Thresholds have been calculated for each indicator which is then used to assign the risk level. For example, the ratio of observed / expected for MRSA is the count of MRSA / total person bed days, this is then converted to a z score and p-value to determine whether the thresholds for risk or elevated risk have been exceeded.

The CQC has categorised 161 acute and specialist Trusts into one of six summary bands, with Band 1 representing highest risk and Band 6 with the lowest. These bands have been assigned based on the proportion of indicators that have been identified as 'risk' or 'elevated risk'. If there are known serious concerns with Trusts (for example, Trusts in special measures) they are automatically categorised as Band 1.

Individual Trust reports can be downloaded for each acute Trust which includes the CQC's analysis of the indicators and the risk levels applied.

This intelligent monitoring data will replace the Quality Risk Profiles (QRPs) held for acute and specialist Trusts.

As part of the development of its inspection and regulation regime, the CQC has announced that it will use results from its 'intelligent monitoring' work to decide when, where and what to inspect. Analysis of the indicators will be used to direct CQC resources to where they are most needed. Furthermore, the CQC will use their inspection regime to continue to refine the intelligence monitoring data used.

The CQC has already begun to use the intelligence monitoring tool to select those Trust's that will form part of the first wave of new inspections.

Attached at Appendix A is a summary of the top 5 indicators for each of the two levels of risk (elevated risk and risk) identified by the CQC following the publication of the first intelligent monitoring reports for each of the 161 acute and specialist NHS Trusts. The proportion of Trusts within the East Midlands and South Yorkshire regions that make up the total number of Trusts with elevated risk and risk for each indicator has also been provided.

Appendix B provides a summary of the elevated risk and risk concerns for each Trust in the East Midlands and South Yorkshire regions.

References

http://www.cqc.org.uk/public/hospital-intelligent-monitoring

Guidance has been produced which describes for each indicator:

- How the numerator and denominator have been constructed (for quantitative indicators);
- How 'risk' and 'elevated risk' has been determined;
- The time period of the data source; and
- The data source and links to the original source (where this is available).

This can be found in the documents titled *CQC Intelligent monitoring: indicators and methodology* and *Intelligence monitoring: Statistical methodology* on the link embedded above.

Appendix A – Summary of Top 5 elevated risk and risk indicators

Top 5 **elevated risk** indicators:

Indicator	No. of the 161 Trusts with elevated risk	% of Trusts with elevated risk	No. of Trusts in EM&SY regions (from 17 Trusts)
Whistleblowing alerts	119	74%	12
Composite indicator: In-hospital mortality - Cardiological conditions and procedures	16	10%	1
Hospital Standardised Mortality Ratio	16	10%	4
Serious Education Concerns	13	8%	1
Summary Hospital-level Mortality Indicator	11	7%	2

Top 5 **risk** indicators:

Indicator	No. of the 161 Trusts with risk	% of Trusts with risk	No. of Trusts in EM&SY regions (from 17 Trusts)
Never Event incidence	54	34%	8
Monitor - Governance risk rating	27	17%	8
TDA - Escalation score	26	16%	2
Serious Education Concerns	19	12%	3
Potential under-reporting of patient safety incidents resulting in death or severe harm	14	9%	1

Appendix B – Summary of elevated risk and risk concerns for each Trust in the East Midlands and South Yorkshire region

Trust	Indicators with elevated risk	Indicators with risk
Barnsley Hospital NHS Foundation Trust	Composite indicator: In-hospital mortality - Endocrinological conditions	Emergency readmissions following an elective admission
	Mortality outlier alert: Fluid and electrolyte disorders	In-hospital mortality: Endocrinology
Burton Hospitals NHS Foundation Trust	Composite indicator: In-hospital mortality - Nephrological conditions	Composite indicator: In-hospital mortality - Cerebrovascular conditions
	Whistleblowing alerts	In-hospital mortality: Cerebrovascular
	Mortality outlier alert: Acute and unspecified renal failure	Never Event incidence
	Hospital Standardised Mortality Ratio (Weekday)	Monitor - Governance risk rating
	Hospital Standardised Mortality Ratio	
Chesterfield Royal Hospital NHS Foundation Trust	Mortality outlier alert: Fluid and electrolyte disorders	Never Event incidence
	Whistleblowing alerts	
	Composite indicator: In-hospital mortality - Endocrinological conditions	
Derby Hospitals NHS Foundation Trust	Whistleblowing alerts	Monitor - Governance risk rating
	Potential under-reporting of patient safety incidents resulting in death or severe harm	Never Event incidence
		In-hospital mortality: Neurology
		In-hospital mortality: Vascular
		Composite indicator: In-hospital mortality - Neurological conditions
		Composite indicator: In-hospital mortality - Vascular conditions and procedures
Doncaster and Bassetlaw Hospitals NHS Foundation Trust		NHS Staff Survey - KF7. % staff appraised in last 12 months
		NHS Staff Survey - KF9. Support from immediate managers
		NHS Staff Survey - KF10. % staff receiving health and safety training in last 12 months

