

Public Document Pack

Supplementary information and late item for 30 October 2013 Scrutiny Board (Health and Well-being and Adult Social Care)

Pages 1-10: Agenda item 7 - Fundamental Review of Allocations Policy: Response on behalf of Leeds North CCG, Leeds South & East CCG and Leeds West CCG to NHS England

Pages 11-30: Agenda item 11 – Care Quality Commission (CQC) hospital inspection programme: Intelligent Monitoring

This page is intentionally left blank



Telephone enquiries, please contact:

Beverly Keeting

Tel: 0113 84 31646

Email: Beverly.Keeting@nhs.net

2180 Century Way
Thorpe Park
Leeds
LS15 8ZB

John Bailey
Head of Financial Strategy & Allocations
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UB

30th September 2013

Dear John

Fundamental Review of Allocations Policy: Response on behalf of Leeds North CCG, Leeds South & East CCG and Leeds West CCG to NHS England

Indicative future CCG allocations were published by NHS England last month. Having attended the national workshops which explain the methodology behind the new calculations the Leeds CCGs agreed with you to submit evidence around the impact on Leeds so you could review as a case study to understand how the formula was working. We therefore wish to highlight a number of additional factors that we feel need to be taken account of in the allocations methodology and its implementation.

These fall into the following categories and are explained in more detail below:

- The need to reflect the deprivation levels in a population as well as age as an indicator of health spend need (and therefore cost)
- Supply variables which would impact on the proposed rate of change in allocations
- A reflection of the distribution resources within a health economy
- A reflection of the level of existing spend in community schemes within a health economy
- Impact of Local Authority cuts within a health economy and the nature of Inner City populations
- Pace of Change

The proposed indicative allocations published by NHS England indicate a huge shift of resource from the North to the South of England. The underlying change in the formula leading to this shift is the move away from funding driven by deprivation to one driven by age. Previously 10% of funding has been “diverted” to deprived areas. It appears that there has never really been any statistical modelling to evidence this requirement, but the adjustment has been made as it has been deemed to be the right thing to do – recognising the additional health need in deprived populations. However, ACRA, driven by statistical modelling (rather than softer intelligence) are now suggesting that diversion should cease.

There also appears to be a view that whilst deprived populations and the health inequalities that arise from that cannot be tackled by CCGs, and the responsibility for that should lie with Public Health and Primary Care.

Deprivation or Age?

Clearly, age is a huge driver of healthcare resource consumption which needs to be reflected in any NHS funding formula. However, it is also well evidenced that deprived populations have greater health need (and notably use proportionately more non-elective services which are more expensive than elective). The fact that this cannot be statistically modelled through an allocations formula does not justify its removal from the formula, rather, as has happened previously necessitates an adjustment to that formula.

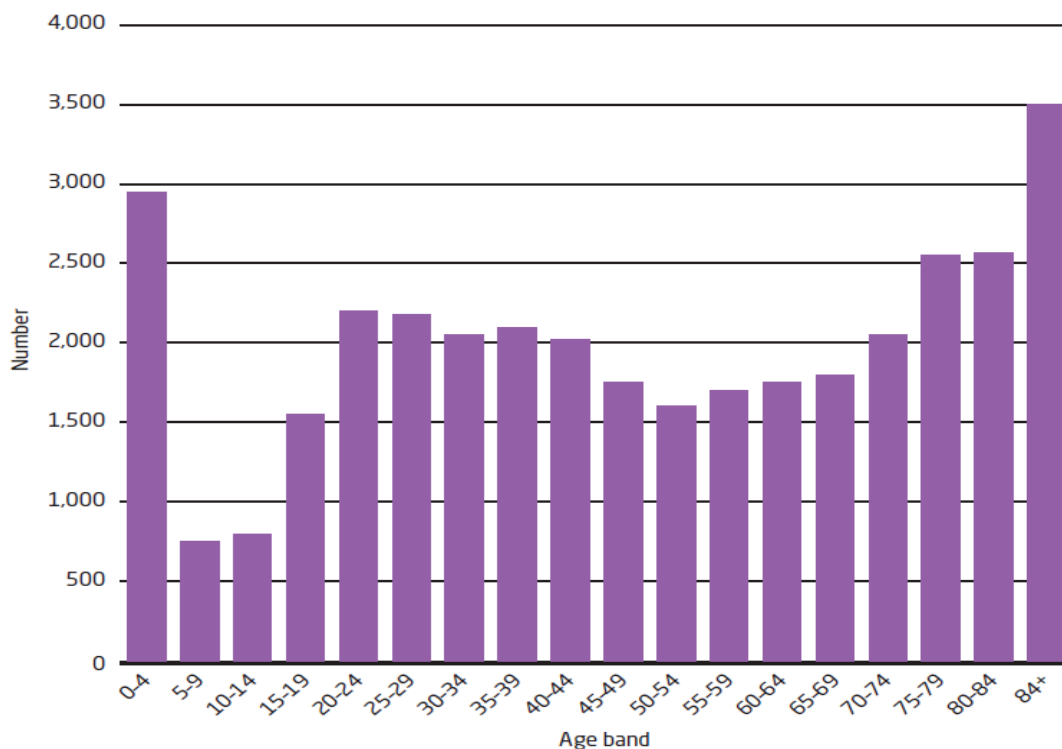
National Evidence

It is well documented nationally that people who live in areas of socio-economic deprivation consume a greater level of healthcare resource than people who live in more affluent areas.

The King's Fund, Avoiding Hospital Admissions (2010) states:

- Age is a risk factor for emergency hospital admission, however only 5-14 year olds have low risk, there are a large number of admissions occurring in those <65 years – see figure 1

Figure 1: Number of emergency admission 2006/7 by age: PCT residents



- There is evidence that people who live in areas of socio-economic deprivation have higher rates of emergency admissions. In the UK, admission rates are significantly correlated with measures of social deprivation. Practices serving the most deprived populations have emergency admission rates that are around 60-90% > than those serving the least deprived populations.
- Policy makers should consider the impact of socio economic deprivation and other socio demographic factors when designing policy around admission rates.

If it is deemed that policy should take cognisance of the impact of deprivation, surely the calculation of resource allocation should reflect this.

