How does the Care Quality Commission’s new approach to acute hospital inspection measure up?

Kieran Walshe, Rachael Addicott, Alan Boyd, Ruth Robertson and Shilpa Ross

Manchester Business School and the King’s Fund.

[Kieran Walshe is a professor of health policy and management and Alan Boyd is a research associate at Manchester Business School; Rachael Addicott is a senior research fellow, Ruth Robertson is a fellow in health policy and Shilpa Ross is a senior researcher at the Kings Fund].

Most people working in an acute hospital will know that over the last ten months, the Care Quality Commission has completely revised its approach to inspecting these huge and complex organisations, in the wake of its own strategic review and influences like the Francis report and the Keogh reviews. Those working in the forty or so NHS trusts where CQC piloted its new approach between September 2013 and April 2014 will have had first hand experience of the new inspections. So how have things changed, and what can be learned from the pilot programme?

CQC used to inspect acute hospitals using its generic regulatory standards, which applied across all health and social care organisations, with small teams of two or three CQC inspectors who often had limited acute sector experience. Each inspection involved a couple of days on-site, and usually involved only one or two specialties or a few ward areas.

The new approach is very different. It uses much larger and more expert inspection teams with both CQC inspectors and external advisors; involves a much more detailed and extensive set of inspection processes drawing on a wider range of data sources and fieldwork; focuses the inspections on eight defined core service areas (A&E, surgery, medicine including care of older people, children and young people, maternity and family planning, end of life care, intensive/critical care, outpatients); assesses and rates performance in each of these core service areas and at hospital and NHS trust level in five domains (safe, effective, caring, responsive and well-led) using a four-point rating scale (inadequate, requires improvement, good or outstanding); and produces a much more detailed and comprehensive inspection report with a full narrative description of services in each of the core service areas alongside the ratings. A typical inspection of a single site acute hospital NHS trust involves around 30 inspectors visiting for 3-4 four days – usually about 90 person-days of inspection fieldwork. This is scaled up for multi-site acute NHS trusts.

CQC commissioned us to undertake an independent evaluation of the new approach to inspection, which has involved us directly observing some hospital inspections, doing 1:1 interviews with around 80 CQC and hospital staff, doing online surveys of CQC inspection team members and hospital staff, observing many meetings and reviewing documents. At the same time, CQC has been seeking to learn from and improve the new approach to inspection during the pilot phase itself.

Overall, CQC’s new acute hospital regulatory model receives more or less universal endorsement from stakeholders, not least from acute hospitals themselves, and is seen as transformative in comparison with the forms of regulation it replaces. It is regarded as much more credible, authoritative, rigorous and in-depth and much less likely to miss any issues of significant concern.
But there are issues with some aspects of the regulatory model, such as its cost, pace and timing, consistency and reliability of assessment, forms of reporting, and impact (see box 1 for some chief executives’ perspectives). The new acute hospital regulatory model has been implemented at scale and pace, and while that has created important opportunities for learning it has also given rise to some challenges which should be resolved in the medium and longer term, as it matures.

Box 1. What some chief executives think about the new inspection model

“I think really there’s no hiding place, so if the inspection is carried out thoroughly, there’s not a lot you can hide from it, it was far broader than anything I’ve experienced.”

“It felt like a full on week, obviously it was a week out of our working lives that was pretty much dominated by it, so it was a big week in that respect. But actually it was very positive, the staff really enjoyed it by and large, you know, the feedback was there seemed to be a buzz around the place, ... The staff felt they were being inspected by peers, people who understood, they enjoyed showing what was good, what they were proud of, they felt they were talking to people who understood them.”

“... Of course in public I’m saying it’s a wonderful report and all of that, fundamentally I would have loved to be in a position of being able to say obviously this is a report I support and endorse, the bold truth is there are things in the report which aren’t right, but the process is such that you can’t really. ... To be fair, there was 80 per cent of the report which I thought was thorough, insightful, appropriate, good”

“So, it comes back to this question of subjectivity. I think, that’s a huge problem for them, because they’ve taken on a gargantuan task, and they don’t have...because they’re being subjective, and not objective, not analytical in their approach, because they have so many different teams, the whole question of regulatory consistency, which is the number one rule of any regulator to be consistent, I think, is...they don’t really have a means of addressing that... “

