

[thebmj.com](http://thebmj.com)

- ▶ News: CQC proposes 9% increase to its fees next year (*BMJ* 2014;349:g6290)
- ▶ Letter: New Care Quality Commission inspection regime is under-resourced (*BMJ* 2013;347:f6027)
- ▶ Views & Reviews: Rather than emulate Ofsted's culture of fear, the UK care regulator must engage clinicians to improve standards (*BMJ* 2013;347:f4611)

# Anatomy of a Care Quality Commission inspection

**Gareth Iacobucci** finds out what a hospital inspection is like

**F**ollowing recommendations from Robert Francis's inquiry into failings at Mid Staffordshire foundation trust, England's healthcare regulator, the Care Quality Commission (CQC), has revamped its regime for inspecting NHS services. The CQC's predecessor, the Healthcare Commission, rated Mid-Staffordshire as good in 2007-08 despite high standardised mortality ratios. Clinicians and "experts

by experience" such as patients are now included on larger inspection teams, while 15 essential standards for assessing services have been streamlined into five key areas: whether services are safe, effective, caring, well led, and responsive to people's needs. Services now receive an overall rating of outstanding, good, requires improvement, or inadequate, the same metrics used by the schools regulator Ofsted. The added expenditure of implementing the

new regime means the average cost of inspecting an acute hospital is now £80 000-£150 000 depending on its size. I recently shadowed an inspection team at Kettering General Hospital, a small acute trust in Northamptonshire, to see how the new process was working in practice.

**DAY "0"** (2 September 2014)  
The day before the official inspection begins, the team meet to discuss preparation.



## HOSPITAL INSPECTION TIMELINE

### 2009

The Care Quality Commission is established. It was created under the Health and Social Care Act 2008, is established to replace the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission.

### 2009



The scandal over "appalling conditions of care" and apparently high mortality at Stafford Hospital over many years emerges, prompting questions about why the problems at the hospital were not identified sooner.

### 2013

**February:** An inquiry into the failings at Mid Staffordshire Trust, led by Robert Francis QC, recommends the CQC should have dedicated hospital inspection teams

**May:** Mike Richards, a former national cancer director (right), is appointed as the CQC's first chief of inspectors of hospitals. He pledges to inspect all acute NHS trusts by 2015.

**July:** 11 NHS trusts are placed under special measures, a new process for supporting failing trusts to ensure they improve.



### 2014

**July:** All 11 trusts have improved sufficiently to be removed from special measures. Similar measures planned for GPs.



## PARTICIPANTS' PERSPECTIVES

### Fiona Allinson, lead inspector

Previously I would take around 4-8 people into a trust and spend two to three days there. Here, there are 36 people. Bringing together doctors, nurses, and inspectors gives proportionality that perhaps we haven't had before. The process is much more robust. Equally, we are looking at patient experience and the good things we can highlight that other trusts can learn from. We also look at how open and well led a trust is as that filters all the way through an organisation and affects the culture.

Doctors bring a great wealth of experience. Because they live and breathe audits in their own area, they are able to interpret the data on a much more detailed level than a pure analyst. Because they're used to problem solving, they tend to look at the bigger picture. They can draw those things together a lot easier than other people.

Before, one person wrote the whole trust report. Now ownership lies with the inspectors and it is everyone's report. That can be difficult if two members of the team give very different viewpoints, but generally those get ironed out throughout the inspection. We also involve other key stakeholders a lot more now.



**Bringing together doctors, nurses, and inspectors gives proportionality that perhaps we haven't had before**

### Dhaneesha Senaratne, foundation stage 2 doctor and member of medicines subteam

Within our team there are three with clinical experience and three with non clinical experience. I bring information about things like suitable documentation, suitable interventions, and how efficacious treatments are. I have less experience of working in hospitals than the other two clinicians in the subteam, but what I can do is get access to and speak to junior doctors. When you tell them you're from the CQC, junior doctors are understandably a bit nervous. When you explain that you're just another F2 doctor and you normally work in a different hospital, it allows you to have a frank conversation. If it's from another doctor on your level, you're more willing to have that conversation. A few people expressed surprise that they involve junior doctors on the team and some were interested in doing it themselves. I never did any inspections under the old system. But I can't imagine how five or six people could possibly represent what's going on in a trust. With 30-40 people here it's still quite hard to accurately represent all of the areas.



