

Cross checking trusts' CSA declarations

Guidance notes on the cross checking process

Suggested audience: Chief executives, board members, trust stakeholders, heads of information, performance and corporate governance

1. Introduction

The Care Quality Commission (CQC) cross checks trusts' declarations of compliance with the core standards against a wide range of available information in order to target our inspection activity to where we estimate there is the greatest likelihood of undeclared non-compliance. The cross checking process is only applied to those standards with which a trust has declared compliance, either for the full year or by end of year.

The cross checking process is an effective and efficient way of targeting our inspection activity. In 2007/08 we qualified trusts' declarations for approximately 33% of standards selected for risk-based inspection, compared to 22% in our randomly selected inspections.

This guidance gives a brief introduction to the process of cross checking trusts' declarations, and explains how trusts and standards have been selected for inspection in 2008/09. Further details on the cross checking method are given in part five of the guide.

2. Cross checking declarations in 2008/09

The CQC aimed to use a wide range of existing sources of data to build up a profile of information for every NHS acute, mental health, ambulance trust and Primary Care Trust (PCT) provider and commissioner arm. Comparative analysis of this data was used to prioritise trusts for risk-based inspection.

It is important to recognise that **cross checking does not provide a judgement** as to whether a trust is compliant with a core standard. There are many reasons why a trust that raised concerns in cross checking data might legitimately declare compliance. The trust will have access to much better local sources of assurance than are available to the Commission at a national level, and will also have the benefit of the most up-to-date information. It might also be that, while a trust is not performing well compared with other trusts, they are still meeting the minimum needed to be compliant with a standard.

3. How were trusts selected for inspection?

3.1 Provider trusts

Two groups of provider trusts were selected for inspection:

1. Approximately 12.5% of acute and mental health trusts, PCT provider arms and one ambulance trust were selected for **risk-based inspection**. These were the trusts with the greatest number of core standards declared as compliant and cross checking assessed as having a **high likelihood of**

undeclared non-compliance, or where local information identified significant concerns around a trust's declared compliance with the standards

2. Approximately 7.5% of acute, mental health trusts, PCT provider arms and one ambulance trust were selected for an inspection using stratified random sampling, with approximately 7.5% of trusts selected in each CQC region. These trusts are referred to as the **random inspection group**

3.2 PCT Commissioners

This year the CQC is assessing PCT provider and commissioning functions separately against the core standards for the first time. Consistent with our approach to provider trusts, nine PCTs were selected for risk-based inspection of their commissioning arms, while nine were chosen via stratified random sampling, ensuring that one was selected in each of the CQC regions.

The method for selecting PCT commissioning arms for risk-based inspection was different from that used for provider trusts.

Declarations by PCT commissioners for all standards were cross checked. However, the CQC decided that standards reviewed at inspection of PCT commissioners should be chosen from the eight standards most closely linked to commissioning (C5a, C6, C7e, C17, C18, C22ac, C23 and C24). To this end, standards from these eight that had a high estimated likelihood of undeclared non-compliance were given greater weight in selecting **trusts** for risk-based inspection, i.e. a PCT commissioner with five standards with high estimated risk of undeclared non-compliance that were all in the eight standards listed above was a greater priority for inspection than a trust with five standards that were all outside these eight.

3.3 Further information on selection of trusts for random inspection

For both provider trusts and commissioners, the final selection of trusts in the random inspection group took place once the risk-based group had been identified and excluded from selection.

In line with our commitment to reduce the burden of regulation where appropriate, trusts that were selected for a random inspection in 2006/07 or 2007/08 were not eligible for a random inspection this year - these trusts remained eligible for a risk-based inspection. Trusts formed by merger in the last two years were not excluded from selection where previous random inspections had covered predecessor organisations.

In making our selection of trusts for random inspections we also considered the extent of other CQC activities. Any trust undergoing an investigation by the CQC was not eligible for a random inspection. Those trusts undergoing an initial consideration for investigation by CQC were eligible for selection.

For PCTs, selection of either a provider or commissioner arm for risk-based inspection meant that the other arm was not eligible for random inspection. Similarly, no PCT could be selected for random inspection of both its provider and commissioner arms.

