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Inspection as a driver for quality improvement

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ABSTRACT

Following publication in 2013 of the report by Robert Francis QC into care at the Mid Staffordshire Foundation Trust, the Care Quality Commission (CQC) has introduced a new and radically different approach to hospital inspection. This involves much larger teams (typically 30 or more people) including clinicians, experts by experience and CQC staff. Eight core services are assessed against five key questions (domains): Are services safe? Effective? Caring? Responsive to patients' needs? Well led? Each domain of each core service is rated on a four point scale: Outstanding, Good, Requires Improvement or Inadequate. To date 65 (40%) of the 160 acute trusts in England have been inspected, the aim being to inspect all trusts by December 2015. The most important single finding is the huge variation in quality of care that the inspection teams have identified within the NHS. Informal feedback suggests that the new approach to inspection represents a significant improvement on previous CQC inspections, though further improvement is imperative.

KEYWORDS: Care Quality Commission, hospital inspection, quality of care, ratings

Introduction

The reports by Robert Francis QC into care at the Mid Staffordshire Foundation Trust[1] laid bare shortcomings in the National Health Service and also the healthcare regulator. In recognition of this, the Care Quality Commission (CQC) made a commitment to change the way that it inspected health and social care.[2] Three chief inspectors have been appointed to lead the work in hospitals, primary medical services and adult social care.

The new style of inspections represents a radical change from the previous methodology. Moving away from inspecting individual aspects of care (eg medicines management or safety and suitability of premises), the CQC now aspires to inspect a healthcare provider as a whole. Moreover, rather than solely establishing and identifying problems, the CQC wants to be able to get under the skin of the organisation to understand its causes. Using the simple analogy of an unwell patient, it aims not only to determine that the patient has symptoms and signs, but also to be able to reach a diagnosis.

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The CQC's methodology

To do this, the CQC has built on the methodology developed for the 2013 review of 14 trusts in England with high mortality initiated by Sir Bruce Keogh, combining it with rigorous evidence collection already utilised by the CQC.[3] It seeks to assess five key questions, each related to a domain of quality:

- Is it safe (are people protected from harm)?
- Is it effective (do patients have good outcomes)?
- Is it caring (do staff look after people well)?
- Is it responsive (does the trust organise its services in a patient-centred manner)?
- Is it well led?

In acute trusts, eight core services have been defined that will always be inspected – accident and emergency, medicine, surgery, critical care, maternity, paediatrics, end-of-life care and outpatients – on the grounds that these either are high-risk areas or represent areas with large volumes of clinical activity.

A comprehensive assessment is now divided into three parts: the inspection itself and pre- and post-inspection phases. During the pre-inspection phase, intelligence is gathered from national data sources, the trust and stakeholders. The CQC's own intelligent monitoring system (which includes over 100 data items collated to assign a priority band for inspection) is combined with other sources of information to form a 'data pack' concerning the five domains of care.

A large team comprising clinical experts, laypeople, CQC inspectors and analysts is brought together to undertake the inspection over a 2- to 4-day period. A total of around 30 members might cover a medium-sized acute trust (Table 1).

Divided into subteams to represent each of the eight core services, members observe care being delivered, interview staff and patients, and analyse service level data to gain an understanding of the quality of care provided. Alongside this, focus groups are held with specific staff groups (including consultants and junior doctors), and interviews are undertaken with board and executive team members. In addition, a 'listening event' is held offsite with members of the public who are encouraged to provide their opinions on the standard of care provided by the trust. After completion of the announced inspection, all trusts receive an unannounced visit, most often conducted out of hours. Typically this involves three to four members of the original team and lasts only a few hours.

The rating of services represents another important addition to the methodology. A four-point scale identical to that used

Location 1

	Safe	Effective	Caring	Responsive	Well led	Overall
A&E	I	UA	G	I	RI	I
Medical care	G	G	G	RI	G	G
Surgery	RI	G	G	G	RI	RI
Intensive/critical care	G	G	G	G	G	G
Maternity and family planning	RI	G	RI	G	RI	RI
Children's care	RI	G	G	G	G	G
End-of-life care	G	G	G	G	G	G
Outpatients	G	UA	G	RI	G	G
Overall	RI	G	G	RI	RI	RI

Location 2

	Safe	Effective	Caring	Responsive	Well led	Overall
A&E	G	UA	G	RI	G	G
Medical care	G	G	G	G	G	G
Surgery	G	G	G	G	G	G
Intensive/critical care	O	G	G	G	O	G
Maternity and family planning	RI	G	G	G	G	G
Children's care	RI	G	G	RI	RI	RI
End-of-life care	G	G	G	G	G	G
Outpatients	G	UA	G	RI	G	G
Overall	RI	G	G	RI	G	RI

Trust

	Safe	Effective	Caring	Responsive	Well led
Provider level	RI			RI	G
Overall provider level rating	RI				

Key

O	Outstanding
G	Good
RI	Requires improvement
I	Inadequate
UA	Unassessable

Fig 1. Example of ratings for a trust with two locations. Note that at present we are not attributing a rating to the effective domain in accident and emergency departments or outpatients.

by Ofsted (the education regulator) is employed using the descriptors Outstanding, Good, Requires Improvement or Inadequate. It is recognised that hospital trusts are much larger and more complex than schools, and that patients and the public are interested in the quality of individual services. Ratings are therefore also ascribed at each hospital location, by domain, service and domain within the service. A single site trust therefore receives over 50 ratings in total. An example of ratings for a trust with two localities is shown in Fig 1.