**When you explain that you're just another F2 doctor it allows you to have a frank conversation**

### David Sissling, chief executive of Kettering General Hospital NHS Foundation Trust

The mixture of clinicians and non clinicians gave them a very strong sense of credibility. The mixture of data, observation, intelligence and interviews followed up by some announced visits hopefully allowed the team to get a fairly rounded picture of the trust.

The staff found the inspectors approachable and receptive to the comments they received. Naturally some were perhaps a bit apprehensive about people descending on us but they found the experience quite developmental.

I think [inspection] provides a degree of reassurance and confidence in the eyes of the public, and an opportunity for organisations to supplement what they should be doing routinely. I wouldn't say it's a distraction from our core business. It's also an opportunity to test yourself against best practice and understand that it's not just about identifying the below the line issues, the goal should be to drive towards the "outstanding" category.



**I wouldn't say it's a distraction from our core business. It's an opportunity to test yourself**



The trust briefs the CQC team at 4 00 pm on issues that may be relevant over the course of the inspection. At 6 30 pm the CQC and trust host a listening event at the hospital, where members of the public are asked to offer feedback on their experience of services in the past 12 months. Around 35 people attend the event.

### DAY 1 (3 September)

The team assemble at 8 45 am. Lead inspector Fiona Allinson asks the team to look for any trust-wide problems that they spot such as lack of cleanliness or compliance with audits. The team divides into seven subteams of 5-6 people, each led by an inspection manager employed by CQC. The seven areas covered are urgent and emergency services, medical care (including older people's care), surgery, critical care, services for children and young people, end of life care, and outpatients and diagnostic imaging.

### Medical care

In the morning I shadow the medical care subteam led by Phil Terry, a CQC inspector. The subteam will inspect 12 medical wards over two days. The team holds a focus group with around seven nurses in a hall at the hospital.

The nurses are asked about incident reporting, ward action plans, and staffing. They are asked to describe elements of care they are proud of and areas in which the trust could do better.

The team inspects acute medical wards, checking staffing levels, ratios, and sanitation. A discussion is held about patient mix on specific wards. The team asks about discharge procedures and how these are affected by social care.

Terry's self deprecating manner puts staff at ease. He speaks one to one with the ward matron before checking the cleanliness of the ward and the condition of the premises. He then speaks to junior staff—this often gives inspectors a completely different perspective, he says.

He later speaks to a consultant. Terry says corroboration is important and that inspection teams must be wary of any discrepancies between what is said by senior management and what is said by those on the ground.

Inspectors monitor whether patients are addressed by their name. Patients are asked about the standard of care they are receiving and whether they are being looked after by named staff and clinicians. They are asked whether they would recommend this hospital.

#### End of life care

In the afternoon I move to the end of life care subteam led by CQC inspector Fiona Collier. The team checks the records and talks to nurses and patients as we visit a ward and the trust's 24 bed stroke unit. The team also asks about care pathways, mindful that what happens outside hospital can impact on what goes on within it.

Nurses are asked to describe how the ward is run, to detail any serious incidents that have taken place, and how staff respond to individual situations.

Team member David Smithard, a consultant geriatrician and stroke physician, talks to the medical registrar and other staff, while Colin Hill, an expert by experience who is a patient representing Age UK, speaks to patients.

Smithard is calm when talking to staff, as if he's talking to a patient. "I can imagine it's quite intimidating for staff to see us coming," he says. "If you're a clinician, you've got to think back to your own work." Smithard knows exactly where to look when analysing records. He asks questions about ward rounds, how often consultants come round, and levels of experience.

The subteams reconvene at 4 00 pm. Inspection chair Kathy McClean leads the discussion. Whereas the lead inspector is typically a CQC employed inspector, the chair



### We see lots of cleaners on the ward. The team discusses whether this is for the benefit of the inspectors or a typical situation

is appointed from an outside organisation to oversee the inspection. McClean's day job is medical director at the NHS Trust Development Authority. Each subteam is asked to give two good things they identified, two bad things they identified, and a provisional rating for their department. There is some disagreement between members of the inspection team on specific elements. Allinson encourages the team to think of overall messages. It is her job to arrive at a judgment on whether the issues raised are isolated or endemic across the trust.