The new inspection teams are very large, and CQC has brought into its inspections a new cadre of external inspectors (known as specialist advisors), with content knowledge, seniority and expertise it does not have in-house, working alongside its own inspectors who have regulatory experience. Many of these specialist advisors, who range from medical and nursing directors at board level to junior doctors and student nurses, have experience of other forms of inspection (like Keogh reviews, Royal College or deanery reviews, etc). The large inspection teams provide “feet on the ground” in numbers which allow CQC to cover the eight core service areas in depth, but are hard to manage. The costs and sustainability of these very large inspection teams are problematic, and CQC could move in future to make use of smaller, more expert teams with strong regulatory, content and data analysis expertise. Inspection teams also need more formal training and development – it was evident that hospital staff perceived the inspectors as the public face of CQC – and work on this is underway.

The inspection process itself has been a formidable exercise in planning and execution, giving a depth and granularity to the inspection process that was missing before. The pace and intensity of inspections has been acute, with teams often working from early morning to late in the evening.
There is scope to do more preparatory work before inspections, to focus data collection more closely around the key lines of enquiry that CQC has developed to guide inspections, and to allow more time during inspections for analysis and reporting. At the moment, CQC inspections collect more data than is needed or than can be used in performance ratings and reporting.

Although CQC have only piloted the use of ratings in some NHS trusts, hospitals have generally welcomed the return of ratings, and the use of ratings at a clinical service level. They largely agree with the ratings as assessed by CQC inspection teams – the overall agreement is about 77%, though on the whole hospital staff rate their services slightly higher than CQC, and levels of agreement are lower in areas where CQC has given a “requires improvement” or “inadequate” rating.

But hospital staff often have some concerns about the consistency of the rating process. As one person put it:

“I think there does need to be a bit of calibration of these teams, I think there has to be some guidance given about the extent to which they are at liberty or not to make qualitative judgements, the extent to which they actually need to triangulate and base on evidence, and there’s probably something about how you kind of calibrate across the reports as well.” [Trust interviewee]

The rating process is highly implicit and very reliant on professional judgement. In tests of individual rating consistency with CQC inspection team members, we found that levels of agreement about what domain to assign particular items of evidence to varied widely – for example from 98% assigning “Staff left ampules of medicines in labour rooms instead of locking them away” to the safety domain, to 36% assigning “Frail elderly patients with complex needs are given additional guidance and rehabilitation to prepare for surgery” to the responsiveness domain (with others categorising it elsewhere). Agreement on performance ratings of these examples also varied widely – overall, typical agreement was around 65-70%. Published ratings go through an extensive quality review process led by the Chief Inspector of Hospitals, but there are ways that CQC could improve reliability and consistency without sacrificing the scope for appropriate professional judgement, through more detailed definitions and guidance for inspectors, more training on how to rate, simplification of the domain and rating scales, and ongoing monitoring.

Hospitals have generally welcomed the much more detailed and narrative inspection reports, though they see some scope to focus them, and reduce repetition in the narrative. For some, the written report has seemed more negative than initial verbal feedback, and they have been quick to spot any inconsistencies either within their own report or between it and those for other hospitals.

After each inspection, there has been a “quality summit” just after the written report is published, at which CQC has presented its findings and the NHS trust and other stakeholders have responded. We found these were important capstone events to the process, but were too early after publication to provide an effective mechanism for action planning and follow-up. The NHS Trust Development Authority and Monitor have a key responsibility for oversight of performance following inspection, but their engagement in the process has seemed quite variable.

Overall, CQC’s new approach to hospital inspection is a work in progress – as they themselves acknowledge. Indeed, they have already been adapting and changing their methodology during and
after the pilot programme, and more improvements can undoubtedly be made. This is a much more costly and intensive form of inspection, but these are very large, complex, multiservice, high risk and very costly organisations, which probably require this level of scrutiny. But if the new approach to inspection is to be seen as good value for money in the longer term, the key issue for may be how CQC’s inspections are going to be used and acted upon by NHS trusts themselves and by other parts of the complex system architecture created by the Health and Social Care Act (particularly Monitor, the NHS Trust Development Authority, and NHS England). Ultimately, the impact of these inspections on hospital performance is likely to be the most important metric in future evaluations.

[1391 words excluding box]