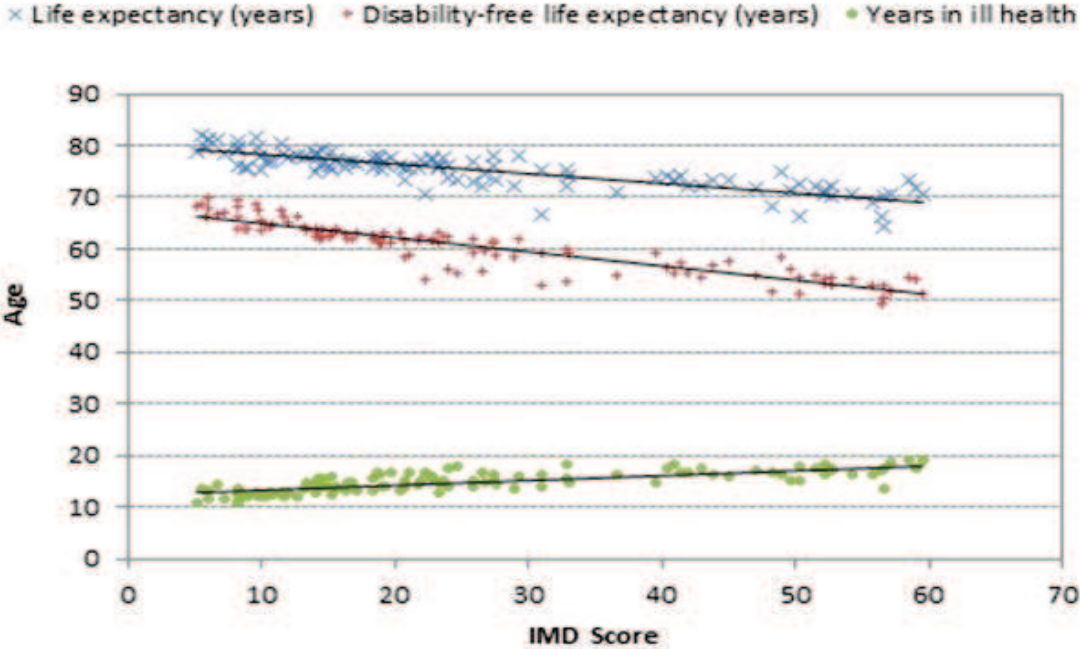
Local Evidence

The impact of the new indicative allocation in Leeds appears to mirror the national shift. It is felt that local evidence demonstrates the flaws that exist in the newly proposed formula. There are three CCGs in Leeds, each with diverse populations. Leeds South & East (LSE) has a significantly more deprived population. Whilst the other two CCGs do have areas of deprivation, Leeds West (LW) has a significant student population and Leeds North (LN) has a higher proportion of elderly population. It is not the intention of the case presented in this letter, to move resource within Leeds, but to highlight that three diverse populations appear to have relatively the same treatment in the allocation formula.

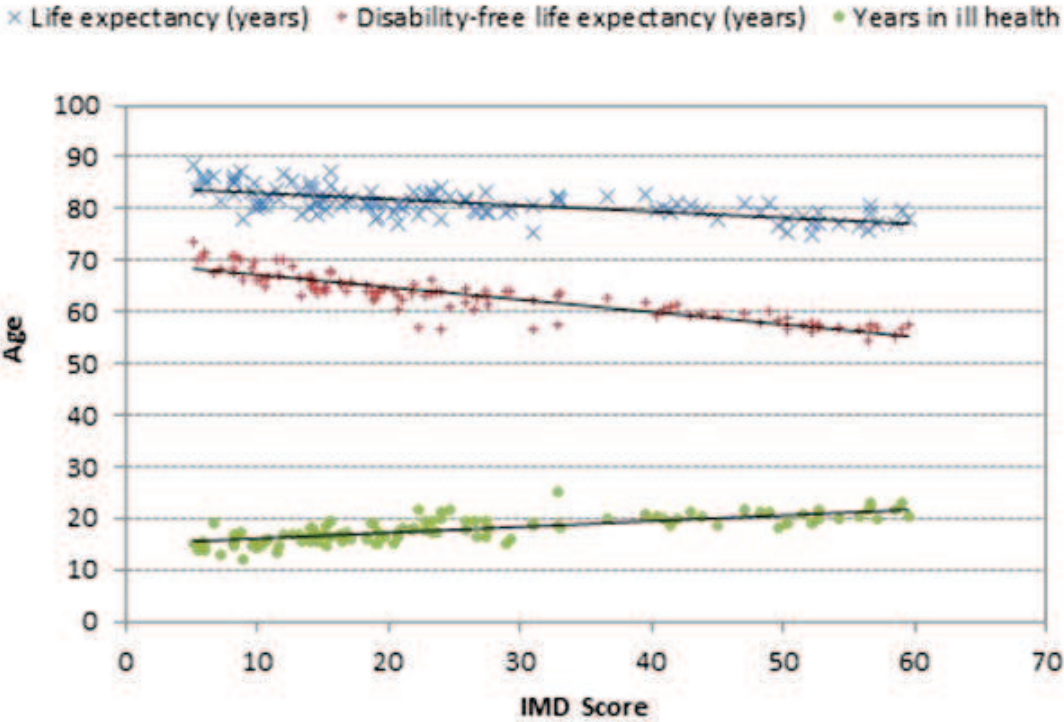
LSE have analysed public health intelligence in relation to healthy life expectancy to estimate need in their elderly population. The basic premise is that in deprived populations people develop life-limiting conditions at younger ages and live in ill health for longer when compared to their peers in more affluent communities. This statement is backed up by data which shows a **greater gap** between healthy life expectancy (aka disability-free life expectancy) and life expectancy in deprived communities (see charts below which is for all MSOAs in Leeds). This is reflected for the male and female population in figure 2.

Figure 2 – Gap in Healthy Life Expectancy and Life Expectancy in Deprived Populations