4. How were standards selected for inspection?

The core standards framework is composed of 24 standards, with a total of 44 part-standards (referred to as standards henceforth). In previous years five standards have been reviewed in trusts selected for inspection. However this year the CQC decided that each inspection (in both providers and commissioners) should cover **four** standards. Scoring rules for the Annual Health Check (AHC) have been amended to reflect this change.

Any standard where a trust declared itself compliant by 31st March 2009 was eligible for selection for inspection. This includes standards with which a trust declared “not met” or “insufficient assurance” with the lapse(s) resolved by 31st March 2009.

4.1 Provider trusts

4.1.1 Risk-based inspection

For 2008/09 the CQC decided that all inspections of provider trusts should review at least one standard out of C1a, C1b, C4b and C5a. Where one or more of these standards was at high estimated risk of undeclared non-compliance, the standard with the highest risk score was chosen for inspection. Where none of the standards had a high estimated risk of undeclared non-compliance, one of the four was selected at random.*

A trust selected for risk-based inspection, may have several core standards assessed as having a high likelihood of undeclared non-compliance. The other three inspected core standards were those with the highest estimated likelihood of undeclared non-compliance. Standards declared “compliant” for the full year were prioritised for inspection over those with declared lapses resolved by 31st March 2009. It should be noted that more than one standard from C1a, C1b, C4b and C5a could be selected for inspection, should they be among those with the highest risk estimates.

In recognition of the ongoing programme of inspections of acute trusts monitoring compliance with the duties set out in the Hygiene Code, and the registration of provider trusts against the Hygiene Code registration requirement from 1st April 2009, no acute trust was eligible for risk-based inspection of C4a and C4c **except where:**

- Either the trust was found to be *not met* on five or more subduties of the Hygiene Code at their initial 2008/09 HCAI inspection
- Or the trust had conditions imposed on their registration against the Hygiene Code registration requirement

Acute trusts where these did not apply also had their risk of inspection on standard C21 reduced, reflecting the link between HCAI inspections and the element of this standard relating to cleanliness. Please see section 5.4.4 for more details.

* If a provider trust selected for risk-based inspection declared themselves to be non-compliant on C1a, C1b, C4b and C5a, none of these standards could be inspected. Instead, the four core standards with the highest likelihood of undeclared non-compliance were selected for inspection.

4.1.2 Random inspection

As for risk-based inspections, all random inspections of provider trusts should review at least one standard from C1a, C1b, C4b or C5a. For each inspected trust, one of these four standards was selected at random.**

It should be noted that more than one of these standards could be selected for inspection. The other three standards were chosen on a random basis from among the remaining eligible standards. For some standards there is little or no national data available to cross check trusts' declarations. These standards were weighted to increase their chances of selection.

Where a trust had received an inspection in 2007/08, any standard that was inspected and not qualified in 2007/08 was not eligible for random inspection in 2008/09.

In recognition of the ongoing programme of inspections monitoring compliance with the duties set out in the Hygiene Code, no acute trust was eligible for a random inspection of standards C4a or C4c. Please see section 5.4.4 for more details.

** In the event that a provider trust selected for random inspection declared themselves to be non-compliant on C1a, C1b, C4b and C5a ongoing into 2009/10, then none of these standards could be inspected. Instead, all four standards were selected at random from all eligible standards.

4.2 PCT Commissioners

4.2.1 Risk-based inspection

For PCT commissioning arms, four standards were selected for inspection from the eight standards most closely linked to commissioning (C5a, C6, C7e, C17, C18, C22ac, C23 and C24). The four inspected standards were those with the highest estimated likelihood of undeclared non-compliance.

4.2.2 Random inspection

For PCT commissioning arms the four standards selected for inspection were chosen on a random basis from the eight standards most closely linked to commissioning (C5a, C6, C7e, C17, C18, C22ac, C23 and C24).

Where a trust received an inspection in 2007/08, any standard that was inspected and not qualified in 2007/08 was not eligible for random inspection in 2008/09.

5. Cross Checking Process – Detailed Information

The process for cross checking trusts' declarations of compliance to core standards has five key stages. These stages are outlined below.

5.1 Identify sources of information relating to the core standards

The Care Quality Commission (CQC) aims to use as wide a range of existing sources of data as possible to build up a profile of information for every NHS acute, mental health, ambulance trust and PCT provider and commissioner arm. These profiles contain items of information measuring trusts' inputs, processes and outcomes relating to the Department of Health's core Standards for Better Health framework.

