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Monitor, the Care Quality Commission and the Future Hospital: the medical director's tale

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ABSTRACT

The Future Hospital Commission suggested a number of ways in which hospital and other services should evolve to meet the changing medical needs of the communities they serve. The Health and Social Care Act (and the requirement that places on the regulator, Monitor) focuses on the need for competition and tendering of services to drive up standards. The Care Quality Commission on the other hand, partly in response to well publicised shortcomings, has changed its inspection programme to focus on quality, and the centrality of well led co-ordinated patient care. This article describes the author's recent experience of a CQC inspection to his own hospital and some of the lessons learned. It is perhaps possible to align the goals of the CQC and their inspection teams with those of the organisation, to improve patient care in line with the Future Hospital recommendations.

KEYWORDS: Future Hospital, Care Quality Commission, Monitor, intelligent monitoring, CQC inspection

Introduction

The report of the Royal College of Physicians' Future Hospital Commission (FHC), published in September 2013, represents a laudable attempt to improve the care delivered to patients over the next two or more decades. However, it is important to understand the regulatory framework within which such changes will need to be made. Although there are a large number of bodies responsible for specific aspects of the regulation of individuals, groups of professionals and whole organisations within the nationalised and private health care sectors, the two principal bodies are the Care Quality Commission (CQC) and Monitor, hitherto the economic regulator. The CQC has recently changed its inspection process. This paper seeks to describe these changes and how they align with those of Monitor, and the aspirations of the FHC, from the perspective of the medical director of a recently CQC-inspected Trust, Homerton University Hospital NHS Foundation Trust in east London.

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The Future Hospital

The FHC report[1] suggests a number of changes to the way the healthcare system, and hospitals in particular, approach the needs of acutely unwell medical patients, particularly those with multiple comorbidities and the frail elderly. The report notes the evolution of the patient population that will drive this change. In particular, patients' needs are a consequence of increasing longevity and clinical and social complexity. While there are currently excellent models of care that fulfil aspects of this ambition, the hospital service as currently configured does not allow consistent delivery of the whole. It is obvious that in future services will have to be organised to respond to patients with multiple acute and chronic medical conditions, paying equal attention to mental health and well-being and social needs. The customary approach of focussing on specialist services relating to single organ illness will continue to be needed by some patients, but not the majority. Whether elderly care physicians, with their increasing outreach into the community, surgical and orthopaedic wards represent exemplars in this regard is arguable, in that acute, emergency and critical care physicians also provide aspects of such care. The priorities recommended in the report are as summarised in Box 1.

Moreover, while national bodies regulate healthcare provision in England, many decisions about how care is commissioned and delivered are being devolved more locally. How this balance between local decision making will address potential conflicts

Box 1. Care priorities identified by the Future Hospital Commission.[1]

- Safe, effective and compassionate medical care for all who need it as hospital inpatients
- High-quality care sustainable 24 hours a day, 7 days a week
- Continuity of care as the norm, with seamless care for all patients
- Stable medical teams that deliver both high-quality patient care and an effective environment in which to educate and train the next generation of doctors
- Effective relationships between medical and other health and social care teams
- An appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs
- Transfer of care arrangements that are realistic

with national priorities and standards remains to be seen, but crucial to this evolution are the roles of the CQC and Monitor.

Care Quality Commission

The CQC describes its function as ensuring that 'the care provided by hospitals, dentists, ambulances, care homes and home-care agencies meets government standards of quality and safety'.[2] It also sets out what patients can expect from healthcare providers registered with the CQC. These include being treated with respect, being involved in decision making and being told what is happening at every stage of treatment. The CQC are also responsible for ensuring that organisations provide safe care delivered by staff with the right skills to do their jobs properly. There is an expectation that healthcare providers will check, as a matter of routine, the quality of their services, whether funded through the NHS or privately. The CQC has three arms, dealing respectively with hospital services, primary care providers and mental and community care. The CQC has had a chequered history. Following a capability review in 2009 and the departure of its chief executive Cynthia Bower, to be replaced by David Behan and (in 2012) the appointment of David Prior as chair, radical alterations to its existing hospital inspection methodology were introduced. A chief inspector of hospitals, Professor Sir Mike Richards, a former oncologist and the first national cancer director, was appointed to oversee the process. The main drivers for change were the findings of the Francis Inquiry into failures of care at Mid-Staffordshire,[3] the 2013 Keogh Review[4] of hospitals with elevated adjusted mortality rates, and the Berwick Report,[5] which was a government-commissioned response to Francis with a particular emphasis on patient safety. It has become clear to all that a 'generic inspector' which defined the previous CQC model was less likely to identify deficiencies and excellence than inspectors hired for experience as providers or users of hospital services. This convergence between the thinking of the CQC and the FHC will be addressed later in the article.