Male Population



Female Population

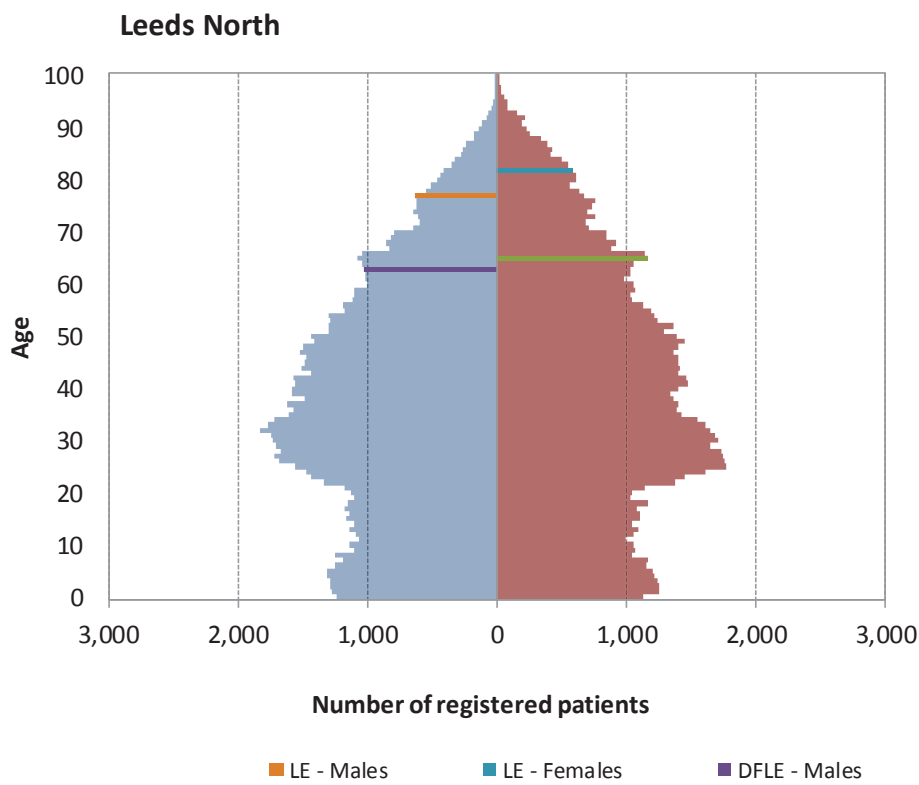
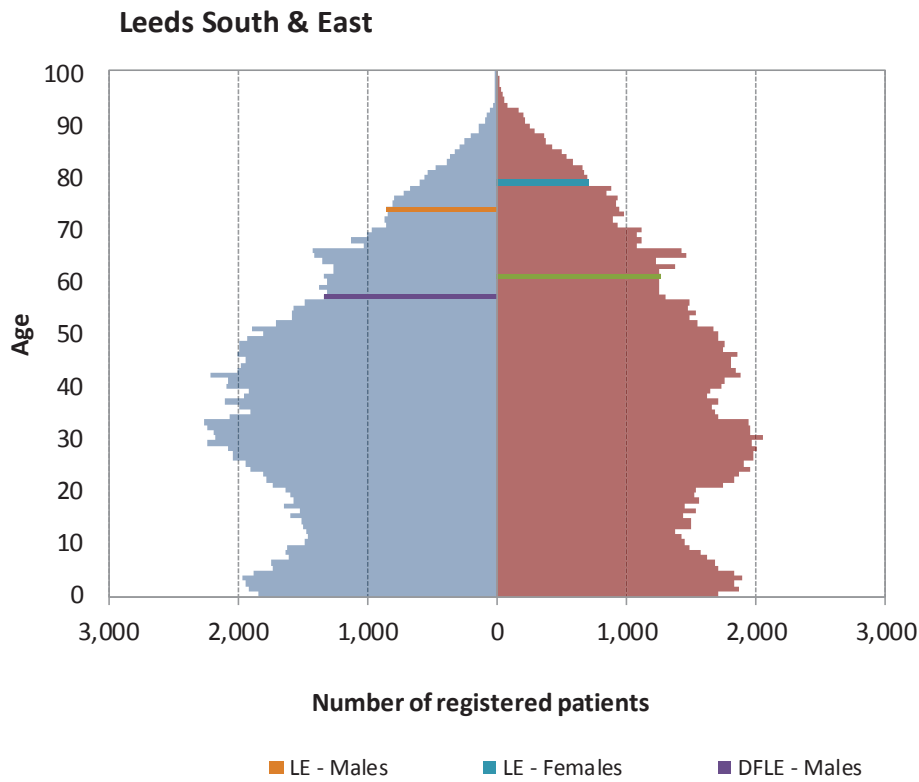


The difference in both life expectancy and healthy life expectancy between deprived and more affluent populations has important implications for the numbers of patients requiring healthcare input. Due to the age-sex structures of populations, which typically show significant falls in the numbers of patients above the age of 70 owing to mortality, **lowering the healthy life expectancy rate by just one year can add a significant number of patients to the population living in ill-health.** This phenomena means that whilst a CCG like Leeds South & East has only 4,800 patients aged 85 and over (which equates to 1.83% of its total population), it has 54,800 patients over the healthy life expectancy age (20.8% of its population), and an estimated 37,211 patients in ill-health (14.1% of its population). By contrast, Leeds North CCG has 4,650 patients aged over 85 (2.3% of its population), 34,340 patients over the healthy life expectancy age (16.8% of its population), and an estimated 23,330 patients in ill-health (11.4% of its population).

These figures illustrate that whilst Leeds South & East has proportionately fewer elderly in its population when compared to Leeds North; its elderly population suffering from ill health represents a greater proportion of its population.

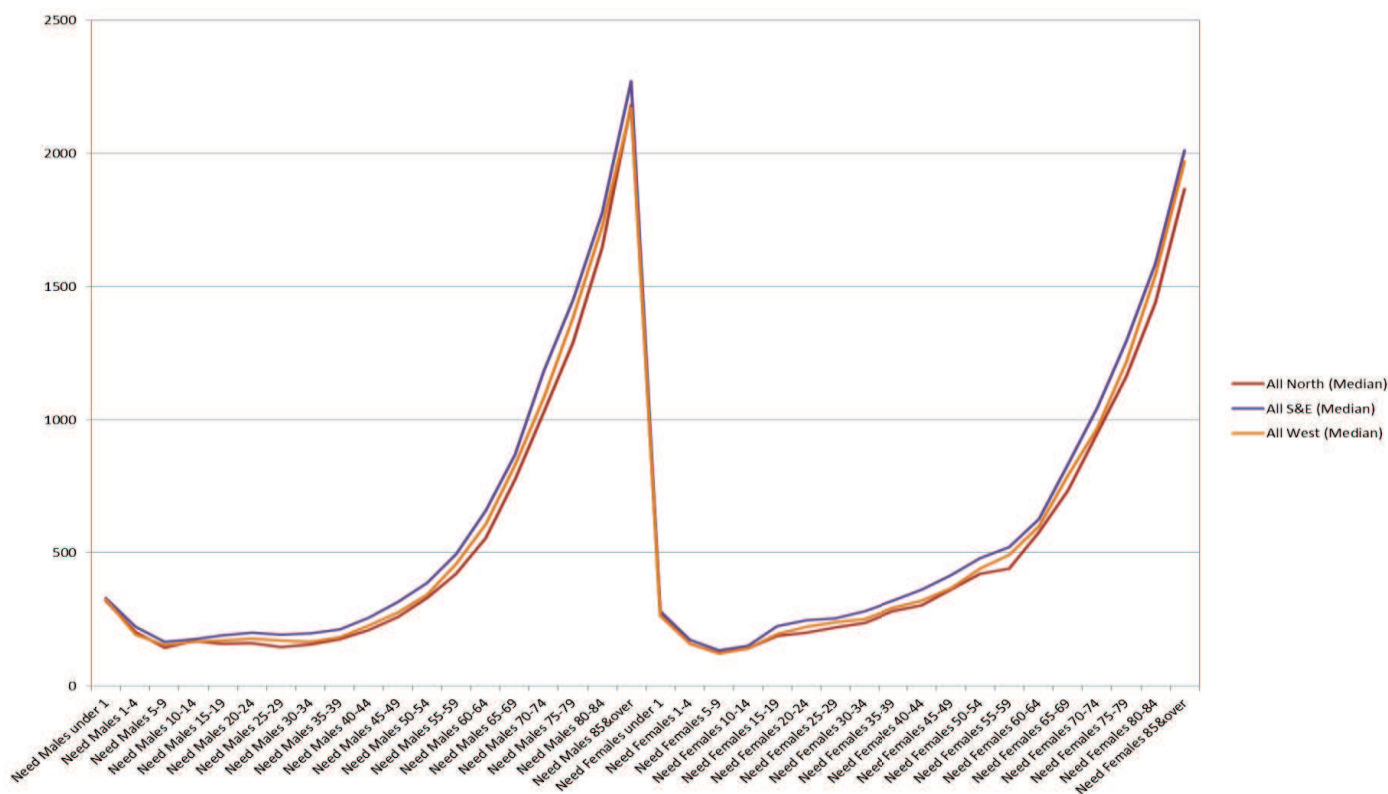
This is shown in the age sex profiles in figure 3 below:

Figure 3 – Age Sex Profiles



Taking this in to account you would expect the new formula to reflect the increased need at differing age of the population within Leeds. The graph below (Figure 4) shows health need by age band as calculated in the newly proposed formula, for each of the Leeds CCGs. However, whilst clearly it has been identified that LSE requires slightly more resource than the other Leeds CCGs, the shape of the need curve is very similar for each. We believe that the need curve for LSE (indeed for any CCG with a deprived population), should be much steeper at a younger age as their populations suffer ill health from a younger age and for a longer time period.

