The new CQC approach to hospital inspection

Inspection as a driver for quality improvement

November 2013

Our purpose and role

Our purpose

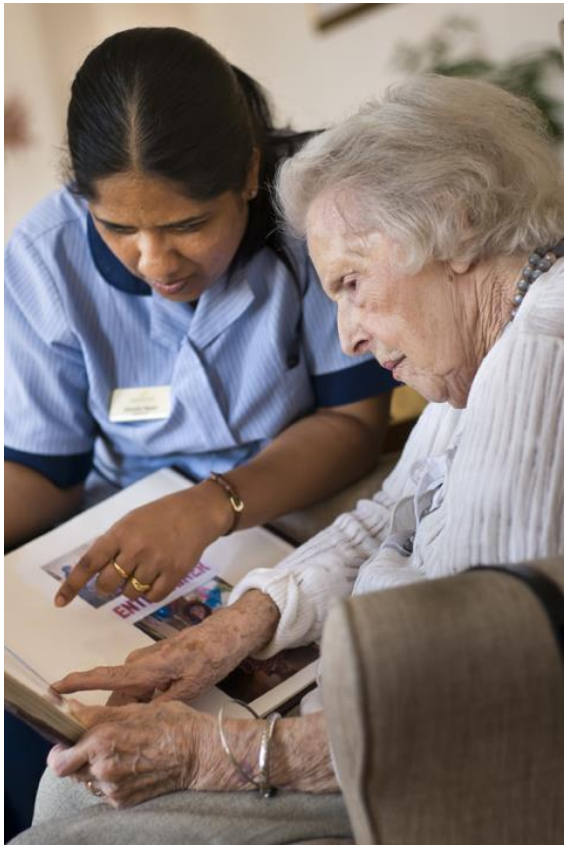
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

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

Asking the right questions about quality and safety

- Safe
- Effective
- Caring
- Responsive to people's needs
- 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 will build on the Keogh Reviews process for 14 acute hospitals with high mortality.
- We are aiming to bring together the best of both approaches (and more)
- We aim to be robust, fair, transparent and (hopefully) helpful.

The Chief Inspector of Hospitals' task

- To inspect all acute NHS hospital Trusts/FTs by December 2015.
- To assess whether a Trust is safe, effective, caring, responsive to patients' needs and well-led.
- To provide a rating on each Trust:

  Outstanding
  Good
  Requires improvement
  Inadequate

- To re-inspect when necessary and to undertake focused reviews in response to specific concerns.
- To extend the programme to include mental health, community service and ambulance trusts (and independent sector equivalents).

CQC's approach

- 3 phases:

1. Preparation
2. Site visits
3. Report

Phase 1: Preparation

- Development of a datapack combining
  - Intelligent Monitoring
    (Safety, effectiveness, caring, responsiveness, well-led)
  - Local data from the Trust
  - Data from other sources
    (e.g. CCG, NHS England, HEE, Healthwatch, Royal Colleges, GMC)
- Development of Key Lines of Enquiry (KLOEs)
- Recruitment of inspection team members

Phase 2: Site visits

- Announced and unannounced components
- Announced
  - Interviews: CEO, MD, DoN, COO, Chair + NEDs
  - Focus Groups: Doctors (senior/junior), nurses (registered/student), AHPs, Governors, admin + others
  - Patient and public listening event
  - Direct observation (e.g. wards, A+E, OPD)
- Unannounced visit – will pick up on issues identified at the announced visit.

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

Core services

- The following core services will always be inspected (as they carry the highest risk):
  - A+E
  - Emergency medical services, including frail elderly
  - Emergency surgical services, including theatres
  - Critical care
  - Maternity
  - Paediatrics
  - End of Life Care
  - 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

Specialist services

- We are aware that many services will not be routinely covered through these inspections e.g.
  - Diagnostics
  - Specialist services (e.g. ophthalmology, dermatology, renal)
- The current model will not be appropriate for assessing specialist Trusts (e.g. Alder Hey, Royal Marsden). Further work is in progress on this.
- Accreditation and peer review programmes will be vitally important. CQC will, in effect, ‘accredit’ accreditation programmes.

Rationale for ratings

- The public 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 improvement

Ratings: Proposed 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: Proposed 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: Proposed approach (3)

We will rate at:

- at location level for each domain for every acute core service provided;
- at location level for each acute core service;
- at trust level for each of the five domains;
- an overall trust level rating for all relevant core acute services.

	A&E	Maternity	Acute Medical	Acute Surgical	Critical Care	Paediatrics	End of Life Care	Out-patients
Safe								
Caring		Good						
Effective								
Responsive								
Well-led								
Overall								

Trust level				
Safe	Caring	Effective	Responsive	Well-led
	Good			

Overall trust level rating
Good

During Wave 2 we will be testing how we report at location (hospital level) and whether we will be rating at this level.

Safety

Data/Surveillance

- Never events
- Serious incidents
- Infections
- Safety thermometer
- Staff survey (selected items)

Direct observation

- Safe environment
- Safe equipment
- Safe medicines
- Safe staffing*
- Safe processes
- Safe handovers
- Safe information/records

Effectiveness

Data/Surveillance

- HSMR
- SHMI
- Mortality alerts
- National clinical audits

Direct observation

- Management of the deteriorating patient
- Care bundles
- Pathways of care

Caring

Data/Surveillance

- Inpatient survey
- Cancer patient survey
- Friends and Family Test

Direct observation

- Staff/patient interactions
- Comfort rounds
- Patient stories
- Response to buzzers

Responsive

Data/Surveillance

- Waiting time standards
- Cancelled operations
- Ambulance stays
- Analyses of complaints

Direct observation

- Patient reports
- Translation facilities
- ‘Comfort factors’

  (e.g. TVs, seating areas, rooms for parents)

Well-led

Data/Surveillance

- Staff survey (7 items)
- Staffing levels
- Sickness rates
- Flu vaccination rates
- Board minutes
- Quality governance minutes
- Mortality reviews
- Handling/learning from complaints
- Risk register

Direct observation

- Interviews (CEO, MD, DoN etc.)
- Focus groups
- Board/ward interactions
- Staff reports (e.g. of bullying)

Summary

1. The new approach to inspecting hospitals represents a radical change.

2. Quality will genuinely be at the heart of everything we do.

3. Please help us to shape the programme and join the inspection teams.