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# Healthcare improvement: enforcement or encouragement?

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The Care Quality Commission (CQC) was two years old at the end of March 2011. Much has happened in that time although, as a busy physician, you may not have been too concerned. The CQC is the regulator for health and adult social care in England. It has registered all NHS trusts, about 25,000 providers of adult social care and 12,500 independent sector providers. By 1 April 2011 it had registered all dental practices and private ambulance services and it is currently working on the registration of all general practices by April 2013. Part of the CQC's day-to-day work includes physically inspecting providers of services as part of either a planned review that takes place routinely every two years, or a responsive review where concerns have been raised. Why is this necessary and what difference does it make?

## Essential standards

Put simply, regulation is about ensuring that registered providers of care comply with essential standards of quality and safety.[1] (These standards are based on the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). This is necessary in order to reassure the public that basic levels of quality exist, and with the move to CQC regulation, for the first time these standards are the same whether care is provided in the NHS, the independent sector, healthcare or social care. The unification of standards is necessary as the UK has witnessed over the past few years a breakdown in the barriers between the NHS and the independent sector as some commissioners choose to contract away from the more usual providers. If the Health and Social Care Bill passes through parliament, this practice may become more common.

In what way does compliance with essential standards encourage improvement? It is almost certain that if all providers of care complied with these standards at all times then quality would improve. The CQC can and does apply conditions to the registration of some providers where evidence of non-compliance is found. These conditions are reviewed regularly and once inspectors are assured that standards are being met the conditions can be lifted. Should a provider persistently fail to comply then there are escalating statutory powers that may be applied – the ultimate one being closure. This would be an extreme measure and the CQC would need to consider the consequences of this action for patients or residents before closing a service. A preferable outcome is to work with the provider to ensure that they know what needs to be done and that appropriate action is taken to bring about the necessary improvements.

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## Outlier programme

Compliance with registration requirements is the main business of the CQC but there are many workstreams that support this. For example, a programme of work that has resulted in some publicity centres on the identification of outliers in relation to certain criteria.[2,3] The CQC began by looking at variation in standardised mortality rates for certain diagnosis and procedure groups based on the Healthcare Resource Group (HRG) on admission. This included a number of medical conditions, such as acute myocardial infarction, pneumonia, stroke and acute renal failure. Only those trusts where analysis has shown that mortality is persistently worse than expected over a period of time, and an alert is triggered, are analysed. Using other information from a wide variety of sources, including the CQC's own analysis of the hospital episode statistics (HES), a panel decides whether to contact the trust to seek an explanation. A case note review of a sample of 30 deaths is generally requested to determine whether there are processes that need to improve relating to the quality of care or if the reason for the alert relates to other matters. The alert is often said to be due to coding issues. Sometimes there has been a failure to code co-morbidities or 'the admission diagnosis was wrongly coded because the eventual diagnosis was different'.

These factors may change the status but they still require action on the part of the trust and maybe the doctors and others writing the notes need to be clearer or more accurate. Coders work on the basis of what they read. It is also important to realise that, to an extent, these coding differences are common so the comparator group, all other trusts in England, may still have a lower mortality rate. What can we learn from this?

This programme was started by the Healthcare Commission and has been running since August 2007. The majority of trusts have been contacted at some time. Most treat the matter very seriously and the quality of response is generally good. These responses, often led by the medical director, identify deficiencies in care that can often be dealt with easily. Plans are constructed with the involvement of all staff disciplines where necessary and timescales for their completion are defined with planned re-audits to assess the effect. This is quality improvement in action.

But this work may be deemed onerous by some. The tone of the response letter sometimes implies that the CQC's intervention is interfering with normal services and how could the Commission possibly believe that the trust's staff were not doing their best for their patients? The best way to respond in these circumstances is to supply anonymous examples of a good case note review and always ask questions rather than make accusations. Most trusts welcome the CQC's intervention as a means of

facilitating improvement, often involving their trust's board in any responses. After all, they are there to act as guardians of quality and probity.