Figure 4 – New Allocation – Health Need by Age Band



This analysis provides some context to why the Leeds CCGs believe deprived CCGs warrant additional funding when compared to other CCGs with more affluent populations. It is recognised that the proposed funding formula does this to some extent. However, the differences between the ‘needs’ adjusted aged-sex profiles for the CCGs in Leeds appear to be relatively small, and age and sex are by far the largest factors controlling the allocation of funds. These differences certainly don’t appear to account for the differences in healthy life expectancy noted above and the longer period of time of ill health which starts sooner in deprived populations.

Other Issues:

Supply Variables

It is evidenced that those who live closer to A&E departments have higher rates of admissions. The guidance issued with the new formula states: *“if an area has lower use of healthcare services because of lower capacity or distance, this is corrected for in the formula”*. Is it therefore the case that areas such as Leeds who have healthcare provision close to their population would have their allocation adjusted downwards? If so, any pace of change policy would need to be very slow in this regard, allowing CCGs time to influence and change their population’s behaviour.

Distribution of Resources within a Health Economy

It has been suggested that the shift of resources appears to be “justified” nationally on the basis that CCGs currently in under spending positions are in line to lose resources in favour of those currently over spending and thus supporting a need to redistribute resources between health economies.

However, within health economies, there also needs to be account taken of the balance of distribution of resources across the health system (i.e. Provider or Commissioner biased). For instance, in Leeds, Newcastle and Liverpool, the CCGs are under spending but their main secondary care providers are running at reference costs indices in the range of 98 to 107 whereas in Birmingham where CCGs are potentially overspending, their providers are running at reference cost indices of 112 to 126. In addition, in Leeds, the main provider is struggling to attain Foundation Trust status due to a number of factors, including financial sustainability. This would suggest that some account of where the “money” resides in the health economy needs to be taken, rather than focus on CCG positions in isolation when using current CCG positions as a yardstick for justification of the reallocation of resources.

Level of Existing Investment in Community Services

The formula appears to be focused mainly on Acute vs. Primary Care spend and does not appear to factor in the level of spend in Community Schemes already in place aimed at both prevention and different ways of tackling health provision.

Impact of Local Authority Cuts and Inner City Populations

Some larger cities are experiencing significant cuts in local authority resources which will restrict their ability to continue with current levels of spend to support both integrated and preventative care. If this is not factored into the formula then those CCGs losing resources will experience a compounded impact in terms of service retraction in other parts of the system concurrently.

There appears to be a general bias of loss of resources towards inner cities as a whole. Given that the allocations are based on registered populations, inner cities will be penalised for treating transient and unregistered populations.

Pace of Change

If it is assumed that Public Health and Primary Care are the areas of the health economy which should be tackling health inequalities, then the pace of change needs to be slow enough for the system to find this new equilibrium. Alongside this there needs to be a clear audit trail of funding going into those areas. For example, if the Local Authority in Leeds receives an increase in allocation for Public Health, it cannot be automatically assumed that this resource will be invested in the deprived areas from which NHS resource has been removed. Consideration should also be given to the fact that given the relative funding levels of CCGs, Public Health and Primary Care, using differential growth to achieve this will take decades (Public Health have received 10% growth, but this pales into insignificance compared with a potential 13% cut to LSE CCG funding).

The Comprehensive Spending Review has equally put unprecedented challenge on to Clinical Commissioning Groups. With significantly reduced growth and upwards of 3% of resource transferred in to the Integration Fund there is a question of the degree of transformation that can be done in a short time. Within Leeds the level of QIPP required to meet the challenges of the Comprehensive Spending Review will already be around 5-6% excluding the impact of the new Allocation Target. Therefore, if implemented there needs to be an appreciation of the size of challenge that any CCG can undertake within a one to five year period, thus suggesting a much longer term Pace of Change Policy would need to be adopted to enable any health economy to find its significantly revised new equilibrium.

We appreciate your consideration of the factors we have raised.

Yours sincerely



Nigel Gray
Chief Officer
NHS Leeds North CCG



Dr Andy Harris
Clinical Chief Officer
NHS Leeds South and East CCG



pp: **Philomena Corrigan**
Chief Officer
NHS Leeds West CCG

Sent on behalf of:
NHS Leeds North Clinical Commissioning Group
NHS Leeds South and East Clinical Commissioning Group
NHS Leeds West Clinical Commissioning Group

This page is intentionally left blank

Report of the Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 30 October 2013

Subject: **Care Quality Commission (CQC) hospital inspection programme: Intelligent Monitoring**

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Summary of main issues

- As part of its new hospital inspection programme, on 24 October 2013, the Care Quality Commission (CQC) announced details of a second phase of hospital inspections – due to commence in January 2014.
- The following 19 NHS trusts have been identified to be inspected using larger, expert teams that include professional and clinical staff and members of the public who use care:

From Band 1 (CQC intelligent monitoring)

- Aintree University Hospital NHS FT (North)
- Heatherwood and Wexham Park Hospitals NHS FT (South)
- Homerton University Hospital NHS FT (London)
- Leeds Teaching Hospital NHS Trust (North)
- Northampton General Hospital NHS Trust (Central)
- Royal Berkshire NHS FT (South)
- University Hospitals of Leicester NHS Trust (Central)

Foundation Trust aspirants

- Hull and East Yorkshire Hospitals NHS Trust (Band 2) (North)
- Oxford University Hospitals NHS Trust (Band 3) (South)
- Royal Cornwall Hospitals NHS Trust (Band 3) (South)
- St George's Healthcare NHS Trust (Band 6) (London)

Keogh inspection follow ups

- Basildon and Thurrock University Hospitals NHS FT (Band 1) (Central)
- Blackpool Teaching Hospitals NHS FT (Band 2) (North)
- Buckinghamshire Healthcare NHS Trust (Band 1) (South)
- Dudley Group NHS FT (Band 4) (Central)

Intermediate trusts

- East Kent Hospitals University NHS FT (Band 3) (South)
- Lewisham and Greenwich NHS Trust (Band 2) (London)
- Peterborough and Stamford Hospitals NHS FT (Band 6) (Central)
- University Hospitals of Morecambe Bay NHS FT (Band 5) (North)

3. The 19 NHS trusts have been identified/ selected for the second phase of inspections based on whether they scored highly using the CQC intelligent monitoring tool; are a foundation trust applicant that Monitor have requested CQC to inspect; or were previously investigated as part of the Keogh Mortality Review. Each of the 19 NHS trust will be given one of the following ratings:

- Outstanding
- Good
- Requiring improvement
- Inadequate

CQC's intelligent monitoring

4. The CQC's intelligent monitoring tool looks at 150 different indicators covering a range of information, including patient and staff experience and statistical measures of performance: The indicators have been selected to provide inspectors with a clear picture of the areas of care that need to be looked at in NHS acute trusts.
5. Together with local information from partners and the public, monitoring helps the CQC to decide when, where and what to inspect and will also help the CQC identify and respond more quickly to hospitals where there is a risk that people might not be receiving safe, effective, high quality care.
6. To help inform more detailed understanding, details of frequently asked questions (FAQs) relating to CQC's intelligent monitoring are attached at Appendix 1.

