

Our new approach to the inspection of NHS acute hospitals

Initial findings from the Wave 1 pilot inspections

March 2014

Contents

Foreword	3
Summary	5
1. Our initial findings about provider quality	8
The overall picture	8
Cross-cutting issues	8
The five questions we ask of all services	11
The core services	18
2. Our new approach	20
Developing the new approach	20
Selecting the trusts	20
Methodology	21
Pre-inspection: preparation and planning	22
Inspection: site visits	24
Post-inspection: Reporting and Quality Summit	26
Rating	27
What we will be doing differently	28
Acknowledgements	34
Appendices	
1: Trusts and hospitals inspected in Wave 1	35
2: List of inspection team chairs	36
3: Shadow ratings	37

Foreword



I joined CQC as the first Chief Inspector of Hospitals to spearhead a more specialist, expert and risk-based approach to hospital inspection, leading teams of specialist inspectors and clinical and patient experts to carry out inspections.

The Francis report into the events at Mid Staffordshire shone a light on the failure to protect patients from unacceptable care. In July 2013, we set out our plans to begin to change the way we inspect NHS acute hospitals – moving from generic to specialist inspection, and from simple statements of compliance with standards to detailed judgement about services, including ratings. The new Care Bill will introduce a single failure regime for hospital trusts to provide a clear and coordinated regulatory approach to identifying and dealing with failures of quality.

Acute hospitals are hugely complex organisations. As Mid Staffs illustrated, they are capable of having both good and unacceptable services within the same trust. The previous CQC approach to inspections, which focused on the detail of regulations and not a thorough assessment of quality across the hospital, did not do justice to this. It was not particularly helpful to the public and did not encourage excellence among NHS trusts.

However it did have good elements, especially around rigorous gathering of evidence. Our new approach maintains this, but also builds on the 2013 reviews into NHS trusts with high mortality ratios, led by Professor Sir Bruce Keogh. Our new approach aims to provide an in-depth commentary on the core services that patients use most often and a meaningful understanding of the quality of care across a trust. And it will aim to answer the questions that we intend to ask of all the services we regulate: are they safe, effective, caring, responsive to people's needs and well-led?

In this report we summarise at a high level what we have learned so far about our new approach, through our first 'Wave 1' pilot of 18 NHS trusts. Wave 1 was a proof of concept pilot designed to test the new approach, including introducing methods as we develop them with the sector. We are committed to continuous learning and improvement and we have commissioned a formal independent evaluation from Manchester Business School and the King's Fund, led by MBS's Professor Kieran Walshe. We will use his findings to develop our understanding.

I personally attended at least one day at all of the 18 inspections. What is clear to me is that inspections work and that we can be confident we are heading in the right direction with our new approach. With just these first few inspections, we have been able to reveal differences in the quality of care between trusts, within trusts and even within a single service in a trust.

With a focus on more specialist, expert inspection, we are finding out much more about the sector than we ever did before. We're getting down to a level of detail that is relevant to the public, providers and professionals. By sending surgeons in to operating departments, intensivists into critical care departments, midwives and obstetricians into maternity units, our new reports have a much greater level of insight and analysis. And by using more Experts by Experience (members of the public with experience of receiving hospital care) on inspections, we are bringing more focus to bear on patients' views and experiences in each hospital.

It means we can both target poor practice and encourage good practice that should result in real, on the ground improvements. We will be back to check that the poor care we have uncovered so far has been addressed.

We acknowledge that we're not getting it completely right as yet, and we have still a lot to learn. We are evolving this new approach all the time in conjunction with the sector, and using the learning we have gathered to refine the process. We will be formally consulting with the acute hospital sector in April about the details of the new approach.

A handwritten signature in black ink, appearing to read 'Mike Richards', followed by a vertical line.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary

This report is a high level overview of what we have learned so far about our new approach to regulating and inspecting NHS acute hospitals, following the completion of our Wave 1 pilot inspections of 18 trusts.

We are strongly committed to learning and continuous improvement, which we are doing all the time. The report covers our initial findings both about provider quality and our new approach and processes. It includes the challenges that we have already identified. We will build on these through the evaluation that we have commissioned from Manchester Business School and the King's Fund, led by MBS's Professor Kieran Walshe.

Our initial findings about provider quality

It is clear from what our larger, more specialist inspection teams heard and saw that there are many positives for NHS staff and the public to be proud of:

- **Compassionate care is alive and well in the NHS.** In every trust and hospital involved in Wave 1, we found care and compassion among frontline staff, and a strong commitment to the NHS. Time and again we met and talked to dedicated staff working very hard under sometimes difficult circumstances, and we saw many examples of high quality care.
- **Critical care services were delivering high quality, compassionate care.** And what's more, they were able to show us how they monitored quality – unlike most other services, they were almost universally able to provide us with comparative clinical audit data.
- **Maternity services were also generally providing good quality care, and were good at monitoring their effectiveness.** Almost all maternity units were using performance dashboards that helped them understand their comparative performance against quality indicators.
- **Many of the trusts were making a determined effort to improve care for patients with dementia.** Several had created dedicated wards, with staff specifically trained in the needs of people with dementia. Some had created systems and pathways to identify patients with dementia so that they could give them the right level of specialist care.

We also found marked variations in quality:

- There was a wide range of quality **between hospitals**: some were good or outstanding throughout, others had a number of poor quality services.
- In several hospitals there were marked variations **between services** – for example high quality maternity care but poor A&E services, and vice versa.
- In some hospitals there was variation **within a service**. This was particularly noticeable where one or two of the medical wards (especially in care of the elderly wards and on 'escalation' wards) were poor – what we call 'worry wards' – while others were good.

The 'shadow' ratings exercise that we piloted in three of the trusts (see appendix 3) illustrate some of the variations in quality that we found.

There were some general areas for concern that providers, commissioners and national bodies such as the NHS Trust Development Authority and Monitor all need to be aware of and act on:

- **A&E departments are under the greatest strain.** Some haven't adapted to increased volumes of patients, which is leading to overcrowding, long waiting times and staff shortages at times. Often though it is the flow of patients through the hospital that is the critical factor. We have seen some trusts that are tackling this issue very actively, and other trusts need to learn from them.
- **Most services don't know whether they are effective or not.** With the notable exceptions of critical care units and maternity, few services appear to be aware of, or to be able to demonstrate, their comparative effectiveness on national clinical audits. There needs to be much better use of data and most services need to be much better at using audits.
- **Outpatient services were poor across the Wave 1 inspections.** More than two thirds of outpatients needed to improve their responsiveness to patients' needs. Patients had to wait unacceptably long times to be seen and some clinics were overcrowded as a result. Clinics were sometimes cancelled or delayed at short notice and administrative problems, leading to medical records being unavailable, sometimes posed potential risks to patient safety.

Our initial findings about our new approach

Our new approach to hospital inspection is a radical change, and we have learned a great deal from this first pilot wave. Our experience so far shows that we are moving in the right direction and we have had positive feedback from providers and others. We have already made a number of changes to our Wave 2 pilot inspections.

The greater expertise that we've brought into the larger inspection teams – both from clinical specialists and from experts and from Experts by Experience – has been invaluable. Inspection teams throughout Wave 1 have been able to get to heart of good care and poor care in a way that was not possible under the previous approach.

We still have a lot to learn, though, and Kieran Walshe's evaluation report will add to our understanding of the improvements we need to make. We have already identified three challenges:

Consistency: It is important that we have a consistent approach in both how we assess services and how we make judgements about quality. This includes selecting and training the right inspection staff and clinical experts, defining key lines of enquiry, and being clear 'what good looks like'.