This year the CQC received data from more than 35 organisations, including the Information Centre for Health & Social Care (IC), Department of Health, Audit Commission, medical royal colleges, charities and other organisations with an interest in healthcare. We also used data collected by the CQC and its predecessors, including surveys of patients and staff and service reviews.

The profiles of trusts were also based on information collected locally about trusts. This included comments on trusts' declarations from third party stakeholders and information derived from the CQC's engagement with trusts and stakeholders. This qualitative information is sometimes referred to as **local intelligence** and is described further in section 5.3.3 below.

For 2008/09 the CQC continued to develop and refine both the process and information used. We are grateful for feedback from trusts on the information and analysis that we use, and made changes to a number of data items based on feedback from and discussion with trusts.

As a principle of cross checking, we use the most up-to-date information available at the time of our analysis (May 2009). Occasionally, certain data sources have been discontinued but are so relevant to cross checking that the most recent data available was used. It is recognised that these data may not be an up-to-date reflection of current performance and they are weighted less heavily in our analysis (see sections 5.5.1 and 5.5.2).

As well as national data sources and local intelligence, the CQC also used findings from the 2007/08 core standards assessment and findings from assessments by the NHS Litigation Authority (NHSLA) and PEAT to influence our selection of trusts and standards for inspection. We have also taken into account the outcomes of acute trusts' registration against the Hygiene Code, and findings from our programme of inspections in acute trusts monitoring compliance with the duties of the Hygiene Code. Further details on this are given in section 5.4.

5.2 Structure the items of information

Over 2,100 items of information were used in our cross checking analysis in 2008/09. Items may be constructed from a question in a staff or patient survey, an outcome measure from Hospital Episode Statistics (HES) etc.

These items were structured by mapping them to the relevant core standard(s). In some cases a single item of information was relevant to more than one standard. For some standards (e.g. C12 – research governance) there is no nationally collected data relating to trust performance.

For most standards all items of information were mapped against the standard and considered together. However, some standards are very broad with a large volume of relevant information. In order to improve our targeting, we structured the information relevant to some standards under a set of topics or modules. We mapped data items to these modules, and analysed each separately, before aggregating the results from each module to obtain an overall estimate of undeclared non-compliance for each standard.

Table 1 below shows the standards and sectors where we have done this, and the modules against which information was mapped:

Standard	Sector	Modules
C5a	Acute Trusts	Cardiac & Vascular Care
		Trauma & Orthopaedics
		Obstetrics & Gynaecology
		Paediatrics
		Appropriate & Effective Care
	PCTs (providers & commissioners)	Cancer Care
		Managing Health in the Community
		Appropriate & Effective Care
		Prescribing
		Mental Health
C9	All sectors	Cancer Care
		Information Governance
C18	Acute Trusts & PCTs	Data Quality
		Access to Services
		Equitable Access
		Infrastructure Accessibility
		Choice
C23	PCTs (providers & commissioners)	Waiting Times
		Cardiac & Vascular Conditions
		Basic Public Health
		Sexual Health
		Mental Health

Table 1: Standards and sectors where data was mapped against modules

5.3 Identify differences between trusts' observed results and expected performance

5.3.1 Analysis of quantitative and categorical items of information

The cross checking process uses a vast amount of information and brings together many different types of data. Each item was evaluated using the most appropriate analysis for that item. For each item of information, we assessed the difference between the observed result for a particular trust and an expected level of performance on a common scale. Further information on our analytic methods is given in a detailed statistical guide available via your trust profile report on our website.

