

FEATURE

STANDARDS OF CARE

Anatomy of a Care Quality Commission inspection

Gareth Iacobucci finds out what a hospital inspection is like

Gareth Iacobucci *news reporter, The BMJ, London, UK*

Following recommendations from Robert Francis's inquiry into failings at Mid Staffordshire foundation trust, England's healthcare regulator, the Care Quality Commission (CQC), has revamped its regime for inspecting NHS services. The CQC's predecessor, the Healthcare Commission, rated Mid-Staffordshire as good in 2007-08 despite high standardised mortality ratios. Clinicians and "experts by experience" such as patients are now included on larger inspection teams, while 15 essential standards for assessing services have been streamlined into five key areas: whether services are safe, effective, caring, well led, and responsive to people's needs. Services now receive an overall rating of outstanding, good, requires improvement, or inadequate, the same metrics used by the schools regulator Ofsted. The added expenditure of implementing the new regime means the average cost of inspecting an acute hospital is now £80 000-£150 000 (€100 000-€190 000; \$125 000-\$230 000) depending on its size. I recently shadowed an inspection team at Kettering General Hospital, a small acute trust in Northamptonshire, to see how the new process was working in practice.

Day "0" (2 September 2014)

The day before the official inspection begins, the team meet to discuss preparation.

The trust briefs the CQC team at 4 00 pm on issues that may be relevant over the course of the inspection. At 6 30 pm the CQC and trust host a listening event at the hospital, where members of the public are asked to offer feedback on their experience of services in the past 12 months. Around 35 people attend the event.

Day 1 (3 September)

The team assemble at 8 45 am. Lead inspector Fiona Allinson asks the team to look for any trust-wide problems that they spot such as lack of cleanliness or compliance with audits. The team divides into seven subteams of 5-6 people, each led by an inspection manager employed by CQC. The seven areas covered are urgent and emergency services, medical care (including older people's care), surgery, critical care, services for children

and young people, end of life care, and outpatients and diagnostic imaging.

Medical care

In the morning I shadow the medical care subteam led by Phil Terry, a CQC inspector. The subteam will inspect 12 medical wards over two days. The team holds a focus group with around seven nurses in a hall at the hospital. The nurses are asked about incident reporting, ward action plans, and staffing. They are asked to describe elements of care they are proud of and areas in which the trust could do better.

The team inspects acute medical wards, checking staffing levels, ratios, and sanitation. A discussion is held about patient mix on specific wards. The team asks about discharge procedures and how these are affected by social care.

Terry's self deprecating manner puts staff at ease. He speaks one to one with the ward matron before checking the cleanliness of the ward and the condition of the premises. He then speaks to junior staff—this often gives inspectors a completely different perspective, he says.

He later speaks to a consultant. Terry says corroboration is important and that inspection teams must be wary of any discrepancies between what is said by senior management and what is said by those on the ground.

Inspectors monitor whether patients are addressed by their name. Patients are asked about the standard of care they are receiving and whether they are being looked after by named staff and clinicians. They are asked whether they would recommend this hospital.

End of life care

In the afternoon I move to the end of life care subteam led by CQC inspector Fiona Collier.

The team checks the records and talks to nurses and patients as we visit a ward and the trust's 24 bed stroke unit. The team also asks about care pathways, mindful that what happens outside hospital can impact on what goes on within it.

Nurses are asked to describe how the ward is run, to detail any serious incidents that have taken place, and how staff respond to individual situations.

Team member David Smithard, a consultant geriatrician and stroke physician, talks to the medical registrar and other staff, while Colin Hill, an expert by experience who is a patient representing Age UK, speaks to patients.

Smithard is calm when talking to staff, as if he's talking to a patient. "I can imagine it's quite intimidating for staff to see us coming," he says. "If you're a clinician, you've got to think back to your own work." Smithard knows exactly where to look when analysing records. He asks questions about ward rounds, how often consultants come round, and levels of experience.

The subteams reconvene at 4 00 pm. Inspection chair, Kathy McClean, leads the discussion. Whereas the lead inspector is typically a CQC employed inspector, the chair is appointed from an outside organisation to oversee the inspection. McClean's day job is medical director at the NHS Trust Development Authority. Each subteam is asked to give two good things they identified, two bad things they identified, and a provisional rating for their department. There is some disagreement between members of the inspection team on specific elements. Allinson encourages the team to think of overall messages. It is her job to arrive at a judgment on whether the issues raised are isolated or endemic across the trust.

Day 2 (4 September)

I spend the morning with the surgery subteam led by CQC inspector Ernie Botley. The team begins by inspecting an ophthalmology ward. Discussions take place about the layout of the ward and how it affects care, preassessment, staffing, and infection control. Staff are also asked about how different procedures are carried out.

