

## An inspector calls

### An insider's guide to preparing for a CQC inspection

#### Key points

- Start preparing as soon as you get your inspection date, or earlier.
- Know your organisation's strengths and weaknesses.
- Have mitigation plans in place for areas that need improvement.
- Use the chair of inspection if you have any issues with the inspection team.
- Further work is required to refine the inspection methodology of complex organisations delivering a wide range of mental health and physical health services.
- The approach to inspecting independent mental health sector providers continues to be developed.
- More needs to be done to ensure the whole health economy has a responsibility to take forward actions from the quality summit.

#### Introduction

One year on from the introduction of the Care Quality Commission's (CQC) new approach to inspection, this briefing provides an account of what mental health providers can expect during an inspection, how to prepare, and some top tips from those who have taken part in an inspection so far.

We draw on the learning of the pilot process, which saw 14 mental health organisations inspected, many of which attended the Mental Health Network (MHN) learning event in October 2014. We have also collated the five top tips from chief executives of some of the inspected organisations and from the chairs of inspection teams to support mental health leaders as they plan for an inspection.

#### Background

In 2013 the CQC revised their approach to regulating, inspecting and monitoring providers. New approaches to inspections of mental health and community services were piloted, prior to roll-out in full from October 2014. At the heart of the revised approach is the CQC's commitment to tailor inspections on the issues that matter in each sector, while setting it within the overall framework of whether services are safe, effective, caring, responsive and well-led.

#### A fresh start

*A fresh start*,<sup>1</sup> set out the CQC proposals to change how they regulate, inspect and monitor providers. The proposals included integrating some of the Mental Health Act monitoring with the wider regulatory model for mental health when specialist mental health services are inspected under the Health and Social Care Act 2008. They also included establishing a national team of expert inspectors that would include clinical and other experts, including people with experience of receiving care ('experts by experience').

1. CQC (2013) *A fresh start for the regulation and inspection of mental health services*.

## Implications for mental health services and providers

Focusing on the rights and the experience of people subject to detention under the Mental Health Act remains a critical area of scrutiny. In the refreshed model of inspection the CQC now have a greater focus on community-based services and on the experience of people on community treatment orders. Key areas of focus for specialist mental health services include:

- deaths under mental healthcare
- Mental Health Act 1983
- Deprivation of Liberty Safeguards/Mental Capacity Act 2005 (MCA)
- crisis care
- transitions and interfaces between services
- Winterbourne View Concordat restrictive practices.<sup>2</sup>

### Top tips from inspection team chairs

#### Do...

- ✓ Invest in preparation and start as soon as you know your date, or earlier.
- ✓ Identify a trust lead with very strong project management skills and give them authority.
- ✓ Talk to trusts that have been recently inspected but beware of bias and talk to more than one. The MHN can advise.
- ✓ Get the logistics right and be welcoming to the inspection team. The impression you give can influence opinion.
- ✓ On Day Zero, highlight the positive but show insight and be honest about your weaknesses and what mitigating plans are in place.

#### Don't...

- ✗ Over-manage and definitely don't tell your staff what they can and can't say or insist they have to report back everything.
- ✗ Treat the inspectors as the enemy.
- ✗ Forget about board members. They may be anxious and will need support.
- ✗ Get into arguments with individual inspectors. Use the chair of inspection if you have an issue.
- ✗ Rely on anything that's said or implied by the inspection team until you see the first draft of inspection report.

## CQC ratings

Services and providers are rated on a four-point scale ('outstanding', 'good', 'requires improvement', 'inadequate') against each of the five key questions (see box on page 3) and, where relevant, an overall rating is produced for the service.

Where a key question is rated as 'requires improvement' or 'inadequate' the CQC make a judgement about whether a regulation has been breached and whether enforcement action is necessary.

For providers that combine a diverse range of services, the CQC aim to come to a rating for a set of core services within each sector (such as mental health or community health). This is then used to inform a judgement on what this means for the quality of service provision for a provider, overall. Providers are now required to display ratings.

### Top tips for chief executives

#### ✓ Prepare, prepare, prepare

Don't underestimate the amount of preparation work that needs to be done – you need at least three months' lead-in.

#### ✓ You only get one chance to make a first impression... the importance of 'day zero'

On the first day the senior team gets half an hour to make a presentation to the entire inspection team – this will be the only time this happens.

