The new CQC approach to hospital inspection

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Our purpose and role

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care
We ask these questions of all services:

- Is it safe?
- Is it effective?
- Is it responsive?
- Is it caring?
- Is it well led?
The new CQC hospital inspection programme

• We recognise that the previous CQC approach was flawed – but it had good elements, in particular in relation to rigorous evidence gathering.
• We have built on the Keogh Reviews process for 14 acute hospitals with high mortality.
• We have brought together the best of both approaches (and more).
• We aim to be robust, fair, transparent and (hopefully) helpful.
The new approach: Acute hospital inspections

3 Phases:

• Preinspection: Selection of trusts
  Development of datapack
  Recruitment of team

• Inspection: 8 core services
  5 key questions
  Large team: Around 30 people.
  Visits to clinical areas + focus groups, listening events and interviews

• Post inspection: Report writing
  Confirmation of ratings
  Quality Summit
Selection of Trusts

• All trusts will be inspected by December 2015

• In the first wave, we deliberately chose some high risk, some low risk and some intermediate to assess our ‘Intelligent Monitoring’ tool and to assess the range of quality in English hospitals

• We are now prioritising ‘high risk’ trusts, but also assessing FT aspirants and some specialist trusts (e.g. children’s hospitals; orthopaedic)
Datapacks

• We collate as much information as possible on the 5 key questions and 8 core services

• Examples include:

  • Safety: STEIS; NRLS; infection rates; safety thermometer
  • Effectiveness: Mortality (HSMR/SHMI); National Clinical Audits
  • Caring: CQC Inpatient Survey; Friends + Family Test
  • Responsiveness: Waiting times; Cancellations; Discharges
  • Well led: Staff survey; Staff sickness rates
### CQC’s 5 key questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe?</td>
<td>Are people protected from abuse and avoidable harm?</td>
</tr>
<tr>
<td>Effective?</td>
<td>Does people’s care and treatment achieve good outcomes and promote a good quality of life, and is it evidence-based where possible?</td>
</tr>
<tr>
<td>Caring?</td>
<td>Do staff involve and treat people with compassion, kindness, dignity and respect?</td>
</tr>
<tr>
<td>Responsive?</td>
<td>Are services organised so that they meet people’s needs?</td>
</tr>
<tr>
<td>Well-led?</td>
<td>Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?</td>
</tr>
</tbody>
</table>
The following 8 core services will always be inspected:

1. A+E
2. Medical care, including frail elderly
3. Surgical care, including theatres
4. Critical care
5. Maternity and family planning
6. Children and young people
7. End of Life Care
8. Outpatients (selected)

We will also assess other services if there are concerns (e.g. from complaints or from focus groups).

The inspection team will split into subgroups to review individual areas, but whole team corroboration sessions are vital.
Inspection Teams

- Chair
- Team Leader
- Doctors (senior and junior)
- Nurses (senior and junior)
- AHPs/Managers
- Experts by experience (patients and carers)
- CQC Inspectors
- Analysts
- Programme management support

Total: Around 30 people
Rationale for ratings

• The public and patients want information about the quality of services presented in a way which is easy to understand.

• The approach taken by Ofsted is seen as a model, though we recognise that hospitals are more complex than schools. Patients/public may, for example, be interested in a particular service (e.g. maternity or frail elderly care) rather than a single global rating.

• Ratings of services and of Trusts should hopefully be a driver for improving services and patient outcomes.
Ratings: Approach (1)

• A four point scale will be used for all ratings
  • Outstanding
  • Good
  • Requires Improvement
  • Inadequate
• Ratings will always take account of all sources of information
  • Intelligent monitoring tool
  • Information provided by Trust
  • Other data sources
  • Findings from site visits
    • Direct observations
    • Staff focus groups
    • Patient and public listening events
    • Interviews with key people
Ratings: Approach (2)

- **Bottom up approach**: Rate each of the 8 core services on each of the five key questions (safe, effective, caring, responsive, well led).

- Then rate the Trust as a whole on the five key questions, including an overall assessment of well led at Trust level.

- Derive a final overall rating.

- **Note**: Where Trusts provide separate services (e.g. A+E or maternity) on different sites we will attempt to rate these separately.
### Ratings Grid

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>RI</td>
<td>NSE</td>
<td>G</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
</tr>
<tr>
<td>Medical care</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>RI</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Surgery</td>
<td>G</td>
<td>G</td>
<td>RI</td>
<td>RI</td>
<td>G</td>
<td>RI</td>
</tr>
<tr>
<td>Intensive/critical care</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>RI</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Maternity &amp; family planning</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Children's care</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>End of Life</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Outpatients</td>
<td>G</td>
<td>NSE</td>
<td>G</td>
<td>G</td>
<td>G</td>
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</tr>
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**Overall**

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<td>RI</td>
</tr>
</tbody>
</table>
Key Findings: General

- Compassionate care is alive and well in the NHS –

- We found a wide range of quality, **between** hospitals and **within** hospitals (between services)

- In some hospitals there was variation within a service. This was particularly noticeable where one or two medical wards were poor (especially care of elderly and ‘escalation wards’).
Key Findings: Staffing levels

- Most core services were adequately staffed

- Use of acuity or safer staffing tools was variable

- Shortages of staff were most frequent in A&E departments and medical wards

- Shortages occur for several reasons e.g. national shortages; local recruitment issues; maternity and sick leave
Key Findings: Flow

• Flow is now commonly used to describe the movement of patients through a hospital

• We observed hold ups at multiple steps
  • From A&E to acute medical unit (AMU)
  • From AMU to medical wards
  • From critical care to wards
  • From wards to discharge

• This results in medical ‘outliers’ on surgical wards, cancelled operations and multiple moves for patients – with impact on safety and patient experience

• Some trusts are tackling flow very actively
Key Findings: Culture

• Culture may be difficult to define but relatively easy to recognise.
• The staff survey and staff sickness levels give a good indication of culture, which can then be explored at focus groups.
• In several trusts we saw a truly open and learning culture, with very positive views from staff about the leadership of the trust – these trusts generally performed well across all or most of the core services.
• In contrast, we observed some trusts with a ‘them and us’ culture between clinicians and managers.
• Staff engagement programmes (e.g. Listening into Action) appeared to be changing the culture in some trusts.
Key Findings by core service

• A&E departments are (unsurprisingly) under the greatest strain, with poor staffing and inadequate facilities
• Critical care, maternity and children’s services were generally providing good care
• Outpatient care was often unresponsive to patients’ needs, with long waits
• Medical care and surgical care varied considerably
Assessment of effectiveness

- National comparative audits are of paramount importance to the assessment of effectiveness

- Some trusts find it surprisingly difficult to demonstrate their comparative effectiveness

- Critical care is a notable exception – almost all units can provide their ICNARC data on request

- Maternity services mostly have dashboards

- We are now working with Royal Colleges and professional associations and trusts to improve assessment of effectiveness in other core services
Interim findings on safety

- First 12 trusts in ‘Wave 2’ (January-March 2014)
- All reports have been published
- 21 locations with 4 or more core services

- Note: These trusts were largely selected on the basis of high risk, but also include some FT aspirants and Keogh trusts. They are NOT likely to be representative of trusts in England.
• We have now inspected over 50 acute trusts (30% of total)

• We have also started inspecting mental health and community health service trusts using the new methodology

• We still have a lot to learn. Our greatest challenges are credibility and consistency
Summary

• The new approach is a radical change
  - It is deliverable, but is very intensive
• Individual trusts have already made improvements as a result of these inspections
• We will assess value for money once we have reached steady state
• We are committed to continuous improvement