Credibility: Senior expert representation on the inspection teams is vital. We were pleased to recruit and involve a large number of specialists and experts from the acute sector during Wave 1, and they brought a significant amount of credibility to the

inspection teams. We recognise that we need to recruit more senior managers with 'trust-wide' roles (such as chief operating officers) and to access the right level of expertise in some specific areas, for example A&E. We also know we need to do more high quality training for teams.

Improving our processes: We know that we have to improve the processes that we were testing in Wave 1. We need to do more to prepare for the main inspection – some areas of assessment are difficult to do in the short space of time available on site, for example looking at complaints handling, looking at clinical information flows, and assessing leadership. There are also issues about the logistics of organising the inspection and making the process sustainable for everyone involved.

1. Our initial findings about provider quality

The overall picture

In every trust and hospital involved in Wave 1, we found care and compassion among frontline staff, and a strong commitment to the NHS. Time and again we met and talked to dedicated staff working very hard under sometimes difficult circumstances, and we saw many examples of high quality care.

We saw some good and outstanding practice in many of the trusts and hospitals we inspected, delivered by doctors, nurses and other healthcare professionals who are passionate about quality of care, about putting patients' needs at the centre of what they do, and about sharing this learning with others.

However we also found problems. There are places where staff are under extreme strain, and where compassion can be neglected or lost.

We found marked variations in quality:

- There was a wide range of quality between hospitals:
 - Some were good or outstanding throughout
 - Others had a number of poor quality services.
- In several hospitals there were marked variations between services – for example high quality maternity care, but poor A&E services, and vice versa.
- In some hospitals there was variation within a service. This was particularly noticeable where one or two of the medical wards (especially in care of the elderly wards) were poor – what we think of as 'worry wards' – while others were good.

The shadow ratings in appendix 3 illustrate some of the variations in quality that we found in three of the trusts.

In general, there was a read across to the risk level identified beforehand by our Intelligent Monitoring process (see section 2 for more detail of Intelligent Monitoring). Those in the highest risk bands tended to perform more poorly, and those in the lowest risk bands tended to provide good care. However, this was not universal. It is very early days in the evolution of both our Intelligent Monitoring and our new inspection process, and more work is needed to understand the correlations between the two.

Cross-cutting issues

There were some specific issues that we were able to draw out that spanned across many of the inspections.

Staffing levels and training

We found that the majority of core services in most trusts had adequate staff and training. Some were regularly using tools (often called acuity tools or safer staffing tools) to assess the numbers of staff they needed. Some wards were increasing transparency by displaying their daily staffing levels. The use of acuity tools and greater transparency should be adopted by all trusts.

However, we had concerns about staffing levels in most A&E departments and some medical wards. Where we judged this could put people at risk, we have required the hospitals to take action to put things right. With night time and weekends being especially prone to staff shortages, hospital staff had some concerns about safety and their ability to provide appropriate care.

The staff shortages we saw were for a number of reasons – from national shortages to local recruitment to maternity and sick leave.

In some trusts, staffing levels had been increased to reflect increases in the number of beds. In others this was still being planned and had not yet been turned into reality.

Both staff and patients felt the brunt of staff shortages. Patients said that when wards were short staffed, they did not receive the expected level of care, respect and dignity they deserved.

We saw a strong link between higher reported and perceived staffing levels and higher mandatory training rates. Staff often told us that training and development opportunities were put on a back burner when there were staff shortages. For example, safeguarding training tended to be incomplete.

Flow

“Flow” is now commonly used as a term to describe the movement of patients through a hospital. We saw hold-ups at multiple steps in patients’ pathways. All of these tend to be reflected in the level of achievement of the A&E four-hour target. In several hospitals that were not meeting the 95% standard, patients were not being actively moved on from the A&E department to the Acute Medical Unit (AMU).

We also observed delays in transferring patients from the AMU to medical wards and from critical care to surgical and medical wards, and delayed discharges to the community. These often resulted in medical patients being treated on surgical wards as ‘outliers’, surgical patients having to stay overnight in theatre recovery areas, operations being cancelled, and patients being moved on multiple occasions between wards. This can impact both on patients’ safety and their experience of care.

In contrast, some trusts are tackling flow very actively, with processes to establish ambulatory care services, introduce early consultant review (both medical and surgical), and actively involve social services to prevent unnecessary admissions and enable early discharge.

Culture

The culture of a trust may be difficult to define. But it can be relatively easy to recognise, through a combination of objective data (such as the NHS staff survey results and staff sickness rate) and the views of staff who take part in focus groups. The research evidence indicates a strong link between the level of staff engagement and better patient outcomes.

In several trusts we saw a truly open and learning culture in which staff had few, if any, negative observations about the organisation or its leadership. These trusts also performed well across all or most of the core services and across the different areas of focus.

In contrast, we observed some trusts with a 'them and us' culture, in which clinicians tended to feel that managers were only interested in finance and not in quality.

A third group of trusts were taking active measures to improve staff engagement through programmes such as "Listening into Action". In these trusts, staff who had initially been sceptical told us that they now felt more engaged and empowered.

Cleanliness

In general, the standard of cleanliness we saw was high. There has been major progress in recent years in improving infection control and tackling infections such as *C. difficile* and MRSA. We also heard of extra efforts to clean wards and other areas in anticipation of the CQC planned visits.

Seven-day services

We found widespread recognition that the NHS should be moving towards delivery of seven-day services. In particular leaders and staff in the NHS recognise the need for equivalent standards of emergency care seven days a week. We also found that most trusts have made some progress towards delivery of seven-day services, for example with consultant ward rounds on Saturdays and Sundays. However, approaches to and levels of implementation varied significantly. We now need to develop better measures to assess progress on implementation, and to incorporate these into future assessments.

The five questions we ask of all services

Of the five questions that we ask about every service, the one where we judged hospitals to be performing the best was in care that is 'caring'. There were very few hospitals or services where our inspection process highlighted significant problems in this area.

While this is to be cautiously welcomed, it is an indicator to us that we need to look carefully at our process for gathering evidence on patients' experiences, to make sure patients' natural gratitude for treatment is not masking underlying concerns.

The areas that needed most improvement were in responsive and safe care.

In judging whether trusts and services were well-led, we found quite a range of performance. There were a number of areas where we identified poor leadership, but also quite a few where leadership was very good. Well-led is another area where we need to work more on making sure we are assessing the right things.

Safety

Good practice example:

Salford Royal Hospital

Safety was a clear priority throughout Salford Royal. At the entrance to each ward, actual staffing levels were prominently displayed alongside the ideal number of staff needed. There was also a sink at each entrance, and a notice asking every person to wash their hands before entering. Junior doctors told us how they had been stopped from going in if they hadn't washed their hands properly.

'Safety huddles' were commonplace at the start of every nursing shift: the team for that shift would discuss the staffing levels that day, any concerns they had, and any incidents that had the potential to affect patient care that day.

Wards were committed to achieving 'SCAPE' (Safe, Clean and Personal) status. This was something awarded to them if they could show that they were a safe ward. There was evident pride from all wards (and from all grades of nursing staff) who had achieved this. SCAPE status can be removed if it is felt that safety has not been maintained, and in fact it had been removed from one ward just before our visit.

The hospital also had a comprehensive electronic record system in place, and it was extremely well used. It meant that a patient could be seen in different parts of the hospital and their medical history was easily available wherever they went.

Most of the services we inspected were found to be safe. However, problems were identified in a significant minority. The main aspects of good and poor safety were:

- **Staffing**

Most of the cross-cutting staffing issues mentioned above have an impact on safety. In addition, we saw that some trusts were over-reliant on bank and agency staff.

‘Escalation wards’ (opened to manage additional admissions, for example in winter), were sometimes almost entirely staffed by bank/agency staff.

