

Item 6

CM/07/14/06

Appendix 1

Evaluating the Care Quality Commission's acute hospital regulatory model: final report

Kieran Walshe

Rachael Addicott

Alan Boyd

Ruth Robertson

Shilpa Ross

July 2014

Contents

	Executive summary	1
1	Introduction	2
2	The logic of inspection	5
	Introduction	
	The need for a new approach to regulating acute hospitals	
	Key features of the new regulatory model	
	Delivering the new regulatory model	
	Intended impact	
	Conclusions	
3	Preparing for inspection	15
	Introduction	
	Preparing trust staff for being inspected	
	Pre-inspection improvement actions	
	Conclusions	
4	Inspection teams and how they work	23
	Introduction	
	Inspector selection and recruitment	
	Team composition and matching	
	Training and preparation	
	Team dynamics and relationships	
	Team roles and responsibilities	
	Conclusions	
5	The process of inspection	34
	Introduction	
	Logistics: organising inspections	
	Using data in the inspection	
	Knowing what to look for: key lines of enquiry	
	Fieldwork: observation, interviews and focus groups	
	Hearing from patients and the public	
	Gathering and synthesising information: note taking and corroboration meetings	
	Unannounced inspections	
	Usefulness of and confidence in using inspection components and methods	
	Conclusions	

6	Ratings and reports	46
	Introduction	
	The rating process: using evidence to develop ratings	
	Using the domains	
	Using the rating scale	
	Verbal feedback at the end of the inspection	
	Producing the written inspection report	
	Conclusions	
7	After inspection: actions and impacts	65
	Introduction	
	Overall impressions of impact	
	Responses to the inspection report and recommendations	
	Inspections as leverage for improvement	
	Conclusions	
8	Conclusions and recommendations	73
	Formative conclusions from the evaluation	
	Recommendations for consideration	
	References	77
Annex A	Research methodology	78

Executive summary

In September 2013, the Care Quality Commission asked a team from Manchester Business School and the King's Fund to undertake a formative evaluation of CQC's new acute hospital regulatory model, which was developed during 2013 and has been piloted in around 40 hospitals between September 2013 and April 2014. The evaluation has examined the diagnostic purpose and value of hospital inspections, and the implementation of the new acute hospital regulatory model. It has provided some early information about the impact of the new model on change and improvement.

Overall, CQC's new acute hospital regulatory model receives more or less universal endorsement from stakeholders, not least from acute hospitals themselves, and is seen as transformative in comparison with the forms of regulation it replaces. It is regarded as much more credible, authoritative, rigorous and in-depth and much less likely to miss any issues of significant concern. But there are issues with some aspects of the regulatory model, such as its cost, pace and timing, consistency and reliability of assessment, forms of reporting, and impact. The new acute hospital regulatory model has been implemented at scale and pace, and that has given rise to some problems which should be resolved in the medium and longer term, as it matures. The pilot programme has provided an important opportunity for experimentation and learning.

The new inspection teams are a work in progress. CQC has brought into inspections a new cadre of external inspectors (known as specialist advisors), with content knowledge, seniority and expertise it does not have in-house, working alongside its own inspectors who have regulatory experience. But the sustainability of the very large inspection teams used seems questionable, and it may be that as the model matures, it can make use of smaller, more expert teams with strong regulatory, content and data analysis expertise. Inspection teams need more formal training and development, and teams need better matching to ensure they have the appropriate expertise and skills for the hospital they are inspecting.

The inspection process itself has been a formidable exercise in planning and execution, with anything from 90 to 320 person-days of inspection fieldwork on each NHS trust inspection, giving a depth and granularity to the inspection process that was missing before. The pace and intensity of inspections has been acute. There may be scope to do more preparatory work before inspections, to focus data collection more closely around key lines of enquiry, and to allow more time during inspections for analysis and reporting.

Although CQC have only piloted the use of ratings in some NHS trusts, hospitals have welcomed the return of ratings, and the use of ratings at a clinical service level. They generally agree with the ratings as assessed by CQC inspection teams, but have some concerns about consistency. The rating process is highly implicit and reliant on professional judgement, and there are ways that CQC could improve reliability and consistency without sacrificing the scope for appropriate professional judgement. Hospitals have also welcomed the much more detailed and narrative inspection reports, though they see some scope to focus them, and reduce repetition in the narrative.