#### ✓ Understand your organisation:

- know your strengths and weaknesses
- be realistic about existing issues so that there are no surprises
- have detailed improvement plans in place and showcase these.

#### ✓ Self-audit and peer review:

- self-audit helped identify areas for improvement
- peer review replicated the CQC inspections and gave staff an understanding of what to expect.

#### ✓ Get the basics right:

- mandatory training and policies are up to date
- a welcoming and safe environment
- core information is available.

2. MHN (2014) *Positive and proactive care: reducing the need for restrictive intervention*.

## Core services

The size and complexity of some providers means that the CQC will not always be able to inspect every service. Therefore, a set of core services has been identified, which if they are provided will always be included in an inspection. There are 11 core services<sup>3</sup> for specialist mental health services, detailed below.

### Mental health wards:

- acute wards for adults and psychiatric intensive care units
- long-stay/rehabilitation mental health wards for adults
- forensic inpatient/secure wards
- child and adolescent mental health wards
- wards for older people with mental health problems
- wards for people with learning disabilities or autism.

### Five key questions CQC inspectors ask<sup>4</sup>

1. **Is it safe?** People are protected from abuse and avoidable harm.
2. **Is it effective?** People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
3. **Is it responsive?** Services are organised so they meet people's needs.
4. **Is it caring?** Staff involve and treat people with compassion, kindness, dignity and respect.
5. **Is it well-led?** The leadership, management and governance of the organisation ensures the delivery of high-quality, person-centred care; supports learning and innovation; and promotes an open and fair culture.

Inspection teams use a standard set of key lines of enquiry (KLOEs) to ensure consistency under each of the questions.

### Community-based mental health and crisis response services:

- community-based mental health services for adults
- mental health crisis services and health-based places of safety
- specialist community mental health services for children and young people
- community-based mental health services for older people
- community mental health services for people with learning disabilities or autism.

These core services have been selected on the basis of the volume of people using the service, risk and vulnerability of people's circumstances.

### Community health core services:<sup>5</sup>

- community health services for adults
- community health services for children, young people and families
- community health inpatient services
- community end-of-life care.

These services were selected as they are seen as carrying the greatest risk and cover the majority of services that people use. Inspections are not, however, limited to core services.

## The inspection team

Inspection teams are led by an experienced CQC manager and often include experts and specialists in their field who are employed by both NHS and independent sector providers. The size and make-up of the team will vary depending on the size and services of independent and NHS providers. Reports vary from there being teams of 30 to teams exceeding 100.

3. CQC (2015) *How CQC regulates: specialist mental health services. Provider handbook.*

4. *ibid.*

5. *ibid.*

# Preparing for inspection

A typical inspection team will include:

- inspection chair (a senior clinician or manager with knowledge of quality and safety in hospital settings)
- inspection lead – depending on the size and complexity of the inspection task this will be either a CQC head of hospital inspection, an inspection team leader or an experienced inspector
- Mental Health Act reviewers
- clinical experts – clinicians and service managers with mental health or learning disability experience. This may include psychiatrists, psychologists, social workers and nurses
- ‘experts by experience’ – people with experience of mental health services, people with learning disabilities or autism, or people with relevant caring experience
- CQC managers and inspectors (varying levels of seniority)
- CQC data analysts
- CQC inspection planner
- CQC administrative support.

## Types of inspection

**Comprehensive** – these are carried out on a rolling programme every one to three years and which review the provider in relation to the five key questions. They typically involve two–four days of announced site visits, plus unannounced site visits.

**Focused** – these may follow up previous inspections or respond to particular concerns or issues. Inspection team size will depend on the focus of the inspection. The duration and whether the visits are announced or unannounced will vary in each case.

**Themed** – these are carried out when a particular type of service is under review (such as the **Review of learning disability services**) or a specific set of standards (such as the **Dignity and nutrition inspection programme**). They look at specific themes that are set nationally in response to current issues or concerns.

## Pre-inspection

At our event in October and through wider feedback, members advise to start preparing as soon as the inspection date is received. Inspected providers have warned not to underestimate the amount of preparation work that needs to be done, with some saying that a three-month lead-in is required. A number of providers appointed a trust lead to take forward the planning and preparatory process. This needs to be considered a board priority and, if a project lead is appointed, they need to be sponsored by the chief executive.