Trust	Indicators with elevated risk	Indicators with risk
		Never Event incidence
		Data quality of trust returns to the HSCIC
		Composite risk rating of ESR items relating to staff registration
		Serious Education Concerns
		Potential under-reporting of patient safety incidents
		Referral to treatment times under 18 weeks: admitted pathway
Kettering General Hospital NHS Foundation Trust	Whistleblowing alerts	The proportion of patients whose operation was cancelled
		Monitor - Governance risk rating
		Never Event incidence
		Serious Education Concerns
		Safeguarding concerns
		Key Indicator 1: Number of patients scanned within 1 hour of arrival at hospital
		Key Indicator 8: Number of potentially eligible patients thrombolysed
		The number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database.
Milton Keynes Hospital NHS Foundation Trust	Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?"	Monitor - Governance risk rating
	Whistleblowing alerts	Inpatient Survey 2012 Q25 "Did you have confidence and trust in the doctors treating you?"
		Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?"
		Serious Education Concerns
Northampton General Hospital NHS Trust	Summary Hospital-level Mortality Indicator	A&E waiting times more than 4 hours
	NHS Staff Survey - KF9. Support from immediate managers	TDA - Escalation score
	Composite risk rating of ESR items relating to staff registration	In-hospital mortality: Gastroenterology and hepatology
	Maternity outlier alert: Elective Caesarean section	The number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database.

Trust	Indicators with elevated risk	Indicators with risk
	Whistleblowing alerts	Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	Composite indicator: In-hospital mortality - Respiratory conditions and procedures	Inpatients response rate from NHS England Friends and Family Test
	Whistleblowing alerts	Monitor - Governance risk rating
	In-hospital mortality: Respiratory medicine	NHS Staff Survey - KF7. % staff appraised in last 12 months
	Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis	
	Hospital Standardised Mortality Ratio	
	Summary Hospital-level Mortality Indicator	
Nottingham University Hospitals NHS Trust	Composite risk rating of ESR items relating to staff registration	PROMs EQ-5D score: Hip Replacement
	Hospital Standardised Mortality Ratio (Weekend)	Emergency readmissions following an elective admission
	Mortality outlier alert: CABG (other)	Emergency readmissions following an emergency admission
	Whistleblowing alerts	
	Composite indicator: In-hospital mortality - Cardiological conditions and procedures	
Peterborough and Stamford Hospitals NHS Foundation Trust		Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds
		Monitor - Governance risk rating
		Composite risk rating of ESR items relating to staff registration
Sheffield Teaching Hospitals NHS Foundation Trust	Whistleblowing alerts	PROMs EQ-5D score: Hip Replacement
		Never Event incidence
Sheffield Children's NHS Foundation Trust		
Sherwood Forest Hospitals NHS Foundation Trust	Hospital Standardised Mortality Ratio	Monitor - Governance risk rating
	Hospital Standardised Mortality Ratio (Weekday)	Never Event incidence
	Hospital Standardised Mortality Ratio (Weekend)	Composite risk rating of ESR items relating to staff sickness rates
	Mortality outlier alert: Acute cerebrovascular disease	In-hospital mortality: Cerebrovascular

Trust	Indicators with elevated risk	Indicators with risk
	Whistleblowing alerts	Potential under-reporting of patient safety incidents resulting in death or severe harm
	Composite indicator: In-hospital mortality - Cerebrovascular conditions	
The Rotherham NHS Foundation Trust	Potential under-reporting of patient safety incidents resulting in death or severe harm	Monitor - Governance risk rating
		Never Event incidence
		In-hospital mortality: Cerebrovascular
		In-hospital mortality: Dermatology
		In-hospital mortality: Trauma and orthopaedics
		Composite indicator: In-hospital mortality - Cerebrovascular conditions
		Composite indicator: In-hospital mortality - Dermatological conditions
		Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures
United Lincolnshire Hospitals NHS Trust	All cancers: 62 day wait for first treatment from urgent GP referral	The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason
	TDA - Escalation score	NHS Staff Survey - KF7. % staff appraised in last 12 months
	Hospital Standardised Mortality Ratio	NHS Staff Survey - KF9. Support from immediate managers
	Hospital Standardised Mortality Ratio (Weekend)	NHS Staff Survey - KF21. % reporting good communication between senior management and staff
	Whistleblowing alerts	Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?"
		Data quality of trust returns to the HSCIC
		Composite risk rating of ESR items relating to staff sickness rates
		Composite risk rating of ESR items relating to staff support/ supervision
		In-hospital mortality: Gastroenterology and hepatology

Trust	Indicators with elevated risk	Indicators with risk
		Proportion of patients risk assessed for Venous Thromboembolism (VTE)
		Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures
University Hospitals of Leicester NHS Trust	A&E waiting times more than 4 hours	PROMs EQ-5D score: Groin Hernia Surgery
	Maternity outlier alert: Puerperal sepsis and other puerperal infections	TDA - Escalation score
	Whistleblowing alerts	Composite risk rating of ESR items relating to staff turnover
	Serious Education Concerns	Composite risk rating of ESR items relating to staff stability
		In-hospital mortality: Paediatrics and congenital disorders
		Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality