1. Breakout session on the ‘Safety Domain’

1.1 Introduction

The CQC has moved to a new approach for defining ‘safety’, with safety key lines of enquiry and prompts that are designed to assess the effectiveness of risk management and mitigation on safety issues. It is therefore a safety model approach, which is a significant change from CQC’s previous, systems-based checklist approach.

The key lines of enquiry for Safety are:

S1 – What is the provider’s track record on safety?
S2 – Has the provider learned when things go wrong and improved safety standards as a result?
S3 – Are there reliable systems, processes and practices in place to keep people safe and safeguarded from abuse?
S4 – How does the provider assess and monitor safety in real-time and react to changes in risk level, including for individuals?
S5 – How well are potential risks to the service anticipated and planned for in advance?

1.2 Delegate feedback on key lines of enquiry

- The new approach is welcomed for having grouped safety together under a single domain, but it has removed significant detail about what specifically will be inspected under safety. There are concerns that this will lead to confusion amongst providers and a lack of transparency and consistency in assessment of the performance between different inspections.
- Monitor’s Quality Governance framework overlaps a lot with the CQC prompts in the key lines of enquiry, which is welcome for its consistency but also
represents potentially unnecessary duplication in regulation and work for trusts.

- Will there still be assessment of compliance with the Hygiene Code? Greater clarity is needed.
- Quality accounts could be a useful prompt in assessing performance for S2.
- For S4 more detail is needed around risk management.
- The key lines of enquiry currently don’t differentiate sufficiently between determining how well staff understand safety systems, from patients and public feedback on safety performance.
- The prompts under S5 don’t encompass the whole risk landscape, only the disruption to services, but risk to service delivery is much wider. The prompts do not encompass the unanticipated - do you know what to look for?, how are you looking for it?, how to anticipate the unexpected?
- Where does patient flow start? Logic and flow doesn’t work in the right sequence.
- How can trusts assure themselves that the day-to-day risk management needs are being met?
- Loss of granularity of details provided by the centralised lists of systems approach to safety. There is a need to ensure consistency of assessment of safety performance across providers and services.

2. Breakout session on the ‘Effective domain’

2.1 Delegate feedback on key lines of enquiry

**Key line of enquiry E1:** Are people’s needs assessed and care and treatment delivered in line with current legislation, standards and nationally / internationally recognised evidence-based guidance?

- From a community services perspective, the word ‘care plans’, included in the description of what ‘good’ looks like for this line of enquiry, might cause some difficulty, e.g. when referring to children developmental checks etc. There is a need to use a more ‘universal’ language when describing the characteristics of good.
- It was observed that the National Institute for Health and Care Excellence (NICE) and the Social Care Institute for Excellence (SCIE) quality standards and guidelines are more of an aspirational best-practice, rather than the baseline to assess services. It is hard to consistently apply such standards across different organisations which contribute to single pathways of care. It would be more helpful to talk about ‘guidance’, which would also allow for those cases where, quite legitimately, decisions that do not follow guidelines are taken.
- Missing from the key lines of enquiry are references to locally developed clinical guidelines, for example why and how they are developed or references to safeguarding.
**Key line of enquiry E2:** How do the outcomes for people using the service compare with other services?

- There needs to be more clarity on the definition of outcomes. What do we mean by outcomes; clinical outcomes, process outcomes, patient reported outcomes or others?
- The use of comparisons is seen as very problematic, both in terms of comparison with other services – different services might have similar outcomes but different levels of intrinsic risk – and in terms of benchmarking across peers – there is a limited number of available benchmarking indicators at a national level.
- A good proxy for comparison would be process indicators, e.g. bundles of care, the Safety Thermometer, etc.
- Under the section discussing the characteristics of good, it states that change to practice is acted upon on a timely manner. It was felt that this was the biggest challenge proposed in this section, since it would be particularly difficult to monitor how such change is embedded in all parts of the organisations and all sites. More clarity is also required on the responsibility of other stakeholders in the local health economy to support change implementation.
- The reference to ‘participation in research and clinical trials’ under the ‘Prompts’ column is not considered to have enough weight from the perspective of a teaching trust given that for them research and clinical trials are a big part of their remit. Conversely, non-teaching trusts mentioned the need for more clarity on what were the exact expectations of their participation in research and clinical trials.

**Key line of enquiry E3:** How does the provider make sure that staff, equipment and facilities enable the effective delivery of care and treatment, which does not impact on quality?

- The line of enquiry should be divided into three different components: staff, equipment and facilities. As it is, the line is too 'crowded' and carries the risk of confusion and diluted analysis.
- It is understood that staff issues are looked at within three different domains: safety, effectiveness and well led. Delegates felt that breaking up the analysis in three distinct components was not helpful, and a single outcome for staff would be more coherent.
- It was questioned if training issues should be assessed under the ‘well-led’ domain.
- Under the column ‘Characteristics of good’, it was felt that the phrasing: “The provider has a process in place for managing the poor or variable performance of staff/teams” was not helpful, since it implies that services are poor because of poor-performing staff. Something on the lines of “tackling staff not being supported” might be more useful to express the inner message around staff engagement.
- There is no link between staff training and the availability of appropriate/ sufficient equipment and facilities. This is very relevant to certain specialties e.g. surgery.
Regarding the line “Design and decoration of buildings and facilities supports a therapeutic environment”, there is need for more clarity on how the CQC will judge those providers who make a conscious choice to invest additional resources in improving/ increasing service provision, rather than spending them in building improvement. Also, design/ decoration requirements might vary across different environment of care.

**Key line of enquiry E4:** How does the provider support and enable multi-disciplinary working within and between services across the organisation and with external organisations?

- It was felt that this outcome is very much based on local relationships, and therefore more clarity would be welcomed on how any rigour can be applied when assessing this dimension.
- It is important to maintain an indicator on coordination, and this might work well for internal joint working and in certain sectors, such as mental health, but externally it would pose a challenge in terms of robust measures. There is a danger that such outcomes, and its related measures, remain aspirational.

### 3. Breakout discussion on the ‘Caring Domain’

#### 3. 1 Delegate feedback on key lines of enquiry

**Key line of enquiry C1:** Are people who use the service treated with kindness, dignity, respect, compassion and empathy while they receive care and treatment from the service?

- Need some measures of subjective terms such as ‘kindness’ – how will this be evaluated by inspectors consistently? Need some prompts to demonstrate how this should be evaluated (e.g. the group felt that ‘kindness’ could only be judged from a patient viewpoint).
- Group generally welcomed more depth in the ‘what good looks like’ column to aid with benchmarking.
- In the mental health guide, the group was keen to have more differentiation for mental health services – e.g. taking a tailored approach for those patients detained under the Mental Health Act.
- Overall the group would welcome more cross referencing between the key lines of enquiry for the different domains i.e. they understood that there was a whole section on safety but they felt that there were implications within ‘caring’ because staff should be anticipating what could cause harm and managing risk as part of ‘caring’.
- The group felt that reference should be made to making reasonable adjustments for patients with particular needs, within caring – examples given included patients with learning difficulties or dementia, or ensuring advocacy.

**Key line of enquiry C2:** How are people who use the service and those close to them involved as ‘partners’ in their care and supported to make informed decisions?

- The group was keen to encourage inspectors to look for evidence of a holistic, joined up approach to the patient, and their family and carers and would like to see some prompts to this effect.
They were equally keen that ‘good’ should reflect evidence of co-ordinated, integrated care where other parties within the NHS or social care were involved in a patient's care.

The group suggested that the handbooks could reflect the learning CQC has taken from its inspections so far and use this in prompts for inspectors to flag those areas we know to be high risk e.g. elderly, do not resuscitate etc.

They flagged a particular prompt around looking for accessible written evidence which they felt wasn’t appropriate for all settings e.g. mental health, ethnicity or frail elderly in some instances. The group would prefer this to be a prompt around ‘accessible communication’ in all forms, including verbal.

There was an overall theme about the complexities of mental health being better reflected where possible. One individual commented that on an autism ward, they wouldn’t have lots of bright, distracting pictures on the walls for instance – whereas on other wards, that might be seen to be creating a more pleasant environment for patients. Another individual suggested that in many instances patients have fewer choices when receiving mental health services, and this may need better acknowledgement in the prompts.

In line with their comments on taking a holistic approach, the group felt that there needed to be some prompts for inspectors to see if a patient’s wellbeing was being taken into account. This could include health promotion e.g. smoking, obesity and mental health issues, regardless of what the primary health need may be.

**Key line of enquiry C3:** Do patients and those close to them receive the support they need to cope emotionally with their treatment and care?

- The group felt that the prompts were a bit under developed here and that the more developed mental health prompts could form a useful base for the other sectors.
- The group suggested some prompts about whether staff knew how to recognise when patients had spiritual needs and can tell when patients need emotional and other support (beyond core clinical treatment), and whether they know how to access that support for them.
- The group felt that moments of transition in a pathway, including discharge are often when emotional needs arise and patients need additional support and that it may be worth exploring if this can be reflected in any way.