In some trusts there were considerable delays in recruitment. In others recruitment problems related to lack of availability of nursing or medical staff. Several trusts were attempting to recruit nurses, in particular from Spain and Portugal.

- **Infection control, cleanliness and hygiene**

As mentioned above, the standard of cleanliness was generally high. However we did find on some wards that hand gel containers were empty, or not easily available.

- **Safe environments/facilities**

Several of the A&E departments we inspected were not fit for purpose, reflecting the major increase in A&E attendances over the past decade. We saw a range of other problems with environments or facilities in individual hospitals (for example, on some wards, theatres and outpatient clinics).

- **World Health Organization surgical checklist**

The WHO surgical checklist is being used in the large majority of operating theatres – but not for all patients in all theatres. Auditing the use of the checklist is variable and needs to be standardised as a matter of urgency. In future inspections, CQC expects to see compliance levels approaching 100%.

- **Managing patients whose condition is deteriorating**

All the hospitals we visited were using some form of early warning score to spot when a patient’s condition might be deteriorating. Almost all hospitals had a critical care outreach service, but there was significant variation in the hours they were on site. Some only ran from 9am to 5pm, Monday to Friday.

Effectiveness

Good practice example:

Royal Liverpool University Hospital

Rather than working as a separate Acute Medical Unit and A&E department, the Royal Liverpool operated an ‘Emergency Floor’. This enabled a more seamless transfer of patients between the two departments. Clinicians from both areas spoke very positively about this. Acute medical staff would ‘in-reach’ into the A&E area, offering early medical support if needed. This meant they were always aware of potential referrals to them before the referrals actually happened. They worked together rather than against each other (which we have not always found to be the case) to make sure patients received the best possible care.

Good practice example:

Airedale General Hospital

Airedale General hosted a ‘telehealth hub’ that was staffed 24 hours a day, seven days a week by healthcare professionals. More than 50 local care homes had access to this, giving them instant access to medical advice from consultants or specialist nurses, without having to refer patients to hospital. This means that unnecessary admissions can be avoided, and care homes reassured that they have urgent access to healthcare professionals at all times of day. As a result of the success of this service, Airedale has been approached by other trusts to share the technology – even from a significant distance. Dartford and Gravesham NHS Trust has linked up their local care homes with the Airedale hub, to provide the same service to their local residents.

To assess effectiveness of treatment and care, we looked for evidence of:

- The extent to which trusts were implementing and following guidelines (whether from NICE or elsewhere)
- Whether trusts were making use of national comparative audits
- The prevalence of dashboards to monitor key performance indicators and other data (for example, in maternity).

With the notable exception of critical care units and maternity, few trusts appear to be aware of, or to be able to demonstrate, their comparative effectiveness on national clinical audits.

The inspections have shown that we need to carry out more detailed work if we are to assess the question of effectiveness more reliably. In particular we will work closely on this with Royal Colleges and professional societies, and with those responsible for national clinical audits.

Caring

Good practice example:

Queen’s Medical Centre, Nottingham

We were impressed with the care provided on the Lyn Jarrett unit at the Queen’s Medical Centre where six weeks after every death in the emergency department, bereavement nurses sent a handwritten letter to relatives. This letter offered condolences and invited recipients to speak with a bereavement nurse or senior doctor, who would be able to answer any questions they may have. This was an area of truly compassionate practice.

Good practice example:

Princess Royal University Hospital, Kent

Staff on the critical care unit were proactive in creating patient diaries. These were written up for patients who had been unconscious for a long time. They aided the patients' recovery by helping them understand things that had happened while they were unconscious.

In almost all of the core services in all 18 trusts, our inspection teams saw high levels of compassionate care.

There were considerable variations, however, between trusts on objective measures such as the CQC Inpatient survey and the national cancer patient survey. The Friends and Family Test (FFT) also showed marked variations between wards within individual hospitals.

We did also hear some harrowing stories from individual patients, particularly at patient and public listening events. CQC inspection teams were then able to follow these up later in the inspection process.

Responsiveness

Good practice example:

Royal Liverpool University Hospital

The end of life care service at the Royal Liverpool University Hospital has introduced several innovative models of care. The specialist palliative care service, which operates seven days per week, has trained over 80 link nurses on wards across the trust with enhanced palliative care skills. They have also trained volunteers who will sit with patients who are dying if nursing staff are unable to do so. In addition they have established a rapid discharge service to enable patients to die in the place of their choice in association with local ambulance and community services.

Good practice example:

Royal United Hospital, Bath

The surgical ambulatory clinic at Royal United Hospital allowed for patients referred by A&E or their GP to be seen directly by a consultant surgeon rather than a more junior doctor. This enabled early decisions to be made about their care, including further investigation, surgery or discharge as appropriate. This had improved the patient pathway, helped avoid unnecessary admissions, and reduced the time that patients waited for emergency surgery.

Good practice example:

Airedale and other hospitals

We have seen many trusts that have started integrating their volunteers far more into the day-to-day working of the hospital, to everyone's benefit. One example of this is trusts who train their volunteers to become 'feeding buddies'. Volunteers come onto the ward at meal times to help support patients who are not able to feed themselves on their own.

The evidence we collected at the pre-inspection stage showed that there were significant problems with A&E waiting times, cancelled operations and delayed discharges.

As mentioned above, patient 'flow' is a major problem in some trusts with:

- Long A&E waits (partly because of a failure to admit patients to acute medical units in a timely way).
- High numbers of patients who need medical care being put on surgical wards (or on 'escalation wards') instead of on medical care wards.
- Cancelled operations.
- Difficulties discharging patients from critical care units to the wards.
- Delays in discharging patients to the community – in some cases due to late discharge planning.

Some trusts have, however, been able to largely overcome these challenges – with processes to avoid admissions and to improve discharge planning.

Well-led

Good practice example:

Frimley Park Hospital

The open culture at Frimley Park was demonstrated at a focus group involving 25 junior doctors. They all praised the leaders of the trust for their visibility and open door approach. Many of the junior doctors had returned to the trust at different stages of their training because of the support and openness of Frimley Park's consultants and other staff. They unanimously rated the care delivered by the trust as outstanding.

Good practice example:

Harrogate District Hospital

Student nurses at Harrogate District Hospital had enjoyed their attachments to the trust. They commended qualified staff for their friendliness and support. A high proportion of the students wanted to return to the trust after qualifying – in some cases despite long travelling distances.

We found that the staff survey results and staff sickness rates frequently gave a good general indication of the overall culture and leadership of a trust.

In some trusts the staff were very well engaged. In others there was a 'them and us' culture – especially between senior doctors and managers. Some trusts appeared to have 'learned helplessness'.

Some trusts appeared to lack a clear vision or strategy. Staff engagement programmes seemed to be more effective in some trusts than others.

Boards and wards were disconnected in several trusts, and information on quality and safety was sometimes insufficient to give Boards the assurance they need about the quality of care.

The core services

We have analysed the results of the Wave 1 inspections by the individual core services.

The service that performed the best across the trusts was critical care, closely followed by maternity and family planning, and services for children and young people.

The services where we found the most problems were A&E, medical care and outpatients.

Splitting each core service by the five questions we ask, all but one performed best in ensuring care was caring. (The exception was maternity and family planning, where the effectiveness of the service was most prominent.) Again, this is causing us to think hard about whether we are being truly objective in our assessments of caring.

The poorest aspect of care in each service varied. And the single poorest aspect of care across all the services was the responsiveness of outpatients services. Nearly three quarters of these needed to improve in terms of being responsive to the needs of patients.

Accident and emergency

A&E had the poorest performance across the eight core services overall. Not surprisingly, this was the service under the greatest strain, with many having problems under one or more of the five questions we ask.