The post-inspection phase consists of report writing, review by a national quality control group (NQCG) and a quality summit (QS). The NQCG, chaired by the chief inspector, aims to ensure consistency of rating and judgements. In the case of trusts for which the well-led domain is rated as inadequate,

Table 1. Typical composition of a team for inspection of a medium sized trust by the Care Quality Commission (CQC).

Number	Description
1	Team chair (senior clinician or healthcare leader)
1	Team leader (CQC head of hospital inspections)
3	Senior managers
5	Doctors (both junior and senior)
5	Nurses (representing a range of bands and a student)
5	CQC inspectors
5	Experts by experience (trained laypeople)
2–3	Analysts
1	Inspection planner
1	Recorder

the chief inspector decides whether to recommend to Monitor or the Trust Development Authority (TDA) (for foundation and non-foundation trusts, respectively) that special measures be initiated. This involves a range of actions to strengthen leadership and thereby drive quality improvement. Monitor/TDA will normally appoint an improvement director. A 'buddy' trust may also be identified to support the trust in special measures and, in some cases, some or all of the trust board may be changed.

The QS is held approximately two months after the main inspection, once the report has been checked by the trust for factual accuracy. The QS permits the CQC and trust representatives to meet together with other stakeholders to discuss the key findings and plan improvements if required. Although the prime responsibility for delivering improvement rests with the trust, others may have important roles to play.

Reflections on the new inspection system

At the time of writing, 65 trusts had undergone this new style of inspection – some 40% of England's 160. The most important single finding is the huge variation in quality of care that the inspection teams have identified. This is not limited to variation between hospitals, but has been detected both between and within services located in a single hospital site. Unsurprisingly, those services found to be working under the greatest strain are accident and emergency departments (A&Es), and gerontology and escalation (eg winter pressure) wards.

Although the 4-hour target is often seen as a measure of performance in A&Es, it also frequently provides a good measure of patient flow within the hospital. Thus, although many are under pressure, significant variation in the approach by trusts to alleviate this have been seen, and it is still not universally accepted that all other services have an important role in supporting flow through A&Es towards and on to discharge.

Staffing levels on most wards have appeared to be adequate, although recognised acuity tools to assess the required nursing establishment for individual wards are not universally in use. Although inspection teams have observed excellent provision of care in many services, where this breaks down it is almost without exception the result of inadequate staffing levels and/or poor local leadership.

The culture within an organisation is recognised as having a significant impact on the quality of care provided[3] and is assessed as part of the 'well-led' domain, through examination of the staff survey and the General Medical Council's national trainees' survey, corroborated with what is heard at staff focus groups. A wide variation in culture has been observed, from complete openness to discernable defensiveness. Thus, although some trusts display a culture of openness, learning and mutual support, others struggle with a 'them and us' approach, with clinicians perceiving that they are the sole guardians of quality and that managers are interested only in finance.

The inspections undertaken so far have been developmental, and changes to processes are being made in the light of experience. A formal external evaluation of the methodology has also been commissioned. The CQC acknowledges that there are still significant challenges to delivery of credible and reproducible judgements and ratings. To achieve this, consistency in data collection, inspection methodology and the judgements used for ratings is needed. This is helped by national benchmarks or standards, but these are not yet available or agreed across all areas, and in some (such as outpatients) they do not exist. The CQC has recently produced a provider handbook for consultation[4] and is keen to work with royal colleges and other professional organisations to define 'what good looks like' in other clinical areas. Ratings will inevitably require judgements to be made, especially across large subject areas such as medicine, eg how should medical care be rated when most wards are good but one or two are inadequate?

The credibility of the inspection is very dependent on the quality of the members of the inspection team. This is not just a case of having suitably senior team members (junior doctors and student nurses are also important), but ensuring that the training provided is of sufficient quality to equip clinical experts with the knowledge that they need. Although over 5,000 clinicians responded to the original call to 'join Mike's army', delays in recruitment has meant that only a small proportion has so far been able to be formally recruited. Both of these aspects need to improve quickly if this new style of inspection is to be sustainable going forward.

Informal feedback suggests that the new approach to inspection represents a significant improvement on previous CQC processes. However, the Commission is likely to face challenges, particularly when unfavourable ratings are awarded. Second, improving the processes further still is imperative. Finally, the CQC is committed to inspecting and rating all acute hospital trusts by December 2015, which will be a demanding target. Nevertheless, the potential rewards in improving patient care and the service that we provide should provide ample incentive to all of us. ■

References

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