### 4. Breakout session on the ’Responsiveness Domain’

#### 4.1 Introduction

The key lines of enquiry for the Responsiveness domain are:

- **R1:** How does the provider plan and deliver its services to meet the needs of different people?
- **R2:** How does the provider make sure that people can access its services in a timely way?
- **R3:** How does the provider take account of people’s needs and wishes, throughout their care and treatment, including at referral, admission, discharge and transition?
R4: How does the provider routinely listen and learn from people’s concerns and complaints to improve the quality of care?

4.2 Delegate feedback on key lines of enquiry

Key points:

- The proactive engagement work necessary with other organisations in the local health economy should be reflected across all prompts.
- The inspection team should proactively seek out positive patient experience and stories and not focus attention on complaints.
- A broader range of data sources should be used, e.g. ‘fit for transfer’ lists and point prevalence audits. Patient survey data and Friends and Family Test results are highlighted in the caring prompts, but are equally applicable here.
- Inspection timetables should be joined together across the board to avoid duplication. An example of how this is already done is the CQC’s links with Royal College of Psychiatry’s quality framework inspections in mental health.
- There should be more recognition of the impact of events in other organisations on planning and delivery within R1.
- Not clear how parts of the care pathway delivered by other providers will be taken account of within R3?
  - CQC confirmed that they would examine the trust’s role specifically within the process and that they are currently taking advice about their approach in the case that the other provided involved isn’t subject to CQC regulations.
- The purpose of data gathering needs to be explicit, to help the quality summit avoiding being mired in potential conflict.
- Prompts should involve evidence gathering.
- There can be a perception that inspections happen in a silo, not fully recognising the joined-up nature of care delivery.

Delegates pointed out the following missing elements:

- The prompts should go further, with more specifics in areas such as commissioner relationships in R1.
- There is currently no prompt in R4 to interview those who have had a good experience.
- Duty of candour reports, whistleblowing reports and PALS records should be added to R4.
- Advanced directives should be added to R3.
- Transition refers to that from child to adult, but should also encompass the move from working age to older people.
- Informal evidence, e.g. NHS Choices feedback, Twitter and patient experience that bypass formal processes should be included.
- It can be dangerous to look at statistics in isolation outside of context. For example, would the inspection team know where to look for the reasons behind a referral to treatment breach?
- It would be helpful for inspectors to examine remedial action plans and whole health economy action plans.
- The impact of clinical networks and specialised commissioning should be acknowledged.
5. Breakout session on the ‘Well-led Domain’

5.1 Introduction

- The key lines of enquiry are set at a level that will also be applicable to combined trusts to achieve consistency and are the same across the sectors.
- The CQC are working with Monitor and the Trust Development Authority to develop a single framework for judging whether or not a service is well-led.

The key lines of enquiry for the Well-led domain are:

**W1:** Is there a clear vision and a credible strategy to deliver high quality care and promote good outcomes for people?

**W2:** Do the governance arrangements ensure that responsibilities are clear, quality and performance are regularly considered and risks are identified, understood and managed?

**W3:** How do the leadership and culture within the organisation reflect its vision and values, encourage openness and transparency and promote delivery of high quality care across teams and pathways?

**W4:** How does the provider engage, seek and act on feedback from people who use the service, the public and staff?

**W5:** How does the organisation strive to continuously learn and improve, support safe innovation, and ensure the future sustainability and quality of care?

5.2 Delegate feedback on key lines of enquiry

- Delegates agreed that the five key questions were appropriate but that, what is crucial is how they will be applied in practice.
- A point was raised about the guidance not taking into account the context of the local health economy e.g. relationships with clinical commissioning groups, local authorities, health and wellbeing boards etc.
- The lack of triangulation on what is well-led is a concern.
- There are mixed views about the prompts for the key lines of enquiry, some find them too mechanistic and others found them helpful.
- Delegates urged the CQC to consider whether they could draw on information that has been carried out on ‘well-led’ previously e.g. are there cultural barometers out there?
- A definition of culture was contested – it could be different across an organisation depending on which department you are part of.
- The definition of well-led veers towards an inward form of leadership rather than conveying a message that leading your organisation is part of working with the local health economy and the rest of the system.
- Delegates felt it useful to use the rating definitions of outstanding and good as the starting point for providers as to where they want to be and then work back.
- There was agreement on the link of culture to quality and safety and engagement with staff. Culture needs to be routed in what providers are delivering for patients.
• Should talk about value rather than finance to ensure a sustainable health economy and consider whether finances are part of defining well-led. Can a trust still be considered well-led if it is in deficit? It could still be delivering quality of care. Should the word ‘value’ be used?

• There was agreement that ‘well-led’ is the most sensitive of the five key questions as it’s about personal judgement.

• Working with others in the health and social care economy should be part of everyday business rather than being restricted to the rating of ‘outstanding’.