Overcrowding, long waiting times and insufficient staffing levels were the commonest problems. We saw high levels of agency staff and locum use in A&E departments, particularly among doctors. Problems in A&E departments are often partly due to staff in other departments not actively facilitating the transfer of patients out of A&E.

Medical care (including older people's care)

Medical care was second only to A&E in relation to the number and severity of problems that were identified by our inspection teams. However, it is important to note that none of the 18 trusts inspected in Wave 1 had statistically high standardised mortality rates.

In several hospitals, we saw good care on the large majority of medical wards but with unacceptable levels of care on one or two wards (what we think of as 'worry wards'). These were exclusively either wards designated for the care of older people or so called escalation wards.

Many of the trusts we inspected were making a determined effort to improve care for patients with dementia. Several have created dedicated wards for people with dementia, looking to create a single safe environment, where all members of staff are sufficiently trained and the facilities match the patients' needs. For those patients not on special wards, some trusts had created systems and pathways to identify dementia patients – and thereby simplify the care for them and improve their experience.

However, it seemed that every trust was taking its own unique approach and programme to caring for people with dementia. While they were similar in essence, there was little coordination in creating a national unified approach. In addition, some dementia services were limited as they did not cover out-of-hours care. CQC inspection teams also need to take a more consistent approach to assessing implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards in future inspections.

Surgery

Surgical services showed some slight variation, with the responsiveness of services raising the most concern. The most significant problem was that of cancelled operations. This was largely due to lack of available beds (often related to medical care patients occupying surgical ward beds). In some trusts we even saw these medical care 'outliers' being looked after on day care units.

In some cases surgical patients had to stay in recovery overnight, which is safe but not ideal from a patient experience point of view. Again, this happens because of a lack of suitable beds.

Critical care

Critical care had the best performance of the eight core services, and in general we found that critical care services were delivering high quality, compassionate care.

There were some trusts, however, that had inadequate provision of critical care beds for the population they serve. Several units had difficulties in discharging patients to surgical wards even when they were fit to be discharged – and thereby potentially reducing access for other patients.

Critical care units were almost universally able to provide us with comparative clinical audit data (ICNARC) – unlike most other core services.

Maternity and family planning

Maternity and family planning services also performed relatively well. Almost all maternity units were using dashboards and were able to assess their own performance against a set of predetermined quality indicators.

We did find problems with staffing in some trusts, either in relation to midwife to birth ratios or consultant hours. Both these could impact on the safety of maternity services.

Services for children and young people

Services for children and young people were generally of a high quality. We have taken a 'child-centred' approach to assessing these services, looking across A&E, inpatient wards, outpatient services and end of life care.

Some trusts, especially those serving smaller populations, did not have adequate staff trained in providing care to children in the A&E department. This could impact on safety. Some did not have separate areas in A&E for children.

End of life care

There were some excellent and innovative services providing end of life care. We saw very high levels of caring and compassion.

We did see some variability in the completion of Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) orders. This was particularly with regards to communication with patients and relatives.

We found that it is difficult to assess quality of care across all conditions and clinical areas – better metrics are needed, especially for those not under specialist palliative care. In addition, in general some specialist palliative care services only operate five days a week, with telephone support and advice offered out of hours.

Outpatients

Outpatients was one of the poorest services across the 18 trusts. More than two thirds of outpatient services needed to improve their responsiveness to patients' needs. Patients had to wait unacceptably long times to be seen and some clinics were overcrowded as a result. Also, clinics were sometimes cancelled or delayed at short notice

Some services lacked leadership within the overall management of the trust. And administrative problems, leading to medical records being unavailable, posed potential risks to patient safety

Some example of changes we've already seen

At **Princess Royal Hospital**, they have already made a number of changes following their inspection, including:

- Installing new alcohol hand-rub dispensers
- Launching a new cleanliness publicity campaign, called "Patient safety is in your hands".
- An insistence that staff wear their ID badges, and make them more readable
- Employing more staff to improve record keeping
- Launching a regular programme of consultant engagement events
- Improving the patient care pathway in the emergency department.

At **University College London Hospital**, we found that the A&E was very cramped. It was designed for a capacity of 65,000 but was dealing with 130,000 patients and rising. At the Quality Summit the trust's chief executive said that he had used our report to persuade his board and governors to agree to an immediate increase in the physical size of A&E and in the staffing capacity. This is in advance of their longer term plan for improvements in 2016.

"Croydon University Hospital was the first hospital to be inspected as part of the new CQC inspection programme. The trust found the inspection was a supportive process which commended the Leadership Team for making a real impact. The inspection provided the opportunity to identify areas for improvement, including the following quick wins:

- The creation of a number of new innovative posts including a nurse specialising team of health care assistants, who have specialist training in dementia alongside ward-based roles in our dementia zone. The project puts the needs of people with dementia and their carers at the centre of our approach to care.
- A Listening into Action Sponsor Group has been established to oversee the improvements to the fracture clinic, to ensure it is welcoming to visitors and meets the needs of patients.
- A 'Releasing Time to Care' programme designed to empower frontline ward staff to deliver and lead sustainable change that will benefit patients, relatives and staff.
- Improvements to the main outpatients physical environment.

Following the inspection, the Quality Summit discussed the findings from the CQC report and considered the trust's response to it. The outputs from this have informed the development of the trust's Quality Improvement Plan and will form part of the trust's overarching Service Improvement and Transformation Plan."

John Goulston

Chief Executive, Croydon Health Services NHS Trust

2. Our new approach

Developing the new approach

In July 2013, we consulted on our new approach to regulating and inspecting NHS acute hospitals. We learned much from what we heard during the consultation, and also from the evaluation of the approach used during the Keogh mortality reviews.

We set out to test a process whereby the Chief Inspector of Hospitals is leading a programme involving larger inspection teams, consisting of specialist hospital inspectors and clinical experts and including patient and public representatives.

Under our new approach, these inspection teams use their professional judgement, supported by objective measures and clinical evidence, to assess the quality of services against five key questions: are they safe, effective, caring, responsive and well-led?

This will include a rating to help people compare services and to highlight where care is good or outstanding and expose where care is inadequate or requires improvement.

It is important to emphasise that we are looking for what is good as well as what is not good. We aim to have inspected and rated all acute hospital trusts by December 2015.

Selecting the trusts

Using our new Intelligent Monitoring system¹, we identified 18 NHS trusts that appeared to represent a spectrum of risk across hospital care. (However, please note this does not mean that the findings from the inspections of the 18 trusts are representative of the country as a whole.) We have therefore been able to test the evolving Intelligent Monitoring tool and how that would align with the variations in quality we might see through inspection.

We carried out the inspections between September and December 2013. We divided the trusts into four separate groups, so that we could pause between each group and develop and evolve the methodology through what we had learned so far. Appendix 1 shows the 18 trusts and the main hospitals we inspected.

¹ The Intelligent Monitoring tool brings together information from more than 100 indicators that cover the five questions (safety, effectiveness, responsiveness, caring and well-led). For the majority of the indicators, where trusts perform significantly worse than the average this constitutes a 'risk'. Trusts are assigned to a risk band depending on their overall level of risk. It is important to emphasise that our judgements and ratings on trusts are not based solely on the banding from Intelligent Monitoring but on a combination of data, information from others and findings from inspection. The purpose of the Intelligent Monitoring tool is to identify trusts which may be at higher risk of delivering poor quality care than others.

Methodology

Our inspection teams set out to answer five key questions about the quality of services. Are they:

- Safe: are people protected from abuse and avoidable harm?
- Effective: does people's care and treatment achieve good outcomes and promote a good quality of life, and is it evidence-based where possible?
- Caring: do staff involve and treat people with compassion, kindness, dignity and respect?
- Responsive: are services organised so that they meet people's needs?
- Well-led: does the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, support learning and innovation, and promote an open and fair culture? It is worth noting that this assessment of the quality of leadership is an innovative approach to the regulation of care, and we are trialling it for the very first time.