Monitor

Monitor (www.monitor.gov.uk) was established as the financial and performance regulator for NHS Foundation Trusts (FTs) until the passage of the Health and Social Care Act 2012, when its functions were extended such that it became the regulator for health services in England. Its stated role is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. Its duties include ensuring that public sector providers are well led so that they can provide high quality care to local communities, that essential NHS services continue if a provider gets into difficulty, that the NHS payment system rewards quality and efficiency, and that choice and competition operate in the best interests of patients.

Organisations achieve FT status through a rigorous assessment process overseen by Monitor, following which they are awarded a licence.[6] All hospital trusts are required ultimately to become FTs or to be merged with or acquired by an FT. Until that time the NHS Trust Development Authority, which is required to consult Monitor, supports them in their attempts to comply with the relevant requirements and standards, both financial and clinical.

How Monitor's duties play out is not yet clear. It is currently a stated requirement of Monitor that it acts in the best interests of patients and uses competition only when that can be demonstrated to be in those interests. It is important however to understand the law governing these issues,[7] which is much less clear in this regard, barely mentioning services to patients. Instead it is almost entirely focussed on the requirements to have an open tendering process by commissioners, and on the rights of alternative providers. There is likely to be conflict in the future as, for example, community services and some services provided or commissioned by local authorities are put out to tender, as the law states they must. The only exceptions seem to be where there is no alternative provider or services cannot be improved, conditions unlikely to be met.

The new CQC hospital inspection

The intelligent monitoring report

The changes to the CQC inspection have recently been introduced and will continue to evolve. Inspections were initially piloted in three groups of hospitals, those adjudged to be at low, medium or high risk of compliance failure. This was Wave 1 of the new process. A report on the first wave of targeted CQC inspections has now been published.[8] The CQC have developed what they term an 'intelligent monitoring report' (IMR), which divides those inspected into six risk bands. The ranking takes into account variables such as avoidable infections; notifications of deaths, severe and moderate harm and abuse; reporting of so-called 'never events'; mortality rates in various health care areas; information from the patient and carer 'Your Experience Form' provided on the CQC website; feedback from patient and staff surveys; and, finally, complaints. This ranking is intended to guide inspectors towards areas that require closer scrutiny during hospital inspections and to give a sense of the urgency with which a visit is required. It is important to emphasise that this banding was not intended alone to judge quality of care. It will probably be refined as the inspection process develops and more accurate assessments of hospitals are made. Whatever the stated objectives of the CQC in developing its IRM, it has been represented in the press as a 'league table', with some Trusts being labelled as failures in some quarters of the media. From the few reports made public at the time of writing, there does appear to be a discrepancy between the assessment that emerges in the form of the IRM and the judgements made after a visit, with variations in both the positive and negative directions. No doubt this variance will be noted more widely, and will need to be acted upon.

This first stage of risk banding for hospitals assessed by the IRM then leads to subsequent, targeted inspections. It is anticipated that all hospitals within all risk bands will have had a formal inspection visit by 2015.

The three stages of inspection

The first stage of a hospital inspection is a request for information from the Trust to collate performance and quality data. This is substantial, comprising, for Homerton, over 250 megabytes of information. This is analysed, together with various other material gleaned from benchmarking (of the sort provided by various commercial organisations and which most organisations use internally), the Health and Social Care Information Centre, patient and staff surveys and a variety of national and local audits. The CQC conducts its own analysis

over and above that provided by the sources already noted and importantly, requests information about services the Trust is particularly proud of, and any that are giving cause for concern. It need hardly be emphasised that problem areas disclosed before the visit will be examined closely. Those discovered by the inspection team that have not been declared prior to the visit are likely to lead to significant adverse comment.

The second stage is the delivery approximately two weeks before the site visit of a report on the hospital based on the information obtained from these sources, the Pre-Inspection Data Pack. This can be challenged by the Trust on matters of fact. The data pack is substantial; in Homerton's case, it was over 100 pages long. The CQC estimate of the reading time (helpfully provided in the pack) is likely to be two to three hours. The report is divided into the five CQC performance domains, which ask if the services provided are safe, effective, caring, responsive and well led.

The final stage is the on-site inspection. This is carried out by a sizeable team (in Homerton's case over 30 individuals, but for some larger organisations in excess of 80 inspectors) from a variety of backgrounds. Some are clinicians (from diverse backgrounds), but many are patients (experts by experience) and managers. The important point to note is that the visiting team is experienced and credible and is provided with a pre-inspection briefing pack about the trust. Usually the first time most of the team will meet, however, is the day before the on-site visit. The first part of this on-site inspection is a forum to which patients and the public are invited. This allows feedback about the Trust from local users and residents, to which the Trust is quite rightly not invited.

