Changing the way CQC regulates, inspects and monitors care

Edward Baker – Deputy Chief Inspector of Hospitals
Ellen Armistead – Deputy Chief Inspector of Hospitals
Our purpose
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role
We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

We will be a strong, independent, expert inspectorate that is always on the side of people who use services
Our new approach

Registration
- Rigorous test
- Legally binding
- Commitment to safe, high-quality care

Intelligent monitoring
- Data and evidence
- Information from people

Quality of care
- Safe?
- Effective?
- Caring?
- Responsive?
- Well-led?

Fundamentals of care

Expert inspections
- Expert
- Thorough
- Talking to people and staff

Judgement & publication
- Outstanding
- Good
- Requires improvement
- Inadequate

Action

Improvements in care
Our focus is on five key questions that ask whether a provider is:

- **Safe?** – people are protected from abuse and avoidable harm
- **Effective?** – people’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
- **Caring?** – staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive?** – services are organised so that they meet people’s needs
- **Well-led?** – the leadership, management and governance of the organisation assure the delivery of high-quality care, supports learning and innovation, and promotes an open and fair culture.
Intelligent monitoring – key features

• Helps prioritise where and what to follow up
• Raises questions about the quality of care in a provider, does not provide a judgement in itself
• Prioritises a set of indicators relating to the five questions
• Can use both quantitative and qualitative sources
• Incorporates most up to date information that CQC can source
• As transparent as possible with outputs (risk summary and/or underlying analyses) available to providers and the public
• **Indicators we have prioritised for routine monitoring**
• **Prompt action** which can include a request for further information, an inspection of a site

• **Wider set of indicators** that are examined along with tier 1 to provide “key lines of enquiry” for inspection
• Do not cause regulatory action if a single indicator or a combination of several indicators breach thresholds

• **“Horizon scanning”** to identify future indicators
• Devised/updated through engagement with Providers, Royal Colleges, Specialist Societies and academic institutions and international best practice

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**Tier 1 indicators**

- Safety
- Caring
- Effectiveness
- Responsiveness
- Well led

**Tier 2 indicators**

Indicators that are available to the CQC at a trust level across all 5 domains

**Tier 3 indicators**

Indicators being developed that are not yet nationally comparable indicators in association with the professional bodies e.g., Royal Colleges
Larger inspection teams including **specialist inspectors, clinical experts**, and **Experts by Experience**

We will use **intelligent monitoring** to decide when, where and what to inspect.

Inspections will focus on our **five key questions** about services

We have developed the **services/groups and pathways** that we focus on in each sector

**KLOEs (key lines of enquiry)** as the overall framework for a consistent and comprehensive approach

**Ratings** to help compare services and highlight where care is outstanding, good, requires improvement and inadequate
# Rating four point scale

<table>
<thead>
<tr>
<th>Judgement &amp; publication</th>
<th>High level characteristics of each rating level</th>
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<tbody>
<tr>
<td><strong>Outstanding</strong></td>
<td>Innovative, creative, constantly striving to improve, open and transparent</td>
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<tr>
<td><strong>Good</strong></td>
<td>Consistent level of service people have a right to expect, robust arrangements in place for when things do go wrong</td>
</tr>
<tr>
<td><strong>Requires Improvement</strong></td>
<td>May have elements of good practice but inconsistent, potential or actual risk, inconsistent responses when things go wrong</td>
</tr>
<tr>
<td><strong>Inadequate</strong></td>
<td>Significant harm has or is likely to occur, shortfalls in practice, ineffective or no action taken to put things right or improve</td>
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# Rating levels