In developing our overall assessment framework and our key lines of enquiry for each of the five questions, we have worked closely from a number of expert partners, for example:

- Safety – Health Foundation
- Effectiveness – National Institute of Health and Care Excellence (NICE) and Royal Colleges
- Caring and Responsive – Healthwatch England and NHS England
- Well-led – King's Fund, Monitor and the NHS Trust Development Authority.

In conjunction with the sector, we have identified eight core services that we will always inspect at every NHS acute hospital where they are provided. These core services were chosen because they represent high volumes within most acute trusts, and/or they carry significant risk:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

There are three broad phases to our new inspection approach:

1. **Pre-inspection** – the preparation and planning phase, where we gather data, build the inspection team and plan which things to focus on

2. **Inspection** – the visits to the hospitals, with judgements (and ultimately ratings) being proposed based on pre-inspection data combined with what we have seen and heard.
3. **Post-inspection** – writing the inspection reports, checking them for quality control, outlining to the trusts what action is required, and working with our partners in the system.

In addition, where we find significant concerns we will continue to take action, either through compliance actions or warning notices.

Our initial reflections on how these three phases worked during Wave 1 are set out below.

Pre-inspection: preparation and planning

Engagement with the trust

- Early engagement with trusts was important. Chief executives and senior leaders from the 18 trusts attended an open day at CQC where the Chief Inspector of Hospitals gave them an overview of the process. The trusts are now part of CQC's online discussion group to test new and evolving products and methods.
- Organising the logistics of the inspection with the trust and within our own team – this is something we didn't do well enough, largely because of the pace we were moving at, and we are looking to improve.

“We found the CQC inspection of the Princess Royal University Hospital in Bromley a valuable experience. Compared to previous inspections, there was more focus, more clinical input and better understanding of the issues.”

Tim Smart
Chief Executive, King's College Hospital NHS Foundation Trust

Building the team

- Key to the success of the new approach was larger inspection teams, and building an experienced, credible inspection team was vital. Teams typically consisted of 30 to 40 people, more than half of whom were practising professionals, including senior and junior doctors and nurses.
- The healthcare professionals on the team – the doctors, nurses and other NHS staff – provided vital expertise and knowledge about current clinical practice.

- The inspection team leaders were senior CQC staff experienced in hospital inspection. They led the process and the relationship with the trust’s CEO. A team chair, who is usually a very senior clinician, assured trusts that leadership of the process was driven by frontline understanding of quality and of how hospitals work. (See appendix 2 for a list of the chairs and CQC team leaders.)
- The teams also included people who can give the patient perspective. These included public representatives and Experts by Experience. Experts by Experience are trained members of the public who have a lot of experience of hospital care. They were a key and successful element of CQC’s previous inspection regimes, and they continue to bring their expertise and valuable perspective as a core part of the new approach.
- Local CQC inspectors brought their significant local knowledge and intelligence, alongside their expertise in professional regulation.
- The earliest inspections in Wave 1 drew heavily on team members from the Keogh reviews carried out in the first half of 2013, and also help from the Royal Colleges and professional societies in putting forward clinicians. As we progressed through Wave 1, we developed more systematic processes for selecting and scheduling team members. This is still work in progress, with more development under way in areas such as training, feedback on performance, and making sure our database gives a full picture of specialists’ experience and interests.

“From my experience of being involved in the news inspections, I have found that my part in the team has been regarded as most important. My personal experiences have meant that patients and clients feel more at ease speaking to me.”

Expert by Experience

Preparing the data pack

- The inspection teams used a wealth of information and evidence to direct their resources where they’re most needed. This included information from our partners in the system, and information from the public. We have developed new triggers – surveillance indicators that form part of Intelligent Monitoring – and key lines of enquiry to guide the teams on when, where and what to inspect.

- Engagement with our partner organisations – including Monitor, the Trust Development Authority, Healthwatch, Health Education England, the Parliamentary Health Services Ombudsman, professional regulators, Clinical Commissioning Groups, Royal Colleges – helped build up local intelligence for each trust.
- This information was used to build a 'data pack'. This was invaluable in bringing together a wide range of information about safety, effectiveness, caring, responsiveness and leadership so that inspection teams could focus their assessments appropriately. However, collecting bespoke information is hard to incorporate in the data pack all at once in what is a very tight inspection timetable. Our manual approach had already outlived its usefulness by the end of Wave 1, as we started to schedule in our pilot waves of mental health and community healthcare inspections.
- We are currently refining the presentation of data packs and extending their content. In particular, we are aligning information where possible with the eight core services.

“We were very supportive of the pre-inspection stage of our assessment. The allocated inspectors were both informative and resourceful. CQC’s requests for data were plentiful. The data was perhaps not circulated with maximum efficiency, as a considerable number of duplicate requests were made during the visits. A nominated information lead for both the inspection team and the trust would help in making better use of the data flow.”

Paul Downes

Associate Director of Governance and Quality Improvement, Salford Royal NHS Foundation Trust

Inspection: site visits

- Typically in Wave 1 the teams spent two to three days inspecting a trust. The rationale for this was that it was important that the teams took as long as they needed to make a thorough assessment of the quality of care provided. However, it was also important to keep the time on site as short as possible so that clinical experts could give their valuable time to take part in an inspection and bring their expertise.
- Each inspection team spent a full preparation day together immediately before the site visit, which was designed to help in binding the team, helping them to work more effectively together and planning the detail of their inspection. This initial day included a presentation from the CEO of the trust, setting out the context in which they were working and giving an overview both of what they were proud of and the challenges and risks they were facing.

- Also during the inspection, we held public listening events at a public venue near to the hospital. The inspection team listened to the stories of local people, and the information we received was valuable in understanding the issues at each trust, what people thought of their local hospital services, and where their concerns had not been addressed or acknowledged.
- These listening events were widely welcomed. Typical quotes were, “It was good to see patients give both positive and negative views on their experience”, “Need more events like this” and “Thank you for listening”. We do have some way to go, however, on making sure the format of these events is working most effectively. We will publish a full evaluation shortly, but some comments for example were about us advertising the events more widely and selecting venues which were easier for people to access.
- For the remaining days on site, the inspection team divided into sub-teams to focus on one or more core services. This involved visiting wards, talking to patients and staff, observing care being given, interviewing individual staff members (clinical and divisional leads), conducting focus groups (including allied health professionals, student and senior nurses, junior doctors and consultants, managers and governors) and interviewing the trust’s Executive Team, Chair and some non-executive directors.
- The inspection team came back together regularly for feedback and corroboration sessions, so that information could be shared and key themes followed up. At these sessions, each sub-team considered how the trust was performing on each of the five questions and was challenged on their judgements by the rest of the inspection team.

“Following the inspection team’s visit we were able to use their comments and observations as a lever for change within a number of teams. As a direct consequence our A&E team have put forward a proposal to work in an innovative and flexible way to increase the consultant coverage for direct patient care.

The agreement at the Quality Summit to produce a strategic commissioning plan for maternity services has created a welcomed momentum and a degree of pace to deliver future clarity. This was a direct result of the inspection team’s findings.

As a trust we recognise the importance of quality inspections, and the responsibility we have for making available staff with the skills and competence to be the very best inspectors.”