Consultant member Mo Adiseshiah talks to doctors, while Botley speaks to patients and nursing staff in groups and one to one. People are offered opportunities to raise issues in private if they prefer. Staff are asked for examples of how patients are treated with confidentiality and dignity. Issues like room temperature, medications storage, and record keeping are also discussed.

A staff leader tells me how she prepared the team for the inspection, "I said be honest, don't get stressed. It is daunting, but these things need to be done."

One staff member mischievously pulls a face after being questioned—more as an outpouring of relief than a lack of respect.

The team move on to inspect a surgical ward. Staff are asked to describe what's happening on the ward to give the team an overview. The discussion then turns to how incidents are investigated and remedied, audits, and escalation processes.

The subteam holds a small focus group with staff from the surgical ward. They are asked what training they have received on dementia and the trust's overall attitude to dementia.

The team checks on the consistency of its findings from ward to ward. This helps build up an overall picture of the trust and identify whether what is found on one ward is typical of the whole organisation.

We see lots of cleaners on the ward. The team discusses whether this is for the benefit of the inspectors or a typical situation.

In the afternoon I shadow Peter Quick, an emergency department nurse who is part of the emergency care subteam. Quick is corroborating the team's findings from day 1. He re-examines the layout and the bed vacancies in the department. Just to show that CQC inspectors aren't the ogres some fear, Quick carries a woman's baby through the doors of the emergency department as she struggles with her bags . . . all part of the service.

The subteams reassemble for the closing deliberations at 3 20 pm. Condensing the findings is a challenge, and the team is conscious that ratings can be used crudely. The phrase "look at the words not the rating" is heard more than once. The team is asked to focus on trust wide themes that can be conveyed back to the board. They then produce the rating and key messages to give to the trust.

Quality summit (18 November)

Two months after the inspection the CQC holds a meeting as a precursor to the publication of the final inspection on 25 November 2014. It is attended by senior trust board members and staff, the foundation hospital trust regulator Monitor, the heads of the local clinical commissioning group (CCG), a local government representative and a patient representative from consumer group Healthwatch.

Allinson leads the first part of the session, outlining the report's headline findings. After the floor is opened for questions, the trust is given time to respond. The CQC displays a willingness to alter some isolated lines in the report after the trust and CCG raise concerns that some words may be misinterpreted by local media and patients.

Monitor then runs through the "must dos," "should dos," and "next steps" that the trust needs to take to ensure it meets its regulatory requirements.

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Participants' perspectives

Fiona Allinson, lead inspector

Previously I would take around 4-8 people into a trust and spend two to three days there. Here, there are 36 people. Bringing together doctors, nurses, and inspectors gives proportionality that perhaps we haven't had before. The process is much more robust. Equally, we are looking at patient experience and the good things we can highlight that other trusts can learn from. We also look at how open and well led a trust is as that filters all the way through an organisation and affects the culture.

Doctors bring a great wealth of experience. Because they live and breathe audits in their own area, they are able to interpret the data on a much more detailed level than a pure analyst. Because they're used to problem solving, they tend to look at the bigger picture. They can draw those things together a lot easier than other people.

Before, one person wrote the whole trust report. Now ownership lies with the inspectors and it is everyone's report. That can be difficult if two members of the team give very different viewpoints, but generally those get ironed out throughout the inspection. We also involve other key stakeholders a lot more now.

Dhaneesha Senaratne, foundation stage 2 doctor and member of medicines subteam

Within our team there are three with clinical experience and three with non clinical experience. I bring information about things like suitable documentation, suitable interventions, and how efficacious treatments are. I have less experience of working in hospitals than the other two clinicians in the subteam, but what I can do is get access to and speak to junior doctors. When you tell them you're from the CQC, junior doctors are understandably a bit nervous. When you explain that you're just another F2 doctor and you normally work in a different hospital, it allows you to have a frank conversation. If it's from another doctor on your level, you're more willing to have that conversation. A few people expressed surprise that they involve junior doctors on the team and some were interested in doing it themselves. I never did any inspections under the old system. But I can't imagine how five or six people could possibly represent what's going on in a trust. With 30-40 people here it's still quite hard to accurately represent all of the areas.

David Sissling, chief executive of Kettering General Hospital NHS Foundation Trust

The mixture of clinicians and non clinicians gave them a very strong sense of credibility. The mixture of data, observation, intelligence and interviews followed up by some announced visits hopefully allowed the team to get a fairly rounded picture of the trust.

The staff found the inspectors approachable and receptive to the comments they received. Naturally some were perhaps a bit apprehensive about people descending on us but they found the experience quite developmental.

I think [inspection] provides a degree of reassurance and confidence in the eyes of the public, and an opportunity for organisations to supplement what they should be doing routinely. I wouldn't say it's a distraction from our core business. It's also an opportunity to test yourself against best practice and understand that it's not just about identifying the below the line issues, the goal should be to drive towards the "outstanding" category.