Rosie Benneyworth, Chief Inspector of Primary Medical Services and Integrated Care, Care Quality Commission (CQC) – Written supplementary evidence (PSC0075)

I would like to thank you for the opportunity to speak to the committee about child vulnerability, and our role in regulating services that deliver care for children and young people.

We agreed to come back to the committee in writing to clarify two areas of our evidence; CQC's inspection processes in hospitals and specific outcomes for vulnerable children; and our thoughts on potential changes and additional powers that could assist us in responding to child vulnerability issues.

Hospital inspections and outcomes

As part of the full children and young people's core service inspection framework, we ask and inspect Patient outcomes as part of our "Effective" key lines of enquiries.

Areas we inspect include:

- Checking information about the outcomes of people's care and treatment (both physical and mental where appropriate) are routinely collected and monitored. This includes looking at national and internal audits, checking that the service has acted on the results and followed up on action plans as a result. Examples of audits may include, National Paediatric Diabetes Audit, Paediatric Intensive Care Audits (HQIP), surgery results.

- We check if outcomes compare to similar services and whether there has been any changes over time.

- We look at participation in relevant quality improvement initiatives, such as local and national clinical audits, benchmarking, (approved) accreditation schemes, peer review, research, trials and other quality improvement initiatives. We assess how relevant staff are involved in activities to monitor and use information to improve outcomes.

While physical inspections have reduced over the course of the current pandemic and have only taken place where there has been a risk identified, we have continued to monitor children and young people's services.

Monitoring takes place through continued engagement by our inspectors with the service. Where extra information is needed, we may sometimes request extra data or information. As part of ongoing monitoring, we also routinely collect and analyse outcomes related data. We have nine specific patient outcomes related indicators. Of these nine, there are five emergency admission and readmission indicators that are created using Hospital Episode Statistics (HES) data (NHS Digital data)[1]. We also receive routine audit data.

[1] Hospital Episode Statistics (HES) - NHS Digital

The table below details indicators related to children and young peoples' outcomes in acute hospitals. The table does not include indicators which have been paused due COVID-19 and/or are under development.

Source	**Indicator**
National Paediatric Diabetes Audit*	Case-mix adjusted mean HbA1c - HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year.
National Paediatric Diabetes Audit*	Median HbA1c - This measure is provided to give an indicator of how performance has changed between the previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant.
Paediatric Intensive Care Audit	Crude 48-hour emergency readmission ratio
Paediatric Intensive Care Audit	Risk-adjusted standardised mortality ratio

* National Paediatric Diabetes Audit context page

We also have access to Strategic Executive Information System (STEIS) serious incidents and complaints that contain outcomes related information.

We also conduct a biannual Children and young people's survey, the last survey had over 33,000 individual respondents. Children and young people up to the age of 15 who have been admitted to hospital as an inpatient, a planned day case, or an emergency patient who did not require an overnight stay were invited to complete the survey. These results help us understand the experience of children and young people in acute hospitals.

Additional powers

We think it's really important that children are included in our ICS assessments, should these form part of the current Health and Care Bill. We need to have the ability to look at all population groups and care of children across all settings, and the associated links (e.g. family and maternity) are very important. We also need to be able to look at transitions of care.

This aim is far wider than SEND and safeguarding. A significant proportion of people on the Urgent and Emergency Care pathway are children, there are elective care and cancer pathways as well as other conditions e.g. Type 1 diabetes or genetic problems that need a specific health focus. OFSTED do not have a remit to look at these issues.

As part of a case tracking approach, we may want to look at a child in a social care setting. For example, a child who has type 1 diabetes transitioning to an adult social care setting. We would be particularly interested in children in this context, as part of our focus on reducing health inequalities.

By taking this system-wide approach, we could identify and drive improvements for the following types of problems, for both adult and children's services:

- Instances where a provider might be impacted by wider system pressures e.g. poor commissioning decisions by an ICB or local authority;
- Instances where providers may not be working well together, leading to fragmented patient pathways and poor patient experience; and
- Instances where system leaders may not be meeting population needs (children are a key population group), either through being unaware of issues or poor resource management.

If the aim of the health and care legislation currently passing through the House of Commons is to be permissive, we are keen that our assessments are inclusive of key population groups when forming a conclusion about the ICS as a whole. We only currently look at children's residential services if the service is registered (i.e. they are delivering regulated health activities). It is important for us to avoid duplicating OFSTED's role, including looking specifically at children's social care, and have no plan to do so in the future. What is most important, and will deliver the best outcomes for children, is for partners (including CQC) within the system to work together and collaborate to meet the needs of the local population (including children), and how that impacts health outcomes. We want to build on the good relationships we have with OFSTED to continue to improve outcomes for children in all settings.

If you have any queries with regards to any of the above, please contact me

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