Jo Cubbon

Chief Executive, Taunton and Somerset NHS Foundation Trust

- Three of the 18 trusts had agreed in advance to be shadow rating pilot sites, and these shadow ratings are shown in appendix 3.
- At the end of each day of each site visit the team Chair and Team Leader reported back any immediate concerns to the senior management of the trust. Headline findings were presented by the team Chair and Team Leader at the end of the announced site visit.
- All the trusts were revisited unannounced within one to two weeks of the first site visit. Frequently these unannounced visits were undertaken out of routine working hours, so that we could assess staffing levels and any impact this might have on quality of care.
- In one inspection, we worked with the Patients Association to carry out some pilot work to look at the way complaints information is used in the inspection process, how to improve this, and how to help develop a model for evaluating a trust's complaint handling and learning processes.

Post-inspection: Reporting and Quality Summit

- Following the site visits, each sub-team produced a draft report on their core service(s), structured in line with the five key questions, and the Team Leader then drew together overviews of the hospitals and of the trust as a whole.
- The full report was discussed by a national quality assurance group, chaired by the Chief Inspector of Hospitals, and was then sent to the trust for 10 days' factual accuracy checking.
- Once finalised, the report was presented at a Quality Summit meeting. The Quality Summit attendees included the inspection team Chair and the Team Leader, some members of the inspection team, several representatives from the trust, and representatives from Monitor or the Trust Development Authority, NHS England, local Healthwatch, Health Education England and the local Clinical Commissioning Groups.

“The three Quality Summits I have been involved in have proved vital in allowing space for the trusts and their partner organisations to reflect on the inspection team's findings, and what must be done to address any challenges. The summits have proved a valuable first step in developing improvement plans for the trusts. In particular, the flexibility of the approach has been important. Each Quality Summit is tailored to meet the need of the trust involved, which maximises the benefit of the process.”

Alwen Williams
 Director of Delivery and Development, NHS
 Trust Development Authority

- At these we presented our findings, followed by a presentation by the trust on how it intended to tackle the most significant issues identified. A third part of the summit focused on system-wide action planning to address the problems identified in our report. In this wave we trialled this third part being chaired by Monitor, the Trust Development Authority or service commissioners in different cases.
- With such a deeper and wider inspection taking place, writing up our extensive findings quickly and succinctly into a report is a significant challenge. So far, we have streamlined the report writing process, so that each sub-team reports on the services they inspected, with the Team Leader bringing these parts together, adding the hospital-wide and trust-wide perspective and agreeing with the inspection Chair.

Rating

All inspections under the new approach will ultimately result in ratings of services within hospitals and trusts.

The public want information about the quality of services presented in a way which is easy to understand, and we believe this is best delivered using ratings. Ratings of service, hospitals and trusts should also be a driver for improvement.

Our approach to the ratings scale is similar to the one used for schools by Ofsted, although it is important to recognise that hospitals are much more complex organisations than schools. Patients and the public may, for example, be interested in a particular service (such as a maternity unit, or care for frail older people) rather than a single rating for a hospital or trust as a whole.

We will use a four-point scale for all ratings:

- Outstanding
- Good
- Requires Improvement
- Inadequate

Ratings will always take account of all the following 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.

Clearly, judgement has to be used in combining all of these sources of information into a rating for an individual aspect of a core service. The sub-teams leading the inspection of a core service will propose a rating for each of the five key domains, but this can be challenged at corroboration sessions involving the full inspection team. The consistency of ratings between trusts will then be considered by the National Quality Assurance Group, chaired by the Chief Inspector of Hospitals.

The ratings will be formulated from the bottom up. We will rate each of the eight core services on each of the five key questions (safe, effective, caring, responsive and well-led). We will also rate a hospital for each service overall, for each of the five questions, and an overall rating for the hospital.

In general, if a core service is found to require improvement on two or more of the five domains, the service will be rated overall as requiring improvement. However, we will also use judgement in aggregating ratings, rather than always adopting an algorithmic approach.

We will then rate the trust as a whole on the five key questions. Finally we will derive an overall rating for the trust as a whole. The overall rating for well-led at trust level will reflect board level leadership and board to ward integration, as well as the ratings for well-led at an individual core service level.

We are currently developing a ratings appeals process.

The shadow ratings from the three rating pilot sites are shown in appendix 3.

What we will be doing differently

Our approach

We recognise the shortcomings of the previous CQC approach to regulating and inspecting NHS acute hospitals. In this new approach, we have built on the best elements of the 2013 Keogh review process, which was in turn designed with advice from the National Quality Board.

But we've also taken it further:

- With our determined focus on the five key questions.
- Our inspection of the same eight core services wherever we go.
- Testing for the first time an approach to ratings for hospitals and trusts, so that the public can clearly understand the quality of different services on offer and so that there is a clear driver for improvement.
- And, importantly, we are now also looking for the care that is good and outstanding – not just what needs to improve or is inadequate.

This is a radical change. We have had encouraging feedback from both trusts and our inspection teams.

Several trusts have commented that the new approach is a marked improvement on what CQC has done previously. And one quote from one of our inspectors sums up the learning they have gained: "I now know more about this trust from one in-depth, comprehensive inspection than the last 15 put together."

This Wave 1 was intentionally developmental. We know that it can be improved, and we have already made some changes for Wave 2. These include more emphasis on the pre-inspection phase, so that we can use the time on site more effectively. Data packs are now being aligned to core services, as well as including trust-wide information.

We have also changed the order we do things on site, for example:

- Asking the CEO to present and holding the public listening event on the initial planning day, rather than after the site visit has started.
- Holding focus groups earlier in the visit.
- Interviewing senior managers towards the end of the visit, so we can bring what we've seen and learned to these interviews.
- And doing more to focus on people's complaints.

We found that safety, caring and responsiveness were relatively easy to assess, although we need to make sure we are fully objective in assessing whether services are caring. We have good data sources and we combine this with what we see and hear on site.

Effectiveness is more difficult to assess. None of the trusts in Wave 1 had high mortality rates. But it was surprisingly difficult to get national clinical audit data from trusts – so how are they assuring themselves on this? Critical care and maternity were notable exceptions.

At present we do not believe we can assess effectiveness in A&E or outpatients accurately; hence these are shown as 'NSE' (not sufficient evidence) on the shadow ratings. We are working with Royal Colleges and professional societies to get this right.

To assess well-led, we are looking at trust, service and ward levels, and on the connections between these. We are working with the King's Fund to enhance the robustness of our assessments, combining objective data (for example, staff survey results) with what we see and hear during our site visits.

Patients and staff were encouraged to express concerns both before and during our site visits. However, formal whistleblowing was not a feature of these Wave 1 inspections. We will, however, always address such concerns in future inspections as and when they arise. They will also contribute to our assessment of well-led.

In terms of the eight core services, A&E unsurprisingly came out less well than other services, reflecting the major increase in activity over the past decade or so.

We need to carry out further work on how we assess end of life care. There is a lack of standardised, system-wide data between trusts in terms of end of life care. So far, we have focused our inspections largely on the care given by palliative care teams, which is very good. We have also looked at bereavement and mortuary services. We have not yet been able to adequately examine the end of life care given to patients on general wards.

Challenges

We know there are major challenges ahead as we roll out our new approach. Kieran Walshe's evaluation will help us understand and overcome these. Three challenges that we have already identified are:

1. Consistency

It will be important that we are able to say with confidence that we have a consistent approach in both how we assess services and the five key questions, and how we make judgements about quality. In other words:

- Defining 'what good looks like' in each area and then defining our key lines of enquiry accordingly. We are currently working with the sector on the details of these, through dedicated 'task and finish' groups.
- Providing clear guidance for trusts.
- Selecting, recruiting and training the right inspection staff and specialists (note that we have already established a 'conversion' training programme for CQC staff).
- Making sure that Heads of Inspection and team chairs work across multiple inspections, to help benchmarking between trusts
- Improving the quality control process, which is chaired by the Chief Inspector of Hospitals
- Having a clear appeals process.