The chief executive of the Trust being inspected is invited to deliver to the inspection team a presentation about the hospital, its services and areas of performance that should be looked at more closely, either because of excellence or concern.

The on-site inspection at Homerton lasted two days, but there were a further two visits carried out at unannounced times during weekends and nights. The areas covered were the accident and emergency department (A&E); medical care (including frail elderly); surgery; critical care; maternity; paediatrics; end of life care; and outpatients. Some cross-cutting themes such as safety in prescribing are also inspected. These services will be inspected consistently across all Trusts in future, although variations for those providing highly specialised services may emerge.

The inspection team uses a variety of interview techniques. A focus group approach is employed when seeing groups of junior doctors and student nurses, consultants, nurses and midwives, specialist nurses and administrative and clerical staff. A room may be requested to permit members of staff to 'drop in' to raise concerns. CQC 'comment boxes' are distributed in prominent positions around the hospital. The openness with which these sessions were conducted was in the author's experience exemplary, and all staff were encouraged to give a 'no holds barred' assessment of their own organisation. No senior managers were permitted to attend.

At the end of the visit informal feedback is provided but the formal written report may take some time to be delivered; in the case of Homerton, this was about 10 weeks after the visit. Again an opportunity is provided to comment on factual errors, but not on the interpretation. Judgement about the Trust banding is based on the five CQC domains (*vide supra*) and the eight physical areas covered. This gives a matrix of 40 variables, each of which is judged as outstanding, good, requires improvement or poor. An overall global indicator of hospital performance is produced based on this matrix, which is released publically shortly after a 'Quality Summit', at which the CQC report their findings back to the Trust. A summary of Homerton's ratings is given in Fig 1, and the full report is publically available.[9]

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Good	Not sufficient evidence to rate	Outstanding	Outstanding	Outstanding	Outstanding
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity	Good	Good	Good	Good	Good	Good
Children's services	Good	Good	Good	Good	Good	Good
End-of-life care	Good	Good	Good	Requires improvement	Good	Good
Outpatients	Good	Not sufficient evidence to rate	Good	Good	Good	Good

Key to CQC ratings

- Outstanding
- Good
- Requires improvement
- Inadequate
- Not sufficient evidence to rate

Fig 1. Example of CQC's system for awarding ratings. Summary of CQC's ratings for Homerton University Hospital NHS Foundation Trust.

Monitor, CQC and the Future Hospital

So how will the roles of the two regulators influence the aspirations of the Future Hospital? Despite the fine sentiments expressed by politicians and Monitor alike, it is clear that the law surrounding competition ('any qualified provider') may impede the ideal of collaborative working across conventional boundaries between acute and community healthcare and social care espoused by FHC. Thus, as written, the legal framework may not permit proceeding towards this service integration without tendering services. Specifically, achieving FHC priorities 3, 5, 6 and 7 (Box 1) may prove problematic.

However, continuity of (and seamless) care for all patients is an ideal worth pursuing. The Commission's report[1] recommends that this should be delivered across community, primary and acute care. This may fall foul of the requirements to put (particularly) community services out to tender, potentially leading to fragmentation when it is clear that integration is what patients prefer. Given recent reforms, effective relationships between medical and other health and social care teams may prove more problematic than anticipated. This is particularly so given the reductions in local authority budgets, on which effective social care delivery depends. In these circumstances satisfactory transfer of care arrangements may not be realistic.

The CQC is adopting a more constructive approach as part of the hospital inspection process, based on the needs of patients. Of course the main focus of the inspection team is inpatient care, but the CQC also has a requirement to assess community services. Those in Homerton have been assessed in the recent past, but separately from the hospital inspection. This separation of inspections should change over time and focus much more on how services are developed and delivered with the patient at the centre.

Many of the questions posed to senior managers during inspections are about how integration might be working and how such arrangements might be consolidated. The suggestion in the FHC report that patients should not be discharged in the conventional sense from hospital care, but instead remain under the care of the organisation, is appealing. It would clearly provide continuity of care and the CQC team visiting Homerton were interested in pursuing this aspect of services more actively. As the current inspection process stands, this is not easy. In time, as the process is reviewed, it could become a very powerful method for promoting such continuity of care. Thus, in contrast to what may be outlined in the legal processes governing competition, the CQC do genuinely scrutinise the extent to which patients feel well cared for.

Conclusion

Applying the recommendation of the FHC will be challenging and will impose upon physicians the requirement to change the way services are delivered. This will take time, effort and goodwill. It remains to be seen how Monitor will police the apparent conflict between acting in the best interests of patients and the requirement to operate within procurement law.[9] Whatever your views concerning the CQC inspection process as a means of delivering improvements in care, it seems to the author that the best way forward is to use this in a positive way to state clearly what the objective is in trying to change the way hospitals work. This might best be achieved by volunteering to become an inspector. ■

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