The outcome of the analysis for each item is an “*oddness*” score which is a statistical measure of how far each trust's performance was from the expected level. The results are presented using the following categories:

Category	Description
Much worse than expected	The trust's performance is much worse than expected – roughly this equates to the trust being outside the 95% confidence interval
Worse than expected	The trust's performance is noticeably worse than expected – roughly this equates to the trust being outside the 90% confidence interval
Tending towards worse than expected	The trust's performance is somewhat worse than expectation, but not at a level that would mean the observation is notable on its own. However, a pattern of items appearing in this category will increase our estimate of the likelihood of undeclared non-compliance
Similar to expected	The trust's performance is broadly in line with expectation
Tending towards better than expected	The trust's performance is somewhat better than the expected level
Better than expected	The trust's performance is noticeably better than expectation – roughly this equates to the trust being outside the 90% confidence interval
Much better than expected	The trust's performance is much better than expected – roughly this equates to the trust being outside the 95% confidence interval

Our analysis methods take account of the possibility that a trust's results may be affected by chance variation. None of our methods penalise (or reward) trusts simply for being at the bottom (or top) of a list - they are designed to look for genuine differences from our expectation. It is entirely possible that all trusts will be performing similarly to expectation on a data item.

The expected level of performance against which a trust is compared can be calculated in several ways. For some items, trusts were compared against the national average of all trusts. In other cases - such as waiting times for example - an expected level of performance has been set down for trusts in government policies. For some data items we recognise that trusts' performance may be significantly influenced by factors beyond their control. In these cases, a trust may be compared to the average result of a group of similar organisations (see section 5.3.2 below).

At this stage each item is analysed on its own merits. However, we recognise that some items will be of greater importance than others. This was accounted for when the results of our analysis were combined to estimate the likelihood of non-compliance for each standard (see section 5.5 of this document).

5.3.2. Take account of local circumstances (the use of benchmarking groups and standardisation)

We recognise that performance on some data items is affected by factors beyond a trust's control, and in large part results maybe outside the scope of healthcare services to improve. In such cases we have ways of adjusting the analysis to present the fairest reflection of performance.

There are two main ways we use to achieve this. Either the 'raw' data for the trust are standardised (for example by age and sex) or we may set our expectation for that trust as the average performance of a group of other organisations with similar local circumstances (referred to as the 'benchmark group'). We use various benchmarking groups in our cross checking analysis, including deprivation, population turnover and estimated disease prevalence.

5.3.3 Use qualitative information about specific trusts - local intelligence

Trust profiles are also based on qualitative information collected locally about each trust. This year qualitative information sources included commentaries on trust declarations by:

- Local Involvement Networks (LINKs)
- Overviews & Scrutiny Committees (OSCs)
- Local Safeguarding Children Boards (LSCBs)
- Learning Disability Partnership Boards (LDPBs)
- Strategic Health Authorities (SHAs)
- Foundation Trust Boards of Governors

We also used information from a range of other sources including:

- Reports from the 2008/09 Audit Commission *Payment by Results* clinical coding audit
- Engage website
- Reports from Joint Area Reviews of services (JARS)
- Reports from inspections of Youth Offending Teams
- Reviews of commissioning of prison health services
- Reviews of commissioning and provision of services for people with learning disabilities
- Local intelligence from CQC assessors
- CQC Investigations & initial considerations

Positive information from local intelligence relating to a standard indicated that the trust was less likely to be at risk of non-compliance. Alternatively, negative comments indicated that the trust was more likely to be non-compliant. Again, further information on our analytic methods is given in a detailed statistical guide available via your trust profile report on our website.

Some local intelligence that is particularly important and of very high quality was given a greater weight when estimating the likelihood of undeclared non-compliance (see section 5.4.6).

5.4 Estimate modifiers

Most of the information used in cross-checking was processed as described in sections 5.3.1 and 5.3.3 above. However, the cross checking process also allows certain local intelligence and other information to have a much stronger effect on the overall estimate for a particular trust and standard.

We call these items “*estimate modifiers*”, and they come from these sources:

- Core Standards Assessment 2007/08 declarations of ongoing non-compliance and inspection outcomes
- Outcomes of registration against the Hygiene Code, and HCAI programme inspections (acute trusts only)
- Findings from NHS Litigation Authority (NHSLA) assessments against their Risk Management Standards (RMS)
- Findings from the 2009 Patient Environment Action Team (PEAT) assessments
- Local intelligence of particular importance and quality

Further information on each of these is given below. Each estimate modifier was given a numeric value, depending on its importance and link to the relevant core standard. Some estimate modifiers effectively trumped all other information used for cross checking and directly set the standard level estimate, while others only strongly influenced the final estimate when combined with the aggregate result from all of the general information items (as described in section 5.5.1).