## Data requests

Data is analysed from a range of sources to help the CQC focus their inspection. This includes drawing on what people, carers and staff say (including the staff survey), complaints, and information from stakeholders and national databases. Information is also gathered from providers and is likely to include requests of:

- management and governance structures
- numbers and locations of services and teams
- safety and quality governance arrangements
- key performance indicators, issues, risks and concerns
- how the board monitors and takes action on safety, clinical effectiveness and patient experience issues.

Providers will be asked to self-assess their performance against each of the CQC’s five key questions, summarising this at overall trust level as well as providing detail for each of their core services.

To gather information from the organisation, the CQC will provide a timeframe to submit the response. Obviously, having your house in order can help to have some information readily available. Inspected providers at our event talked about the importance of having policies regularly updated, ensuring that mandatory training was up to date and that core information was easily accessible.

## Peer review

Conducting self-audits and peer reviews to help identify areas of improvement is recommended.

Knowing your organisation's strengths and weaknesses is important and peer review provides an opportunity to develop a realistic understanding about existing issues. This will ensure that no surprises are identified during the inspection and that improvement plans can be put in place and showcased.

Peer reviews which replicated the CQC inspections also supported staff to understand what might be expected during inspection.

### Communications

Regular communication with staff is encouraged. A number of providers felt that an early process of informing, visiting and supporting staff was important. There is, however, a balance to be had in preparing staff about what to expect and being over-prescriptive about what staff can and can't say. The CQC have been critical of organisations that they perceive are attempting to silence or inhibit staff via over-managing.

The CQC do not expect all staff to have the same level of knowledge and will focus on what the person's role

is, how they provide good outcomes for people and knowing what to do if they have concerns.

### Data packs

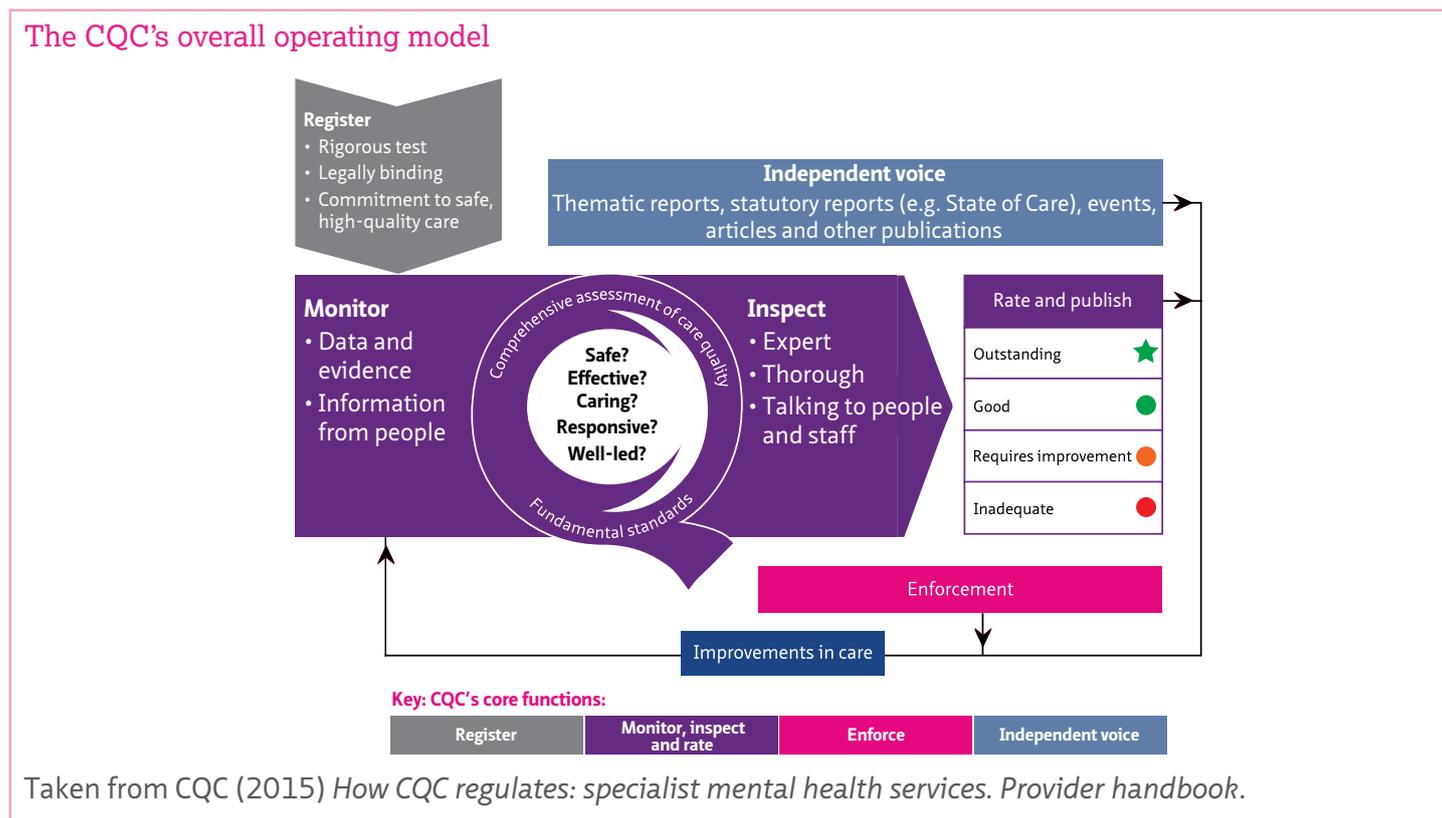
A few days prior to the inspection the CQC will submit data packs to the provider based on the various data sources cited the above, which is used to develop the key lines of enquiry (KLOE) in the inspection.