Hospital inspection programme

7. The first phase of inspections started in September 2013 and by December 2015, CQC will have inspected every NHS Trust in England. Each inspection will seek to answer the following five questions:
 - Are services safe;
 - Are services caring;
 - Are services effective;
 - Are services well-led; and,
 - Are services responsive to people's needs?
8. Inspectors will then make a judgement about the quality and safety of the care provided in each NHS Trust. The second phase of inspections will be the first to see NHS trusts given a rating from the CQC, with care rated as outstanding, good, requiring improvement or inadequate.

Leeds Teaching Hospitals NHS Trust (LTHT)

9. As detailed earlier in this report, LTHT has been identified as one of the 19 NHS Trusts to be inspected as part of the CQC's second phase of hospital inspections – due to commence in January 2014.
10. The CQC's intelligent monitoring report on LTHT (October 2013) is appended to this report.
11. Representatives from the CQC, LTHT and local commissioners have been invited to attend the meeting to address any questions identified by Members and assist the Scrutiny Board in its consideration of the details presented with this report.

Recommendations

12. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to consider the information presented and discussed at the meeting and determine what, if any, further action it wishes to take.

Background documents¹

13. None used

¹ The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

This page is intentionally left blank

Frequently asked questions

Intelligent Monitoring: NHS acute hospitals

Contents

1. What is CQC's Intelligent Monitoring?	2
2. How will CQC use this analysis?	2
3. How have the indicators been selected?	2
4. In the June 2013 consultation document you described 'tier 2' and 'tier 3' indicators. How do these fit with the intelligent monitoring tool?	2
5. Which data sources have been used?	3
6. How up to date are the datasets that you are using?	3
7. How often will the indicators be published and where?	3
8. Do you wait for the refreshed data to make decisions about inspections? What if there's a serious incident at a hospital?	3
9. How have you created the bands used to categorise trusts and how will you use these?	4
10. My local NHS trust is flagged as having a 'risk' or 'elevated risk' for a specific indicator. Is it safe?	4
11. Why are you using Dr Foster's hospital standardised mortality ratios (HSMRs)?	4
12. What's happened to the Quality and Risk Profiles (QRP)?	4

1. What is CQC’s Intelligent Monitoring?

The new Intelligent Monitoring tool has been developed to give our inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust or a specialist NHS trust. The system is built on a set of indicators that look at a range of information including patient experience, staff experience and performance. The indicators relate to the five key questions we will ask of all services: are they safe, effective, caring, responsive, and well-led?

2. How will CQC use this analysis?

CQC will use the indicators to raise questions about the quality of care, but we will not use them on their own to make final judgements. These judgements will always be based on a combination of what we find at inspection, intelligent monitoring analysis and local information from the trust and other organisations.

3. How have the indicators been selected?

The indicators are those that we consider to be the most important for monitoring risks to the quality of care in acute hospital services. We selected these indicators because they measure things that have a high impact on people and because they can alert us to changes in those areas. We have engaged and consulted, and we tested the indicator set with a wide range of stakeholders.

Our inspection programme will help us to refine the intelligence monitoring tool. For example, it will allow us to see whether trusts that don’t flag up with many concerns are judged to be good when we inspect, or whether trusts that appear to be concerning are better than we expect.

4. In the June 2013 consultation document you described ‘tier 2’ and ‘tier 3’ indicators. How do these fit with the intelligent monitoring tool?

Tier 2 indicators include a much wider range of intelligence which, on their own, may not trigger us into taking action. We will check them if the first set of indicators signals a concern, to help us understand the issues raised and decide what an inspection should focus on.

This set of indicators will be considered in the planning stage for inspection, and analyses of these indicators will feature in the data packs that are prepared for each inspection.

We are committed to improving the intelligent monitoring tool as we go, and we know, for example, that there are other aspects of quality that we cannot yet monitor because of limited national datasets. We described the developmental aspects of the model as ‘tier 3’ and we will continue to test new indicator sources.

5. Which data sources have been used?

We have created indicators using existing datasets that CQC can access or information that is submitted directly to CQC. Some of the main datasets that have been used include:

- Hospital Episode Statistics.
- Incidents reported to National Reporting and Learning System.
- 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.
- Staff concerns reported to CQC (whistleblowing information).

For a more detailed explanation of the data sources that we have used to generate these indicators, please refer to the document 'Indicators and methodology' on our [website](#).

6. How up to date are the datasets that you are using?

CQC uses the most up-to-date datasets that we can access. The time period varies depending on the dataset. For some indicators there is a time lag between the date the data was originally collected and the point at which the information is available to CQC, whereas for others we can have access to the data source within a week.

7. How often will the indicators be published and where?

The indicators will be published quarterly on CQC's website: www.cqc.org.uk/hospitalmonitoring.

8. Do you wait for the refreshed data to make decisions about inspections? What if there's a serious incident at a hospital?

We'll continue to carry out inspections whenever we have information that people might be at risk of poor care. Intelligent monitoring helps us to determine our programme of inspections.

If we had concerns that people were at risk, we would carry out an immediate inspection, outside of our planned programme.

9. How have you created the bands used to categorise trusts and how will you use these?

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

The bandings give CQC, and hospitals, a guide to the number of issues we need to look into in more depth. They should prompt hospitals to ask questions about their own performance in relation to others.

10. My local NHS trust is flagged as having a 'risk' or 'elevated risk' for a specific indicator. Is it safe?

The monitoring shows where there are issues we need to look into. It does not mean that people are at risk.

You should always consult your GP or other medical professional about your treatment options.

11. Why are you using Dr Foster's hospital standardised mortality ratios (HSMRs)?

We have included the hospital standardised mortality ratios (HSMRs) calculated by Dr Foster Intelligence because this is a publicly available indicator. CQC has a data sharing agreement with Dr Foster Intelligence to govern the exchange of this information.

12. What's happened to the Quality and Risk Profiles (QRP)?

We will no longer be producing QRPs for acute and specialist trusts. We will phase these out for other types of services over the next year.