Some examples of the consistency challenge at a service level:

Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) – We found that some DNA CPR forms were incomplete, in relation either to consultant sign-off or on information being discussed with relatives. We need to decide what is an acceptable level of completion. And how many should we look at to be consistent?

WHO surgical checklist – We need to decide on an acceptable level of completion and on how this can best be demonstrated through audit.

Whiteboards on wards – We observed many wards with whiteboards showing patient names, and sometimes additional information relating to their condition or care. In some wards this was visible to any visitor to the ward. Is this an unacceptable breach of confidentiality or is this reasonable practice to facilitate safe care?

Some of this is very difficult. It is new, complex and we want it to actively involve judgement – in other words, it is not just a tick box exercise or entirely reliant on an algorithmic approach.

We will be consulting in April and May on our overall approach – this will include detail underpinning these issues.

2. Credibility of inspection teams

Senior expert representation on the inspection teams is vital. Throughout Wave 1 we were pleased to recruit and involve a large number of specialists and experts from the acute sector, and they brought a significant amount of credibility to the inspection teams.

We recognise that we need to recruit more senior managers with ‘trust-wide’ roles (such as chief operating officers). In addition there are difficulties in accessing the right level of expertise in some specific areas such as A&E reflecting the problems of staffing in many A&E departments. High quality training is also vital, and we know we need to do more in these areas.

Also important is early communication with the trust to identify their large, key services, so that we can make sure the inspection teams are appropriately equipped to get to the heart of any issues.

3. Improving our processes

We acknowledge that we have to improve our own processes that we were testing in Wave 1, and we are grateful to all the trust and hospital staff who effectively acted as our guinea pigs throughout the pilot.

Many of the issues relate to the logistics of organising the inspection from start to finish, and making the process sustainable. Among these are:

- Carrying out as much pre-inspection assessment as possible in areas where judgement in a short, intensive period is more difficult. For example, whether a hospital is well-led, whether the right clinical information is readily accessible, and how complaints are handled.
- Early planning with trusts when inspection announcements have been made for a quarter
- Preparing the data pack earlier, improving its design and content, and sharing it with the trust earlier.
- Getting the right experts for the right trusts
- Rationalising our data requests, and making early requests for data from the trusts and others
- Improving the logistical organisation with the trust and the team
- Making the best use of our time on site

- Making the site visits manageable – so that trusts are not overburdened and inspection teams members are willing to return.
- Improving the writing and content of inspection reports – they need to improve to be more useful to both the public and the trust.

We have already made a number of improvements for the Wave 2 pilot inspections (running from January to March 2014):

- We already collect a large amount of information about individual trusts into the data packs during the preparation phase. However, we will in future collect more information especially from national clinical audits to enhance our assessments of effectiveness.
- We've improved the structure of an inspection through more consistent and thorough use of key lines of enquiry.
- We are now routinely asking for more specific information from trusts in advance of the site visits, so that we can incorporate this into the key lines of enquiry.
- We've reduced the number of information requests we make to trusts during the site visit, and targeted our requests more effectively at what we need.
- We are presenting the information for the inspection sub-teams in a way that is easier for them to use when inspecting individual core services.
- We now invite the trust's Chief Executive to make his or her opening presentation towards the end of the planning day (the day before the site visit proper begins). This allows the inspection team to get a 'feel' for the issues facing each trust in advance of the main inspection days. In some cases this has been combined with an informal walk round the trust on the evening of the planning day.
- Complaints are a useful source of information about a trust, covering several of the key questions (for example, safety, caring and responsiveness). Through interviews with non-executive directors, complaints managers, and CEOs, we have started to look at:
 - Numbers of complaints and key themes
 - Handling of complaints
 - Learning from complaints
- We are now piloting an in depth assessment of complaints during the pre-inspection phase
- We have also started work to look similarly at a sample of recent patients with comorbidities or complex needs (case tracking), review a sample of safety incidents, review board minutes.
- We have introduced a conversion training programme for CQC inspectors, to familiarise them with the new approach. We are developing an online training programme for clinical experts.

Conclusion

In conclusion, we have delivered the Wave 1 pilot as we promised to do.

The new approach is a radical change, and we have learned a great deal from this developmental wave of 18 trusts. We believe that the new approach is deliverable. It is very intensive, but our experience so far shows that it is going in the right direction and achieves what we set out to do.

The new approach shows that inspections by larger, more expert teams work, and is the right direction for the regulation of NHS acute hospitals. Individual trusts have already made some improvements as a result of these visits

We are clear that the new approach is evolving all the time, and we are not yet getting it completely right. We also need to assess the value for money of the new approach, once we have reached a settled process, balancing the costs of inspection and the associated processes against improvements in care.

We are committed to continuous improvement. We still have a lot to learn – and we are doing this all the time.

Acknowledgements

The progress made during Wave 1 of the new hospital inspection programme has depended critically on a wide range of people, including doctors, nurses and other health professionals who have been part of the 18 inspection teams, Experts by Experience, CQC inspectors, analysts, the engagement team, programme support staff, team leaders and team chairs.

The teams have been very courteously welcomed by representatives of the 18 trusts. Staff at these trusts have worked hard to ensure that the teams are well supported on site and supplied with information as quickly as possible. We also appreciate the time given up by staff at the trusts to take part in focus groups and interviews.

We are also extremely grateful to patients and carers who have given their time to tell their stories, good or bad, but with a view to improving outcomes for future patients.

Appendix 1: Trusts and hospitals inspected in Wave 1

Trusts	Main hospitals inspected
Airedale NHS Foundation Trust	Airedale General Hospital
Barking, Havering and Redbridge University Hospitals NHS Trust	Queen's Hospital, Romford King George Hospital, Ilford
Barts Health NHS Trust	Whipps Cross, Newham, Royal London, St Bartholomew's, London Chest and Mile End Hospitals
Croydon Health Services NHS Trust	Croydon University Hospital
Dartford and Gravesham NHS Trust	Darent Valley Hospital
Frimley Park Hospital NHS Foundation Trust	Frimley Park Hospital
Harrogate and District NHS Foundation Trust	Harrogate District Hospital
Heart of England NHS Foundation Trust	Birmingham Heartlands, Good Hope and Solihull Hospitals
King's College Hospital NHS Foundation Trust)*	Princess Royal University Hospital
Nottingham University Hospitals NHS Trust	Queen's Medical Centre and Nottingham City Hospital
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Royal Liverpool University Hospital and Broadgreen Hospital
Royal Surrey County Hospital NHS Foundation Trust	Royal Surrey County Hospital
Royal United Hospital Bath NHS Trust	Royal United Hospital Bath
Salford Royal NHS Foundation Trust	Salford Royal Hospital
Taunton and Somerset NHS Foundation Trust	Musgrove Park Hospital
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The Royal Bournemouth Hospital
The Royal Wolverhampton NHS Trust	New Cross Hospital
University College London Hospitals NHS Foundation Trust	University College London Hospital

* The original list for Wave 1 contained South London Healthcare NHS Trust. Princess Royal University Hospital was acquired from South London Healthcare by King's College Hospital NHS Foundation Trust on 1 October 2013.