#### DAY 2 (4 September)

I spend the morning with the surgery subteam led by CQC inspector Ernie Botley. The team begins by inspecting an ophthalmology ward. Discussions take place about the layout of the ward and how it affects care, preassessment, staffing, and infection control. Staff are also asked about how different procedures are carried out.

Consultant member Mo Adiseshiah talks to doctors, while Botley speaks to patients and nursing staff in groups and one to one. People are offered opportunities to raise issues in private if they prefer. Staff are asked for examples of how patients are treated with confidentiality and dignity. Issues like room temperature, medications storage, and record keeping are also discussed.

A staff leader tells me how she prepared the team for the inspection, "I said be honest, don't get stressed. It is daunting, but these things need to be done."

One staff member mischievously pulls a face after being questioned—more as an outpouring of relief than a lack of respect.

The team move on to inspect a surgical ward. Staff are asked to describe what's happening on the ward to give the team an overview. The discussion then turns to how incidents are investigated and remedied, audits, and escalation processes.

The subteam holds a small focus group with staff from the surgical ward. They are asked what

training they have received on dementia and the trust's overall attitude to dementia.

The team checks on the consistency of its findings from ward to ward. This helps build up an overall picture of the trust and identify whether what is found on one ward is typical of the whole organisation.

We see lots of cleaners on the ward. The team discusses whether this is for the benefit of the inspectors or a typical situation.

In the afternoon I shadow Peter Quick, an emergency department nurse who is part of the emergency care subteam. Quick is corroborating the team's findings from day 1. He re-examines the layout and the bed vacancies in the department. Just to show that CQC inspectors aren't the ogres some fear, Quick carries a woman's baby through the doors of the emergency department as she struggles with her bags . . . all part of the service.

The subteams reassemble for the closing deliberations at 3 20 pm. Condensing the findings is a challenge, and the team is conscious that ratings can be used crudely. The phrase "look at the words not the rating" is heard more than once. The team is asked to focus on trust wide themes that can be conveyed back to the board. They then produce the rating and key messages to give to the trust.

#### QUALITY SUMMIT (18 November)

Two months after the inspection the CQC holds a meeting as a precursor to the report publication of the final inspection report on 25 November 2014. It is attended by senior trust board members and staff, the foundation hospital trust regulator Monitor, the heads of the local clinical commissioning group (CCG), a local government representative and a patient representative from consumer group Healthwatch.

Allinson leads the first part of the session, outlining the report's headline findings. After the floor is opened for questions, the trust is given time to respond. The CQC displays a willingness to alter some isolated lines in the report after the trust and CCG raise concerns that some words may be misinterpreted by local media and patients.

Monitor then runs through the "must dos," "should dos," and "next steps" that the trust needs to take to ensure it meets its regulatory requirements.

Gareth Iacobucci news reporter, *The BMJ*, London, UK  
giacobucci@bmj.com

Competing interests: None declared.

Provenance and peer review: Commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2014;349:g7353

# MSF: “Ebola has us near breaking point”

Médecins Sans Frontières is bringing doctors to west Africa to help with the Ebola outbreak, writes **Fiona Godlee**, which is why we’ve chosen it for *The BMJ’s* Christmas appeal this year

Six years ago the *The BMJ’s* UK and global readership forged an enduring relationship with Médecins Sans Frontières (MSF or Doctors Without Borders), after the journal chose it as its inaugural Christmas appeal charity. Since then MSF staff and volunteers regularly update *The BMJ’s* readers through blogs on [thebmj.com](http://thebmj.com) about their rapid response and longer term projects to bring medical aid to where it is most needed. The charity works in more than 60 countries, many ravaged by armed conflict, epidemics such as Ebola virus disease, or natural disasters.

This year we are delighted that MSF will once again be the recipient of donations from readers of *The BMJ*. We were again struck by the charity’s neutrality, independence, and collaborative ethos—a logical fit for *The BMJ*.

Why MSF? The current Ebola crisis certainly played a part in our decision, given its current focus (see [www.bmj.com/ebola](http://www.bmj.com/ebola) for all *The BMJ’s* coverage).