Intelligent Monitoring Report

Report on

Leeds Teaching Hospitals NHS Trust

21 October 2013

Intelligent Monitoring: Report on 21 October 2013

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 we 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. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

What does this report contain?

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for Leeds Teaching Hospitals NHS Trust. We have analysed each indicator to identify two possible levels of risk.

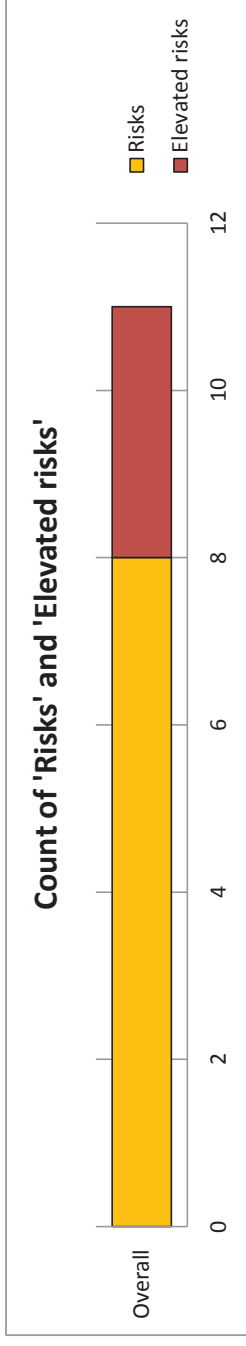
We have used a number of statistical tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include CUSUM and z scoring techniques. For some data sources we have applied a set of rules to the data as the basis for these thresholds - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

Further details of the analysis applied are explained in the accompanying guidance document.

What guidance is available?

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

Trust Summary



Band	1
Number of 'Risks'	8
Number of 'Elevated risks'	3
Overall Risk Score	14
Number of Applicable Indicators	85
Proportional Score	0.08
Maximum Possible Risk Score	170

Elevated risk	Incidence of Clostridium difficile (C.difficile)
Elevated risk	Whistleblowing alerts
Elevated risk	Serious Education Concerns
Risk	Never Event incidence
Risk	Potential under-reporting of patient safety incidents resulting in death or severe harm
Risk	Referral to treatment times under 18 weeks: admitted pathway
Risk	TDA - Escalation score
Risk	NHS Staff Survey - Percentage of staff who would recommend the trust as a place to work or receive treatment
Risk	NHS Staff Survey - KF9. Support from immediate managers
Risk	NHS Staff Survey - KF21. % reporting good communication between senior management and staff
Risk	Composite risk rating of ESR items relating to staff support/ supervision

Tier One Indicators

Section	ID	Indicators	Observed	Expected	Risk?
Never Events	STEISNE	Never Event incidence	-	-	Risk
Avoidable infections	CDIFF	Incidence of Clostridium difficile (C.difficile)	159	95	Elevated risk No evidence of risk
	MRSA	Incidence of Methicillin-resistant Staphylococcus aureus (MRSA)	7	6.77	
Deaths in low risk conditions	MORTLOWR	Dr. Foster: Deaths in low risk diagnosis groups	-	-	No evidence of risk
	NRLSL03	Proportion of reported patient safety incidents that are harmful	0.23	0.28	No evidence of risk
	NRLSL04	Potential under-reporting of patient safety incidents resulting in death or severe harm	0.5	1.49	Risk
Patient safety incidents	NRLSL05	Potential under-reporting of patient safety incidents	241.15	235.27	No evidence of risk
	VTERA03	Proportion of patients risk assessed for Venous Thromboembolism (VTE)	0.95	0.95	No evidence of risk
	SHMI01	Summary Hospital-level Mortality Indicator	Trust's mortality rate is 'As Expected'	-	No evidence of risk
Mortality: Trust Level	HSMR	Dr. Foster: Hospital Standardised Mortality Ratio	-	-	No evidence of risk
	HSMRWKDAY	Dr. Foster: Hospital Standardised Mortality Ratio (Weekday)	-	-	No evidence of risk
	HSMRWKEND	Dr. Foster: Hospital Standardised Mortality Ratio (Weekend)	-	-	No evidence of risk
	COM_CARDI	Composite indicator: In-hospital mortality - Cardiological conditions and procedures	-	-	No evidence of risk
Mortality	COM_CEREB	Composite indicator: In-hospital mortality - Cerebrovascular conditions	-	-	No evidence of risk
	COM_DERMA	Composite indicator: In-hospital mortality - Dermatological conditions	-	-	No evidence of risk
	COM_ENDOC	Composite indicator: In-hospital mortality - Endocrinological conditions	-	-	No evidence of risk
	COM_GASTR	Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures	-	-	No evidence of risk
	COM_GENIT	Composite indicator: In-hospital mortality - Genito-urinary conditions	-	-	No evidence of risk
	COM_HAEMA	Composite indicator: In-hospital mortality - Haematological conditions	-	-	No evidence of risk
	COM_INFEC	Composite indicator: In-hospital mortality - Infectious diseases	-	-	No evidence of risk
	COM_MENTA	Composite indicator: In-hospital mortality - Conditions associated with Mental health	-	-	No evidence of risk
	COM_MUSCU	Composite indicator: In-hospital mortality - Musculoskeletal conditions	-	-	No evidence of risk
	COM_NEPHR	Composite indicator: In-hospital mortality - Nephrological conditions	-	-	No evidence of risk
	COM_NEURO	Composite indicator: In-hospital mortality - Neurological conditions	-	-	No evidence of risk
	COM_PAEDI	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality	-	-	No evidence of risk
	COM_RESPI	Composite indicator: In-hospital mortality - Respiratory conditions and procedures	-	-	No evidence of risk
	COM_TRAUM	Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures	-	-	No evidence of risk
COM_VASCU	Composite indicator: In-hospital mortality - Vascular conditions and procedures	-	-	No evidence of risk	