In principle, there is an opportunity for the organisation to amend inaccuracies in the pack, but in practice the timeframe can be very limited.

### Logistics

Pre-meeting the CQC inspection team was valued by some and facilitated improved working relationships. Good planning and a clear expectation of the CQC remit for the visit made the logistics of the inspection much easier. Usually, this involves identifying a suitable area as a base for the inspection team.

It may be helpful for someone to introduce the inspector to people who use services and to staff, and for someone to be available to accompany the inspector if needed.



# The inspection process



Day  
zero

## Day zero – briefing and planning session

On day one the CQC outline the scope and purpose of the inspection, introduce the inspection team and what the inspection visit entails. The chief executive of the organisation has a 30 minute opportunity to give key messages about the trust, its services, the context for delivery and the chance to raise known challenges.

Members have reported that the importance of 'day zero' should not be underestimated. The presentation was considered vital and was often the only opportunity for the senior team to present to the entire inspection team.



Days  
2-4

## Days 2-4 – announced site visits

The CQC will visit core sites across the organisation, spending time observing care and people who use services. The inspection is also likely to involve:

- talking to patients, service users and staff
- interviews with board members, including non-executive directors
- listening events with the public and carers
- focus groups with consultants/junior and senior doctors, nurses, healthcare assistants, psychologists, administrative staff, foundation trust council of governors
- pathway tracking through care
- reviewing care records and plans
- reviewing policies and procedures.

### Business as usual

An inspection takes place on top of 'business as usual' and inspection team visits or meetings should minimise disruption to service delivery. This includes letting staff know if there are to be changes to planned meetings and to reschedule appointments if there are delays.

The number of inspectors in meetings or in any one place needs to be proportionate. Trusts could sometimes feel overwhelmed by the number of inspectors.

### Data requests

More data and documentation may be requested during the visit. Inspectors might want to see examples of governance systems in action but, generally, on-the-spot requests for data should be avoided. When in doubt, staff should check with the project lead or their manager.

### Inspection chairs

The inspection chair and lead inspector are uniquely placed to set the tone for a good inspection. The inspection chair supports organisations to have open conversations and to help the trust manage broad relationships, staff and service users.

Challenge should be expected in inspections but adversarial approaches are unhelpful. During this stage the inspection team chair proved valuable in keeping the CQC teams on track and as a supportive and bridging role between the provider and the inspection team.



Day  
5

## Day 5 – closing the inspection and feedback

At the end of the announced inspection visit, the inspection chair and inspection team leader will normally hold a feedback meeting with the chief executive, the chair and other members of the provider's board. This also provides an opportunity for organisations to offer feedback and ask any questions.

