Improving Patient Safety:
The role of the Care Quality Commission

Professor Sir Mike Richards
Chief Inspector of Hospitals

December 2013
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.
Asking the right questions about quality and safety

- Safe
- Effective
- Caring
- Responsive to people’s needs
- Well-led
1. Safe: Services are organised to avoid harm occurring to patients

2. Effective: Services are delivered in line with national guidelines and which achieve good outcomes for patients

3. Caring: Direct staff/patient interactions are caring

4. Responsive: The organisation meets the needs of patients (e.g. access, comfort, letters to patients etc.)

5. Well led: Trust level
   Service level
   Ward/team level
The new CQC hospital inspection programme

• We recognise that the previous CQC approach was flawed – but it had good elements, in particular in relation to rigorous evidence gathering.

• We are building on the Keogh Reviews process for 14 acute hospitals with high mortality.

• We are aiming to bring together the best of both approaches (and more)

• We aim to be robust, fair, transparent and (hopefully) helpful.

• Although quality/safety improvement is not specifically part of CQC’s task, we believe that good assessment can help drive quality improvement
The Chief Inspector of Hospitals’ task

- To inspect all acute NHS hospital Trusts/FTs by December 2015.
- To assess whether a Trust is safe, effective, caring, responsive to patients’ needs and well-led.
- To provide a rating on each Trust:
  - Outstanding
  - Good
  - Requires improvement
  - Inadequate
- To re-inspect when necessary and to undertake focused reviews in response to specific concerns.
- To extend the programme to include mental health, community service and ambulance trusts (and independent sector equivalents).
- We have undertaken 18 inspections so far
CQC’s approach

• 3 phases:

1. Preparation
2. Site visits
3. Report
Phase 1: Preparation

- Development of a datapack combining
  - Intelligent Monitoring (Safety, effectiveness, caring, responsiveness, well-led)
  - Local data from the Trust
  - Data from other sources (e.g. CCG, NHS England, HEE, Healthwatch, Royal Colleges, GMC)
- Development of Key Lines of Enquiry (KLOEs)
- Recruitment of inspection team members
Phase 2: Site visits

- Announced and unannounced components
- Announced
  - Interviews: CEO, MD, DoN, COO, Chair + NEDs
  - Focus Groups: Doctors (senior/junior), nurses (registered/student), AHPs, Governors, admin + others
  - Patient and public listening event
  - Direct observation (e.g. wards, A+E, OPD)
- Unannounced visit – will pick up on issues identified at the announced visit.
Inspection Teams

• Chair (a senior figure – usually clinical)
• Team Leader (a senior CQC staff member)
• Doctors (senior and junior)
• Nurses (senior and junior)
• AHPs/Managers
• Experts by experience (patients and carers)
• CQC Inspectors
• Analysts
• Programme management support

Total: Around 30 people
The following core services will always be inspected (as they carry the highest risk):

- A+E
- Emergency medical services, including frail elderly
- Emergency surgical services, including theatres
- Critical care
- Maternity
- Paediatrics
- End of Life Care
- Outpatients (selected)

We will also assess other services if there are concerns (e.g. from complaints or from focus groups)

The inspection team will split into subgroups to review individual areas, but whole team corroboration sessions are vital
Rationale for ratings

• The public want information about the quality of services presented in a way which is easy to understand

• The approach taken by Ofsted is seen as a model, though we recognise that hospitals are more complex than schools. Patients/public may, for example, be interested in a particular service (e.g. maternity or frail elderly care) rather than a single global rating

• Ratings of services and of Trusts should hopefully be a driver for improvement
Ratings: Proposed approach (1)

- A four point scale will be used for all ratings
  - Outstanding
  - Good
  - Requires Improvement
  - Inadequate
- Ratings will always take account of all 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
Bottom up approach: Rate each of the 8 core services on each of the five key questions (safe, effective, caring, responsive, well led).

Then rate the Trust as a whole on the five key questions, including an overall assessment of well led at Trust level.

Derive a final overall rating.

Note: Where Trusts provide separate services (e.g. A+E or maternity) on different sites we will attempt to rate these separately.
We will rate at:

- at location level for each domain for every acute core service provided;
- at location level for each acute core service;
- at trust level for each of the five domains;
- an overall trust level rating for all relevant core acute services.

During Wave 2 we will be testing how we report at location (hospital level) and whether we will be rating at this level.
Data/Surveillance

- Never events
- Serious incidents
- Infections
- Safety thermometer
- Staff survey (selected items)

Direct observation/interviews

- Safe environment
- Safe equipment
- Safe medicines
- Safe staffing*
- Safe processes
- Safe handovers
- Safe information(records

* Staff survey - selected items
Effectiveness

Data/Surveillance
- HSMR
- SHMI
- Mortality alerts
- National clinical audits
- Implementation of NICE guidance

Direct observation/interviews
- Management of the deteriorating patient
- Care bundles
- Pathways of care
- Seven day services
Data/Surveillance
• Inpatient survey
• Cancer patient survey
• Friends and Family Test

Direct observation/interviews
• Staff/patient interactions
• Comfort rounds
• Patient stories
• Response to buzzers
Responsive

Data/Surveillance
- Waiting time standards
- Cancelled operations
- Ambulance stays
- Analyses of complaints

Direct observation/interviews
- Patient reports
- Translation facilities
- ‘Comfort factors’
  (e.g. TVs, seating areas, rooms for parents)
Data/Surveillance

- Staff survey (7 items)
- Staffing levels
- Sickness rates
- Flu vaccination rates
- Board minutes
- Quality governance minutes
- Mortality reviews
- Handling/learning from complaints
- Risk register

Direct observation/interviews

- Interviews (CEO, MD, DoN etc.)
- Focus groups
- Board/ward interactions
- Staff reports (e.g. of bullying)
Summary

1. The new approach to inspecting hospitals represents a radical change.

2. Quality and safety will genuinely be at the heart of everything we do.

3. Good assessment will, I believe, help drive quality/safety improvement.