Section	ID	Indicators	Observed	Expected	Risk?
Maternity and women's health	MATECCS	Maternity outlier alert: Elective Caesarean section	-	-	No evidence of risk
	MATEMERC	Maternity outlier alert: Emergency Caesarean section	-	-	No evidence of risk
	MATSEPSI	Maternity outlier alert: Puerperal sepsis and other puerperal infections	-	-	No evidence of risk
Re-admissions	MATMATRE	Maternity outlier alert: Maternal readmissions	-	-	No evidence of risk
	MATNFORE	Maternity outlier alert: Neonatal readmissions	-	-	No evidence of risk
	HESELRE	Emergency readmissions following an elective admission	2070	1992.56	No evidence of risk
	HESEMRE	Emergency readmissions following an emergency admission	7514	7728.16	No evidence of risk
PROMs	PROMS19	PROMs EQ-5D score: Groin Hernia Surgery	0.98	1	No evidence of risk
	PROMS20	PROMs EQ-5D score: Hip Replacement	1.03	1	No evidence of risk
	PROMS22	PROMs EQ-5D score: Knee Replacement	1.06	1	No evidence of risk
	PROMS24	PROMs EQ-5D score: Varicose Vein Surgery	1.72	1	No evidence of risk
Audit	NHFD01	The number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database.	0.43	0.6	No evidence of risk
	SINAP14	Key Indicator 1: Number of patients scanned within 1 hour of arrival at hospital	Not included	Not included	Not included
	SINAP15	Key Indicator 8: Number of potentially eligible patients thrombolysed	Not included	Not included	Not included
Surgical revisions outlier	SURGHIPREV	Surgical revisions outlier alert: Hip revisions	Not included	Not included	Not included
	SURGKNEREV	Surgical revisions outlier alert: Knee revisions	Not included	Not included	Not included
Compassionate care	IPSurTalkWor	Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?"	6.04	-	No evidence of risk
	IPSurSupEmot	Inpatient Survey 2012 Q35 "Do you feel you got enough emotional support from hospital staff during your stay?"	6.74	-	No evidence of risk
Meeting physical needs	IPSurHelpEat	Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?"	6.87	-	No evidence of risk
	IPSurInvDeci	Inpatient Survey 2012 Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?"	7.02	-	No evidence of risk
	IPSurCntPain	Inpatient Survey 2012 Q39 "Do you think the hospital staff did everything they could to help control your pain?"	8.05	-	No evidence of risk
Overall experience	IPSurOverall	Inpatient Survey 2012 Q68 "Overall..." (I had a very poor/good experience)	7.70	-	No evidence of risk
	FFTNHSEscore	NHS England inpatients score from Friends and Family Test	-	-	No evidence of risk
Treatment with dignity and respect	IPSurRspDign	Inpatient Survey 2012 Q67 "Overall, did you feel you were treated with respect and dignity while you were in the hospital?"	8.64	-	No evidence of risk
	IPSurConfDoc	Inpatient Survey 2012 Q25 "Did you have confidence and trust in the doctors treating you?"	8.80	-	No evidence of risk
Trusting relationships	IPSurConfNur	Inpatient Survey 2012 Q28 "Did you have confidence and trust in the nurses treating you?"	8.32	-	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Access measures	AD_A&E12	A&E waiting times more than 4 hours	0.02	0.05	No evidence of risk
	RTT_01	Referral to treatment times under 18 weeks: admitted pathway	0.84	0.9	Risk
	RTT_02	Referral to treatment times under 18 weeks: non-admitted pathway	0.94	0.95	No evidence of risk
	DIAG6WK01	Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test	0	0.01	No evidence of risk
	WT_CAN26	All cancers: 62 day wait for first treatment from urgent GP referral	0.85	0.85	No evidence of risk
	WT_CAN27	All cancers: 62 day wait for first treatment from NHS cancer screening referral	0.98	0.9	No evidence of risk
	WT_CAN22	All cancers: 31 day wait from diagnosis	0.98	0.96	No evidence of risk
	CND_OPS02	The proportion of patients whose operation was cancelled	0.01	0.01	No evidence of risk
	CND_OPS01	The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason	0.09	0.07	No evidence of risk
	AMBTURN06	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes	0.02	0.02	No evidence of risk
Discharge and Integration	DTC40	Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds	0.02	0.02	No evidence of risk
Reporting culture	NRLS14	Consistency of reporting to the National Reporting and Learning System (NRLS)	6 months of reporting	-	No evidence of risk
	SUSDQ	Data quality of trust returns to the HSCIC	-	-	No evidence of risk
	FFRESP02	Inpatients response rate from NHS England Friends and Family Test	0.34	0.26	No evidence of risk
Partners	MONITOR01	Monitor - Governance risk rating	Not included	Not included	Not included
	TDA01	TDA - Escalation score	4 Material issue	-	Risk
	NTS12	GMC National Training Survey – Trainee's overall satisfaction	Within Q2/IQR	-	No evidence of risk
Staff survey	STASURBG01	NHS Staff Survey - Percentage of staff who would recommend the trust as a place to work or receive treatment	0.55	0.64	Risk
	NHSSTAFF04	NHS Staff Survey - KF7. % staff appraised in last 12 months	0.74	0.82	No evidence of risk
	NHSSTAFF06	NHS Staff Survey - KF9. Support from immediate managers	0.59	0.65	Risk
	NHSSTAFF07	NHS Staff Survey - KF10. % staff receiving health and safety training in last 12 months	0.72	0.74	No evidence of risk
	NHSSTAFF11	NHS Staff Survey - KF15. Fairness and effectiveness of incident reporting procedures	0.6	0.63	No evidence of risk
	NHSSTAFF16	NHS Staff Survey - KF21. % reporting good communication between senior management and staff	0.18	0.27	Risk

Section	ID	Indicators	Observed	Expected	Risk?	
Staffing	ESRSIC	Composite risk rating of ESR items relating to staff sickness rates	-	-	No evidence of risk	
	ESRRReg	Composite risk rating of ESR items relating to staff registration	-	-	No evidence of risk	
	ESRTO	Composite risk rating of ESR items relating to staff turnover	-	-	No evidence of risk	
	ESRSTAB	Composite risk rating of ESR items relating to staff stability	-	-	No evidence of risk	
	ESRSUP	Composite risk rating of ESR items relating to staff support/ supervision	-	-	Risk	
	ESRSTAFF	Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy	-	-	No evidence of risk	
	FLUVACO1	Healthcare Worker Flu vaccination uptake	0.53	0.48	No evidence of risk	
	Qualitative intelligence	WHISTLEBLOW	Whistleblowing alerts	-	-	Elevated risk
		GMCconcerns	Serious Education Concerns	-	-	Elevated risk
Safeguarding		Safeguarding concerns	-	-	No evidence of risk	
SYE		Your Experience	-	-	No evidence of risk	
NHSchoices		NHS Choices	-	-	No evidence of risk	
P_OPINION		Patient Opinion	-	-	No evidence of risk	
CQC_COM		CQC complaints	-	-	No evidence of risk	
PROV_COM		Provider complaints	-	-	No evidence of risk	

Appendix of indicators used in the composite mortality indicators

Section	ID	Indicators	Risk?
Cardiological Conditions and Procedures	HESMORT24CU	In-hospital mortality: Cardiological conditions	No evidence of risk
	MORTAMI	Mortality outlier alert: Acute myocardial infarction	No evidence of risk
	MORTARRES	Mortality outlier alert: Cardiac arrest and ventricular fibrillation	No evidence of risk
	MORTCABGI	Mortality outlier alert: CABG (isolated first time)	No evidence of risk
	MORTCABGO	Mortality outlier alert: CABG (other)	No evidence of risk
	MORTCASUR	Mortality outlier alert: Adult cardiac surgery	No evidence of risk
	MORTCATH	Mortality outlier alert: Coronary atherosclerosis and other heart disease	No evidence of risk
	MORTCHF	Mortality outlier alert: Congestive heart failure; nonhypertensive	No evidence of risk
	MORTDYSRH	Mortality outlier alert: Cardiac dysrhythmias	No evidence of risk
	MORTHVD	Mortality outlier alert: Heart valve disorders	No evidence of risk
MORTPHD	Mortality outlier alert: Pulmonary heart disease	No evidence of risk	
Cerebrovascular Conditions	HESMORT21CU	In-hospital mortality: Cerebrovascular conditions	No evidence of risk
	MORTACD	Mortality outlier alert: Acute cerebrovascular disease	No evidence of risk
Dermatological Conditions	HESMORT35CU	In-hospital mortality: Dermatological conditions	No evidence of risk
	MORTSKINF	Mortality outlier alert: Skin and subcutaneous tissue infections	No evidence of risk
	MORTSKULC	Mortality outlier alert: Chronic ulcer of skin	No evidence of risk
Endocrinological Conditions	HESMORT29CU	In-hospital mortality: Endocrinological conditions	No evidence of risk
	MORTDIABWC	Mortality outlier alert: Diabetes mellitus with complications	No evidence of risk
	MORTDIABWOC	Mortality outlier alert: Diabetes mellitus without complications	No evidence of risk
	MORTFLUID	Mortality outlier alert: Fluid and electrolyte disorders	No evidence of risk