This is to give high-level feedback only, and indicative ratings are not provided at this stage. Organisations should interpret the feedback as very high level rather than a reliable indication of the final report. Some have found these conversations misleading and that the later

draft report and actions contradicted conversations at the feedback stage.

### Reporting

Organisations will receive a copy of the draft inspection report, and have an opportunity to check the report for factual accuracy. This is the only opportunity providers have to comment on the content of the report before it is published on the CQC website. The judgements made will also update the organisations profile page on the CQC website.

## Quality summits – action planning with local partners

The purpose of the quality summit is to agree a plan of action and recommendations based on the inspection team's findings as set out in the inspection report. The plan is developed by partners in the local health and social care system and the local authority, including commissioners. Quality summits need good planning to have focus and identify improvements. There needs to be advance notice of the date, with clear responsibilities outlined to ensure that the right people can be engaged and are available.

### Accountability of the wider health economy

The quality summit might highlight weaknesses/inadequacies that are the responsibility of the provider to fix. However, there is a need to look at other organisations' role in the problem and finding the solution. Our members have reported the significant challenge of disengaged commissioners – how can they be held to account? Services may not have been commissioned well for a number of years, leaving a provider limited potential to improve services.

Some providers reported having a positive pre-quality summit meeting with commissioners and at the summit. They were, however, disappointed that the momentum for engagement plateaued post-summit. A number of members have reported that their commissioners have not followed up with any actions or money and providers are left frustrated and in some cases powerless to initiate the service changes required.

## MHN viewpoint

It is clear from all those involved in the inspection process, whether it is the provider organisation or an inspection chair, that good planning and early preparation is crucially important for an inspection to go smoothly. Having a clear expectation of the CQC remit and needs during visits made the logistics of the inspection much easier. Generally, people have welcomed the new approach and value the introduction of more mental health expertise in the process. The introduction of the inspection team chair also seems to be a valuable addition, offering a supportive and bridging role between the provider and the inspection team.

Quality summits were particularly noted to need good planning, focus and commitment from the

## Ongoing challenges

The CQC uses a combined inspection approach for complex organisations that deliver mental health and physical health community services. The pilot process identified the challenge for the CQC to get a real sense of a whole organisation, when community health and mental health inspection teams operate very separately. The number of services and their physical spread across a geographical area creates a challenge to plan site visits.

It is also clear that commercial and not-for-profit sector organisations cannot be judged through the lens of the NHS and the CQC. In taking forward refinements to these sectors the CQC will need to account for:

- structure and governance differs significantly to the NHS (and each other) as does the culture
- data collections are not collated in the same way; therefore, benchmarks in the NHS are not as apparent (data from the NHS survey, friends and family, Monitor targets are not available)
- how these providers should prepare for the quality summit and what to expect, with a focus on clarifying the responsibilities of NHS England and the role of Monitor. The CQC aim to provide more information on the approach to inspecting independent mental health section providers, later in 2015.

wider health economy to be of value. One of the key strategic challenges is how to engage the wider health and social care community. Providers described feeling they could not progress the action plans due to the lack of commitment of the commissioners. More needs to be done to ensure the whole health economy has a responsibility to take forward actions – in particular, how are commissioners to be held responsible for their role in an action plan?

For more information on the issues covered in this briefing, contact Claire Mallett, Policy Manager at [claire.mallett@nhsconfed.org](mailto:claire.mallett@nhsconfed.org)

The CQC have a range of resources to support providers, available at [www.cqc.org.uk](http://www.cqc.org.uk)

## Mental Health Network

The Mental Health Network is the voice of mental health and learning disability service providers for the NHS in England. We represent providers from across the statutory, independent and voluntary sectors.

We work with Government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of our members and to influence policy on their behalf.

The Network has 70 member organisations, which includes 92 per cent of statutory providers (NHS foundation trusts and trusts) and a number of independent, third sector and not-for-profit organisations. Our membership also includes housing associations to reflect the link between mental wellbeing and safe, affordable accommodation.

For more information about our work, visit [www.nhsconfed.org/mhn](http://www.nhsconfed.org/mhn) or email [mentalhealthnetwork@nhsconfed.org](mailto:mentalhealthnetwork@nhsconfed.org)



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