Appendix 2: Inspection team chairs and team leaders

Inspections	Inspection team Chair	Inspection team leader
Airedale NHS Foundation Trust	Dr Jane Barrett	Cathy Winn
Barking, Havering and Redbridge University Hospitals NHS Trust	Professor Sir Mike Richards	Margaret McGlynn
Barts Health NHS Trust	Dr Andy Mitchell	Michele Golden
Croydon Health Services NHS Trust	Professor Ted Baker	Jane Ray
Dartford and Gravesham NHS Trust	Dr Peter Cavanagh	Lisa Cook
Frimley Park Hospital NHS Foundation Trust	Dr Linda Patterson	Sheona Browne
Harrogate and District NHS Foundation Trust	Mrs Celia Ingham Clark	Sandra Sutton
Heart of England NHS Foundation Trust	Dr Ian Abbs	Fiona Allinson
King's College Hospital NHS Foundation Trust (Princess Royal University Hospital)	Professor Stephen Singleton	Margaret McGlynn
Nottingham University Hospitals NHS Trust	Dr David Levy	Carolyn Jenkinson
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Dr Mike Bewick	Lorraine Bolam
Royal Surrey County Hospital NHS Foundation Trust	Ms Gill Harris	Elaine Biddle
Royal United Hospital Bath NHS Trust	Mr Alastair Henderson	Joyce Frederick
Salford Royal NHS Foundation Trust	Dr Kathy McLean	Tracey Devine
Taunton and Somerset NHS Foundation Trust	Dr Chris Gordon	Joyce Frederick
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Dr Mike Anderson	Joanne Ward
The Royal Wolverhampton NHS Trust	Ms Liz Redfern	Debbie Widdowson
University College London Hospitals NHS Foundation Trust	Dr Chris Gordon	Robert Throw

Appendix 3: Shadow ratings

To help us develop a robust approach to rating, three of the 18 trusts kindly agreed to act as pilots and to be given 'shadow' ratings. These were:

- Royal Surrey County Hospital NHS Foundation Trust
- Dartford and Gravesham NHS Trust
- Heart of England NHS Foundation Trust

We are now into Wave 2, which is still a developmental stage, but will include ratings for all trusts. At the end of Wave 2 we will consult on how we plan to take this learning forward.

The shadows ratings that we felt able to assess are set out below. Note that our approach to ratings uses judgement in aggregating ratings, rather than adopting an algorithmic approach.

Key to ratings	
Outstanding	O
Good	G
Requires improvement	RI
Inadequate	I
Not sufficient evidence ²	NSE
Not assessable	NA

Royal Surrey County Hospital NHS Foundation Trust

The Royal Surrey County Hospitals NHS Foundation Trust is based at the Royal Surrey County Hospital. It is a general hospital with specialist tertiary services for cancer, oral and maxillofacial surgery and pathology. The trust has around 500 beds and 3,100 staff.

It serves a population of 320,000 for emergency and general hospital services. Every year, the trust sees 240,000 outpatients, 58,000 inpatients, and 72,000 patients in accident and emergency. It delivers more than 3,200 babies every year.

We found that the Royal Surrey County Hospital was providing services that were safe, effective, responsive, caring and well-led. Staff we spoke to were positive and engaged, and patients we spoke to were generally very positive about the care that they had received at the hospital.

We did find that most departments were operating at full capacity – and that this was, at times, having a negative impact on patient experience. There are improvements that

² NSE – at present we are not collecting sufficient evidence on the effectiveness of A&E or outpatients to give a rating. We will be working with professional associates to do so in future inspections

could be made here to improve the care delivered to local people, but overall we judged this to be a good hospital.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident & Emergency	G	NSE	G	G	G	G
Medical care	RI	G	G	G	G	G
Surgery	G	G	G	G	G	G
Intensive/critical care	G	G	G	G	G	G
Maternity & family planning	G	G	O	G	O	G
Children's care	G	G	G	O	G	G
End of Life	G	G	G	G	G	G
Outpatients	G	NSE	G	RI	RI	RI
Overall	G	G	G	G	G	G

Dartford and Gravesham NHS Trust

Darent Valley Hospital, run by Dartford and Gravesham NHS Trust, offers a comprehensive range of acute hospital-based services to around 270,000 people in Dartford, Gravesham, Swanley and Bexley. The hospital opened in September 2000. It now has around 463 inpatient beds and around 100,000 patients attend A&E each year.

We found that most of the services at Darent Valley Hospital were good. The majority of patients told us that they were happy with the care and treatment that they had received, and we identified a number of examples of good practice. Overall, we found a culture where staff were positive, engaged and very loyal to the organisation, and the staff and management at the hospital were open and transparent about the challenges they faced.

We did, however, find a number of areas in which the trust needed to improve, including A&E and surgery.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident & Emergency	RI	NSE	G	RI	RI	RI
Medical care	G	G	G	RI	G	G
Surgery	G	G	RI	RI	G	RI
Intensive/critical care	G	G	G	RI	G	G
Maternity & family planning	G	G	G	G	G	G
Children's care	G	G	G	G	G	G
End of Life	G	G	G	G	G	G
Outpatients	G	NSE	G	G	G	G
Overall	G	G	G	RI	G	RI

Heart of England NHS Foundation Trust

The Heart of England NHS Foundation Trust is one of the largest hospital trusts in England. It provides general and specialist hospital and community care for the people of East Birmingham, Solihull, Sutton Coldfield, Tamworth and South Staffordshire. The trust comprises three main locations: Birmingham Heartlands Hospital, Solihull Hospital, Good Hope Hospital and has more than 1,500 beds.

We found that most people described their care as good, telling our inspection teams that staff were caring, despite being busy. However, while most services were delivered safely at the trust, the safety of patients in all the A&E sites, the acute medical unit at Good Hope Hospital and the Critical Care Unit at Solihull needed to be improved. We were concerned about staffing levels in some parts of the trust. However, the trust had an active recruitment programme and could demonstrate that significant numbers of staff were due to start work in early 2014.

Given the seriousness of the concerns that we uncovered, we have formally warned the trust it must improve. We will continue to monitor the service closely and our inspectors will be returning unannounced to check on whether improvements have been made and standards are being met.

We issued a Warning Notice to the trust with regard to the quality of care in A&E at Good Hope Hospital.

Overall trust					
Safe	Effective	Caring	Responsive	Well-led	Overall
RI	G	RI	RI	RI	RI

Birmingham Heartlands Hospital						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident & Emergency	RI	NSE	RI	RI	G	RI
Medical care	G	RI	G	RI	G	RI
Surgery	G	G	G	RI	G	G
Intensive/critical care	G	G	G	G	G	G
Maternity & family planning	RI	G	G	G	RI	RI
Children's care	G	G	G	G	G	G
End of Life	G	G	G	G	G	G
Outpatients	RI	NSE	G	RI	G	RI

Good Hope Hospital						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident & Emergency ⁺	I	NSE	RI	I	RI	I
Medical care	RI	RI	RI	RI	RI	RI
Surgery	G	G	G	G	G	G
Intensive/critical care	G	G	G	G	G	G
Maternity & family planning	RI	G	G	RI	RI	RI
Children's care	RI	G	G	G	RI	RI
End of Life	G	G	G	G	G	G
Outpatients	G	NSE	G	G	G	G

+ We recently re-inspected this A&E through an unannounced visit. Considerable improvements in safety and responsiveness were observed. A formal report will be published soon.

Solihull Hospital						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident & Emergency	NSE*	NSE	G	RI	G	RI
Medical care	RI	RI	G	G	G	RI
Surgery	G	G	G	RI	G	G
Intensive/critical care	RI	RI	G	RI	G	RI
Maternity & family planning	G	G	G	G	RI	G
Children's care	NA	NA	NA	NA	NA	NA
End of Life	NA	NA	NA	NA	NA	NA
Outpatients	G	NSE	G	RI	RI	G

* Safety of the A&E department at Solihull has not been rated. This service is signed as an A&E, but is in fact a minor injuries unit. We are concerned that members of the public, including children, could come to this site expecting a full A&E, but then require urgent transfer to Birmingham Heartlands.