Section	ID	Indicators	Risk?	
Gastroenterological and Hepatological Conditions and Procedures	HESMORT27CU	In-hospital mortality: Gastroenterological and hepatological conditions	No evidence of risk	
	MORTALCLIV	Mortality outlier alert: Liver disease, alcohol-related	No evidence of risk	
	MORTBILIA	Mortality outlier alert: Biliary tract disease	No evidence of risk	
	MORTGASHAE	Mortality outlier alert: Gastrointestinal haemorrhage	No evidence of risk	
	MORTGASN	Mortality outlier alert: Noninfectious gastroenteritis	No evidence of risk	
	MORTINTOBS	Mortality outlier alert: Intestinal obstruction without hernia	No evidence of risk	
	MORTOGAS	Mortality outlier alert: Other gastrointestinal disorders	No evidence of risk	
	MORTOLIV	Mortality outlier alert: Other liver diseases	No evidence of risk	
	MORTOPJEJ	Mortality outlier alert: Operations on jejunum	No evidence of risk	
	MORTPERI	Mortality outlier alert: Peritonitis and intestinal abscess	No evidence of risk	
Genito-Urinary Conditions	MORTTEPBI	Mortality outlier alert: Therapeutic endoscopic procedures on biliary tract	No evidence of risk	
	MORTTEPLGI	Mortality outlier alert: Therapeutic endoscopic procedures on lower GI tract	No evidence of risk	
	MORTTEPUGI	Mortality outlier alert: Therapeutic endoscopic procedures on upper GI tract	No evidence of risk	
	MORTTOJI	Mortality outlier alert: Therapeutic operations on jejunum and ileum	No evidence of risk	
	HESMORT31CU	In-hospital mortality: Genito-urinary conditions	No evidence of risk	
	MORTUTI	Mortality outlier alert: Urinary tract infections	No evidence of risk	
	Haematological Conditions	HESMORT28CU	In-hospital mortality: Haematological conditions	No evidence of risk
		MORTDEFI	Mortality outlier alert: Deficiency and other anaemia	No evidence of risk
	Infectious Diseases	HESMORT26CU	In-hospital mortality: Infectious diseases	No evidence of risk
		MORTSEPT	Mortality outlier alert: Septicaemia (except in labour)	No evidence of risk
Conditions Associated With Mental Health	HESMORT33CU	In-hospital mortality: Conditions associated with Mental health	Not included	
	MORTSENI	Mortality outlier alert: Senility and organic mental disorders	No evidence of risk	
Musculoskeletal Conditions	HESMORT36CU	In-hospital mortality: Musculoskeletal conditions	No evidence of risk	
	MORTPATH	Mortality outlier alert: Pathological fracture	No evidence of risk	
	MORTSPON	Mortality outlier alert: Spondylosis, intervertebral disc disorders, other back problems	No evidence of risk	

Section	ID	Indicators	Risk?
Nephrological Conditions	HESMORT30CU	In-hospital mortality: Nephrological conditions	No evidence of risk
	MORTRENA	Mortality outlier alert: Acute and unspecified renal failure	No evidence of risk
	MORTRENC	Mortality outlier alert: Chronic renal failure	No evidence of risk
Neurological Conditions	HESMORT34CU	In-hospital mortality: Neurological conditions	No evidence of risk
	MORTEPIL	Mortality outlier alert: Epilepsy, convulsions	No evidence of risk
Paediatric and Congenital Disorders and Perinatal Mortality	HESMORT32CU	In-hospital mortality: Paediatric and congenital disorders	No evidence of risk
	MATPERIMOR	Maternity outlier alert: Perinatal mortality	No evidence of risk
Respiratory Conditions and Procedures	HESMORT25CU	In-hospital mortality: Respiratory conditions	No evidence of risk
	MORTASTHM	Mortality outlier alert: Asthma	No evidence of risk
	MORTBRONC	Mortality outlier alert: Acute bronchitis	No evidence of risk
	MORTCOPD	Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis	No evidence of risk
	MORTPLEU	Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse	No evidence of risk
	MORTPNEU	Mortality outlier alert: Pneumonia	No evidence of risk
Trauma and Orthopaedic Conditions	HESMORT37CU	In-hospital mortality: Trauma and orthopaedic conditions	No evidence of risk
	MORTCRAN	Mortality outlier alert: Craniotomy for trauma	No evidence of risk
	MORTFNOF	Mortality outlier alert: Fracture of neck of femur (hip)	No evidence of risk
	MORTHFREP	Mortality outlier alert: Head of femur replacement	No evidence of risk
	MORTHIPREP	Mortality outlier alert: Hip replacement	No evidence of risk
	MORTINTINJ	Mortality outlier alert: Intracranial injury	No evidence of risk
	MORTOFRA	Mortality outlier alert: Other fractures	No evidence of risk
	MORTREDFB	Mortality outlier alert: Reduction of fracture of bone	No evidence of risk
	MORTREDFBL	Mortality outlier alert: Reduction of fracture of bone (upper/lower limb)	No evidence of risk
	MORTREDFNOF	Mortality outlier alert: Reduction of fracture of neck of femur	No evidence of risk
MORTSHUN	Mortality outlier alert: Shunting for hydrocephalus	No evidence of risk	

Section	ID	Indicators	Risk?
Vascular Conditions and Procedures	HESMORT23CU	In-hospital mortality: Vascular conditions	No evidence of risk
	MORTAMPUT	Mortality outlier alert: Amputation of leg	No evidence of risk
	MORTANEUR	Mortality outlier alert: Aortic, peripheral, and visceral artery aneurysms	No evidence of risk
	MORTCLIP	Mortality outlier alert: Clip and coil aneurysms	No evidence of risk
	MORTOFB	Mortality outlier alert: Other femoral bypass	No evidence of risk
	MORTPVA	Mortality outlier alert: Peripheral and visceral atherosclerosis	No evidence of risk
	MORTREPAAA	Mortality outlier alert: Repair of abdominal aortic aneurysm (AAA)	No evidence of risk
	MORTTOFA	Mortality outlier alert: Transluminal operations on the femoral artery	No evidence of risk

This page is intentionally left blank