5.4.1 Declarations & inspection outcomes from CSA 2007/08

The CQC used findings from the 2007/08 core standards assessment in cross checking declarations for 2008/09. These findings were used as follows:

- For trusts inspected in 2007/08 where a trust declared “*met*” for 2007/08 or declared lapses that were resolved by 31st March 2008, and the Healthcare Commission confirmed that the trust had evidence of compliance by 31st March 2008, the likelihood of risk-based inspection of the relevant standard(s) this year was reduced
- Where inspection in 2007/08 found that the trust did not have sufficient evidence of compliance by 31st March 2008 to support their declaration, this automatically put the standard at high risk of undeclared non-compliance in 2008/09
- Where a trust declared that it was ‘*not met*’ or had ‘*insufficient assurance*’ for a standard in 2007/08 continuing into 2008/09 this also automatically put the standard at high risk of undeclared non-compliance in 2008/09

5.4.2 NHS Litigation Authority (NHSLA) assessments

Last year the Healthcare Commission used the overall level achieved at NHSLA assessments against their Risk Management Standards (RMS) as sufficient evidence of assurance of compliance for certain standards.

Evaluation showed that this was not always appropriate, and so for 2008/09 the Care Quality Commission altered its approach to using NHSLA findings, which allowed the CQC to make greater use of this information, but in a way that is more appropriate.

For acute, ambulance, and mental health trusts, and PCT provider arms, we used NHSLA assessment findings in cross checking as follows:

- Information from NHS LA RMS assessments at level 2 or 3 have only been used in a positive way
- Findings were used at the level against which the trust was assessed, regardless of the overall level achieved
- Findings were used at criterion level, and individual NHS LA criteria were mapped to core standards
- When all criteria relevant to a core standard were assessed as met by NHS LA at level 2 or 3, the final risk estimate was significantly reduced
- In addition, achievement of level 2 or 3 overall reduced the final risk estimate for core standard C7ac
- Information from NHS LA assessments was used from all years when there has been a full (i.e. not a pilot) NHS LA RMS assessment programme. This means in acute trusts NHS LA results from 2007/2008 were used
- The impact of NHS LA findings on the final risk estimate took into account the year the NHS LA assessment occurred and the level that the trust was

assessed at. Assessments at level 3 in 2008/09 had the biggest impact on reducing the chances of inspection

It should be noted that NHSLA findings have also been used as items in cross checking, as described in section 5.3.1.

5.4.3 Patient Environment Action Team (PEAT) assessments

As with the NHSLA, last year the Healthcare Commission used findings from PEAT assessments as sufficient evidence of assurance of compliance for certain standards.

Following evaluation the CQC decided for 2008/09 to amend its approach to the use of PEAT information. This year we have not automatically excluded standards from selection for inspection on the basis of 2009 PEAT assessments. Instead findings have been used to modify the likelihood of risk-based inspection.

For all provider trusts, achievement of a score of *excellent* at all sites for Food in the 2009 PEAT assessment resulted in a significantly reduced risk of inspection on standards C15a and C15b. A similar process applied to C20b where trusts achieved a score of *excellent* at all sites for Privacy and Dignity, and C21 where trusts achieved a score of *excellent* at all sites for Environment. The reduction in the risk estimates was lower for C15a and C21, reflecting that only part of these standards are covered by the PEAT assessment.

5.4.4 Use of HCAI Inspection Findings

In recognition of the ongoing programme of inspections of acute trusts monitoring compliance with the duties set out in the Hygiene Code, 2008/09 inspection findings and outcome have been taken into account in cross checking declarations of compliance for acute trusts. CQC have also taken into account the outcome of registration of provider trusts against the Hygiene Code registration requirement from 1st April 2009.

No acute trust was eligible for a random inspection of standards C4a or C4c. Acute trusts were also excluded from the possibility of risk-based inspection on these standards **except where:**

- Either the trust was found to be *not met* on five or more subduties of the Hygiene Code at their initial 2008/09 HCAI inspection
- Or the trust had conditions imposed on their registration against the Hygiene Code registration requirement

Acute trusts who did not meet either of these conditions also had their risk of inspection on standard C21 reduced, reflecting the link between HCAI inspections and the element of this standard relating to cleanliness.