But while Ebola may have the global media’s attention, MSF has long running projects worldwide. In the Central African Republic, for example, 300 MSF staff, working alongside 2000 local colleagues, have provided 171 990 malaria consultations, treated more than 3908 patients for violence related wounds, and delivered 4182 babies in 2014.

The ongoing conflict in South Sudan has displaced more than a million people and forced health workers to flee. The new country’s destroyed infrastructure has left many thousands



JOHN MOORE/MSF

**While Ebola may have the global media’s attention, MSF has long running projects worldwide**

of people without access to healthcare. MSF has more than 3800 national and international staff working across 26 projects in the stricken country. In addition to responding to disease outbreaks, its teams provides surgery, maternal and child healthcare, vaccinations, emergency obstetric services, and treatment for malnutrition, kala-azar, HIV, and tuberculosis.

MSF can remain independent and neutral, while working alongside local agencies to provide medical aid where it is most needed, because it limits funding from governments

and chooses to rely mainly on private donors. Between now and the end of January we hope to raise thousands of pounds to support MSF’s work.

Paul McMaster, chairman of MSF UK, said, “This has been a very difficult 12 months for MSF. This time last year Typhoon Haiyan struck in the Philippines. We continue to see very challenging situations in South Sudan, the Central African Republic, Syria, and Iraq. These and many other places require MSF’s medical involvement.”

McMaster added, “But in truth it has been the west African Ebola disaster that has stretched us to near breaking point. We have struggled to contain the epidemic and bring some relief to terrified communities and distraught families.

“This epidemic is still far from over. MSF continues to open new Ebola centres, putting in yet more medical teams, even though they face real personal risks and many return exhausted.

“*The BMJ’s* Christmas appeal and the support of medical colleagues will allow MSF’s volunteers to continue to expand this effort. It is immensely encouraging to us all. Thank you.”

In the Christmas 2008 appeal *The BMJ’s* readers donated more than £15 000 to support MSF’s work. Readers raised a similar sum in Christmas 2009. Let’s try to exceed that figure this time. You can find out more about volunteering for MSF at [www.msf.org.uk/work-us](http://www.msf.org.uk/work-us).

**Fiona Godlee** editor in chief, *The BMJ*  
[fgodlee@bmj.com](mailto:fgodlee@bmj.com)

Cite this as: *BMJ* 2014;349:g7402

## Médecins Sans Frontières’ doctors need your support: please give generously

**DONATE ONLINE:**  
[www.msf.org.uk/thebmj](http://www.msf.org.uk/thebmj)

**DONATE BY PHONE:**  
0800 408 3897



Post this to: Freepost RTGZ-KUHJ-XHKU, *BMJ* Christmas Appeal 2014, 2A Halifax Road, Melksham SN12 6YY

- I’d like to donate £53, which can send a doctor to the field for a day
- I’d like to donate £153, which can provide lifesaving blood transfusions for three people
- I’d like to donate £..... to MSF

I enclose a cheque made payable to Médecins Sans Frontières, UK

Title ..... Name .....

Address .....

Postcode ..... Telephone number .....

Email address .....

MSF respects and values every one of their supporters. They won’t allow any other organisations to have access to your name and address. Neither will they send you constant appeals. They do want to share the reality of their work with you. When you give them your details, you agree to receiving information about their work and the difference your support makes. If you would prefer not hear about them please email Anne Farragher at [uk.fundraising@london.msf.org](mailto:uk.fundraising@london.msf.org), call 020 7404 6600 or write to: Anne Farragher, Médecins Sans Frontières, 67-74 Saffron Hill, London, EC1N 8QX.

I wish Médecins Sans Frontières (MSF) to treat all gifts in the last 4 years, this gift and all future gifts as Gift Aid donations. I confirm I have paid or will pay amount of Income tax and/or Capital gains tax for each tax year, that is at least equal to the amount of tax that all charities and CASC’s that I donate to will reclaim on my gifts for that tax year. I understand that other taxes such as VAT and Council tax do not qualify; and that the charity will reclaim 25p of tax on every £1 that I donate.

Today’s date

/  /

Registered charity number 1026588

7381