This work programme now has a high profile within the CQC and is expanding its remit to include non-fatal outcomes. Various measures within maternity care are being observed and outliers for readmission after certain conditions are being analysed. Work is in hand to identify conditions that cross the CQC-regulated sectors. For example, admissions to hospital from nursing or care homes, of patients with pressure ulcers, medication errors or dehydration. The CQC is also keen to look at admissions to hospital for end-of-life care from nursing homes. Some of these admissions may not be in a patient's best interests and if the Commission can identify how common this is and where there are high numbers, it may be able to encourage a change in practice.

Being involved as physicians in this sort of improvement activity is a way of gathering supporting information for revalidation. The data that the CQC use are all available on HES.

## Quality and risk profiles

I have already mentioned the wide variety of sources from which the CQC obtains information about the quality of care a registered organisation provides. This comes from its own inspection processes; planned reviews that look at all registered activities at least twice-yearly or responsive reviews that occur in the interim, often in response to a concern focused on one or two activities. The Commission also relies on other regulators through information-sharing agreements, for example the NHS Litigation Authority, the National Patient Safety Agency, bodies that represent patients' interests, individual members of the public, and many others.

The CQC has recently developed a complex software programme that can collate all of this information and using a process of statistical weighting, can turn validated data into an indication of how the organisation is positioned in terms of compliance with regulated standards. This is called the quality and risk profile (QRP) and the organisation in which you work almost certainly has one. It is available now for trusts to access and, in time, the public will have access to it to a certain level once the Commission is confident of accuracy. One of the strengths of the QRP is that it can change from day to day so that it has the potential to provide patients, the public and even commissioners, with an indication of how well the organisation is performing and where it may need to focus more attention.

This addresses a fault of previous rating systems that were once-yearly snapshots of performance. For the QRP to be a success the CQC relies on receiving good quality information from any source provided it can be substantiated. It is hoped that information from the Royal College of Physicians (RCP) may be passed on to CQC where it is deemed appropriate. An example might be significant concerns about a trust's performance discovered as a result of issues raised with the RCP about training. Depending on the importance of the concern, findings of an invited service review may also have a bearing on a trust's compliance with essential standards and so should be reported to the CQC.

## The seven-day hospital

The CQC is working hard to make sure that people get better care. It takes note of important reports, such as that from the RCP which stated '…patients are still not getting the care they deserve at night and at weekends…'.[4] This report was based on a survey of 126 hospitals, 114 of which were in England. Nearly three-quarters of hospitals in the survey had no cover from consultant physicians specialising in acute medicine over the weekend. Does this matter? According to analysis by Dr Foster at Imperial College, people admitted in an emergency to English hospitals at the weekend have, on average, a seven per cent higher mortality rate than people admitted on a weekday.[5]

The CQC has to be realistic. It cannot demand that this matter is addressed immediately. However, it can ask questions about how this matter might be addressed and there is a statutory regulation that supports this and with which all trusts must comply.[1] It states that '[the registered provider]….must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity'. To deny that there is a problem here or to give in to its inevitability is to ensure that no improvement in this area will ever occur. Meanwhile, more than a quarter of those trusts surveyed are starting to address the problem. If efforts to comply with this regulation lead to increased senior cover then the UK can expect improved outcomes at weekends.

## Training

The CQC has no statutory remit for the quality of training. However, the environment in which training is delivered to professional staff is important. The Commission has a memorandum of understanding in place with the Nursing and Midwifery Council, the General Medical Council (GMC), Health Professions Council and others, specifically to ensure that information that is relevant to each other is exchanged when it is necessary to do so. For example, international medical graduates and UK graduates new to full registration with a licence to practise, or those returning to the medical register with a licence to practise after prolonged absence from UK practice, are required to work initially within an approved practice setting.[6] An approved practice setting is an organisation that has systems for the effective management of doctors, systems for identifying and acting upon concerns about doctors' fitness to practise, systems to support the provision of relevant training or continuing professional development, and systems for providing regulatory assurance. The GMC has worked closely with the CQC, the health departments and other quality assurance bodies in the UK's four countries to ensure that their criteria for approval are met.

## Conclusion

The CQC exists to ensure compliance with essential standards of quality and safety in England and so encourage improvement in health and adult social care. It relies heavily on information received not only through its own inspection processes but from partner organisations that share a responsibility for quality. The Commission can enforce change but it prefers to encourage improvement.

## References


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