5.4.5 Late Declarations

Trusts who submitted their declaration against the core standards after the deadline of 12pm on 1st May 2009 had their likelihood of inspection on standard C7ac (clinical and corporate governance) increased, reflecting CQC concerns around governance in organisations who are unable to submit their declaration on time.

5.4.6 Sentinel Qualitative Intelligence

A small amount of the qualitative information that we receive (see section 5.3.3) is of particularly high quality and relevance to a trust's compliance with the core standards. This information, which can be either positive or negative about a trust's performance, comes from a range of sources including local intelligence from CQC assessors, commentaries from local stakeholders on trust declarations, and CQC investigation reports, amongst others.

This information was given a much higher weight than other qualitative data in cross checking trusts' declarations, and so had a much greater impact on the estimated likelihood of undeclared compliance.

5.5 Identify core standards with a high likelihood of undeclared non-compliance

The cross checking process was applied to all core standards with which a trust has declared compliance, including declared non-compliance or insufficient assurance resolved by 31st March 2009. Cross checking aims to assess the consistency between a trust's declaration of compliance with the information available to the CQC. To assess this consistency we combined our analyses of all information items mapped to each standard.

There are two key aspects of the way in which we bring the item information together:

- how do the trust's results compare with expectation?
- how confident are we in our assessment of the likelihood of undeclared non-compliance?

5.5.1 Calculate estimate of likelihood of undeclared non-compliance

For each item of information, we assessed whether the trust's result was in line with what we would expect, as outlined in section 5.3.1 above. The results for all items mapped to a core standard (including qualitative information) were then aggregated together, and combined with any estimate modifiers (see section 5.3.4). This produced an estimated likelihood of undeclared non-compliance with the core standard expressed as a numeric value.

In order to give greater weight to those items of information that are most closely related to the core standard or impact on the experience of patients, each item of information was weighted by scoring on two factors:

- **Patient Experience** - the degree to which an item impacts on, or reflects the *experiences of patients* using a three point scale (where 1 means it has a low impact on the patient experience, and 3 is high impact)
- **Causality** - how closely an item reflects the *intention of the core standard*, again using a three point scale (where 1 is least closely related, and 3 means the item is very well aligned with the standard)

Our method of combining the results from each item of information is not to calculate a simple average, but instead enables us to highlight patterns of poor performance. For example, a core standard may be assessed as being at high risk of undeclared non-compliance where several items of information are **worse** or **tending towards worse** than expected.

5.5.2 Consider our confidence in results

As well as estimating the likelihood of undeclared non-compliance with each core standard, it is important that we also take into account the volume and quality of information that was used to generate each likelihood estimate. This ensures that our inspection activity is targeted where we have sufficient evidence to produce a reliable assessment of the likelihood of undeclared non-compliance.

For each standard our confidence measure takes into account the quality of the items of information available for the trust, and the extent to which they reflect the intent of each core standard. These factors are measured as:

- **Causality** – as defined in section 5.5.1
- **Data Quality** – assessed against a number of measures, including how it was obtained (e.g. self-assessment is given lower weighting than information validated by inspection or other means), and the age of the data, on a three point scale (where 1 is low, 2 is average and 3 is high)

For each standard, our confidence score is based on the data quality and causality of items that are in line with the overall likelihood estimate. For example, on a standard where estimated a high likelihood of undeclared non-compliance, our confidence score was based on the data quality and causality of those items where performance was lower than expected.

Similarly, where cross checking estimated a low likelihood of undeclared non-compliance, the confidence score was based on the data quality and causality of those items where performance was better than expectation.

Therefore, for each standard we can state whether we have sufficient confidence in our estimate. These bandings loosely imply that:

- We believe that the information driving this estimate is strong enough to infer potential compliance status (**Adequate confidence**)
- The information driving this estimate is not of sufficient strength, volume or data quality to infer compliance status (**Inconclusive**)

It is important to note that a outcome of **Inconclusive** is not a comment on the performance of a trust, but is a reflection of the information available to the CQC relating to the trust on that core standard.

5.5.3 Selection of trusts and standards for inspection

In order to reduce the burden of inspection on trusts, we have targeted our inspection activity to where we have estimated the highest likelihood of non-compliance to core standards, and where we have adequate confidence in the estimates. This is described in section three of this guide.