## NHS acute hospitals

<table>
<thead>
<tr>
<th>Level 1: Every key question for every core service provided</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
</tr>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Good</td>
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<tr>
<td>Medical care (including older people’s care)</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Surgery</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Intensive/critical care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<td>Good</td>
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<tr>
<td>Maternity &amp; family planning</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
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<tr>
<td>Services for children &amp; young people</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
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<tr>
<td>Outpatients</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Inadequate</td>
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<table>
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<tr>
<th>Level 2: Aggregated rating for every core service provided</th>
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<tbody>
<tr>
<td>Overall</td>
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<td>*</td>
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<tr>
<th>Level 3: Aggregated rating for every key question</th>
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<tbody>
<tr>
<td>Overall</td>
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<tr>
<td>*</td>
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<tr>
<th>Level 4: Overall rating for the location</th>
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<tr>
<td>Overall location</td>
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<tr>
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### Timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>September 2013</td>
<td>Wave 1 acute inspections start.</td>
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<tr>
<td>January 2014</td>
<td>Wave 2 acute inspections start (including shadow ratings). Wave 1 mental health and community inspections start.</td>
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<tr>
<td>April 2014</td>
<td>Quarter 1 inspections start (acute, mental health and community) (including shadow ratings). Consultation on provider handbooks.</td>
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<tr>
<td>June 2014</td>
<td>Consultation on provider handbooks closes.</td>
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<tr>
<td>July 2014</td>
<td>Consultation on regulations guidance and enforcement policy. Quarter 2 inspections start (acute, mental health, community).</td>
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<tr>
<td>September 2014</td>
<td>Final versions of provider handbooks, regulations guidance and enforcement policy publishing.</td>
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<tr>
<td>October 2014</td>
<td>New approach rolling out across all providers (acute, community and mental health) – including ratings for all.</td>
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Consultation on draft provider handbooks

We are currently consulting on draft provider handbooks for:

- NHS acute hospitals
- Specialist mental health services
- Community health services

Consultation closes on 4 June 2014

Get involved:

- Web form at [www.cqc.org.uk](http://www.cqc.org.uk)
- Twitter [@CareQualityComm](https://twitter.com/CareQualityComm)
- Email [CQCchanges.tellus@cqc.org.uk](mailto:CQCchanges.tellus@cqc.org.uk)
- Provider online community: join at [www.cqc.org.uk](http://www.cqc.org.uk)
Evaluation of the acute hospital model
• The King’s Fund worked with Manchester Business School to carry out an evaluation of wave 1 of the acute hospital model

• Led by Professor Kieran Walshe, Professor of Health Policy and Management at Manchester Business School

• Interviews with people in CQC and outside about the new acute hospital regulatory model

• Observed hospital inspections – non-participant observation, plus review of documents, attending QA group meetings, quality summits etc

• 1:1 telephone interviews with CQC inspection team members and NHS trust staff following inspections
Overview of emerging findings

- Changes to the approach to analysis of data and development of key lines of enquiry
- Inspection teams successful, require experienced clinicians and senior managers
- Refinements in the timetable and management of the on-site inspection process
- Collection and use of evidence for judgements, ratings and reports
- Trust preparation and resources and the management of the quality summit
Plans for improvement

• Maximise the quality of inspection team members through selection, training, deployment, experience and review/feedback

• Maximise validity, reliability, efficiency and utility of inspections through greater structure/process without constraining flexibility or losing scope for professional judgement

• Maximise validity/reliability of ratings through definition, simplification, training/testing

• Start to measure impact after the inspection to drive change and improvement
Emerging findings from inspections
Initial findings from Wave 1 acute inspections

Many positives for NHS staff and the public to be proud of:

• Compassionate care is alive and well in the NHS
• Critical care services were delivering high quality, compassionate care
• Maternity services were generally providing good quality care, and were good at monitoring their effectiveness
• Many of the trusts were making a determined effort to improve care for patients with dementia
Initial findings from Wave 1 acute inspections

But we also found marked variations in quality:

- Wide range of quality **between hospitals**
- In several hospitals, there were marked variations **between services**
- In some hospitals, there was variation **within a service**

General areas for concern:

- A&E departments are under the greatest strain
- Most services don’t know whether they are effective or not
- Outpatient services were poor across the Wave 1 inspections