After inspections, the quality summit has been an important launchpad for the CQC inspection report, but less effective as a mechanism for action planning and securing change and improvement. More work could be done to examine what happens after inspections, and to explore the roles of key stakeholders such as commissioners, Monitor and the Trust Development Authority.

1. Introduction

In September 2013, the Care Quality Commission asked a team from Manchester Business School and the King's Fund to undertake a formative evaluation of CQC's new acute hospital regulatory model. The design of that new acute hospital regulatory model is described in the inspection framework [1] and related guidance, and in other CQC documents such as the logic model which specifies how the new regulatory model is meant to work [2]. It is an almost complete departure from the approach used by CQC in the past.

Key differences in the new regulatory model include the use of much larger and more expert inspection teams; the introduction of a much more detailed and extensive set of inspection processes drawing on a wider range of data sources and fieldwork; focusing the inspections on eight defined core service areas (A&E, surgery, medicine including care of older people, children and young people, maternity and family planning, end of life care, intensive/critical care, outpatients); assessing and rating performance in each of these core service areas and at hospital and NHS trust level in five domains (safe, effective, caring, responsive and well-led) using a four-point rating scale (inadequate, requires improvement, good or outstanding); and producing a much more detailed and comprehensive inspection report with a full narrative description of services in each of the core service areas alongside the quantitative ratings.

The new regulatory model clearly draws on past experience in regulation and inspection in the NHS and elsewhere, and it is, of course, a much more resource intensive model of regulation. This new model has been introduced very rapidly with a limited amount of time for preparation, the development of inspection guidance and processes, the recruitment and training of CQC inspection teams, and the planning and implementation of inspections themselves. CQC has made considerable efforts to learn from the early implementation of the new model, and to introduce revisions to the model progressively over the period in which it was piloted from September 2013 to April 2014.

Our evaluation is a formative one, designed to help CQC improve the regulatory model. We have focused on two key questions:

- **Diagnostic purpose** – does the new model provide a better diagnostic analysis of the performance of an acute hospital, are the measures used valid and reliable, is the data meaningful, does it add significantly to what is already known, and does it help not just to assess performance but to understand the causes of performance variation?
- **Implementation** – how does the new model actually work in practice, how are inspections planned, prepared, undertaken and reported, what features of the regulatory team, standards, documents, processes and results seem to have positive or negative effects, what does the process cost and could it be done more effectively or efficiently?

We have been less well placed, as a formative evaluation, to assess the impact of the new model on the hospitals being inspected, though we have sought to understand the early effects of the new model on the hospitals being inspected.

The methodology for our evaluation is described in detail in Annex A to this report. In brief, between September 2013 and May 2014 we gathered and analysed information from a wide range

of sources across both waves of the pilot inspection programme and from some inspections after the pilot programme was completed, including:

- Documents about the new regulatory model and the acute hospital inspection framework, including guidance, templates and the documents produced for the inspections.
- Face-to-face interviews with 18 people from CQC and some other agencies (NHS England, Department of Health, Monitor, the Trust Development Authority) undertaken in autumn 2013 about the new acute hospital regulatory model, how it had been developed and how they thought it was intended to work across all of the organisations involved.
- Observed inspections for 6 acute hospitals drawn from groups 2-4 of wave 1 (in October to December 2013), chosen to provide a range of size/scale, geography and risk/performance. The observations focused on what happens during the inspection process. For each inspection two researchers attended the inspection from start to finish, observed most or all aspects of the inspection process and had many informal discussions with participants from CQC and the hospitals, totalling about 48 person-days of observation. One unannounced inspection was observed by a single researcher.
- Telephone interviews following the 18 wave 1 inspections (both those we observed and those we did not). There were 61 interviews in total.
- Attending and observing 4 meetings of the national quality assurance group which reviews reports, the quality summits for 5 of the acute hospitals where we observed inspections and 1 hospital where we did not observe the inspection, and the CQC feedback meeting for representatives from acute hospitals in wave 1.
- An online survey of members of CQC inspection teams from wave 2 (between January and April 2014), and an online survey of a sample of senior managers and clinicians working in the wave 2 acute hospitals. We would note that the latter survey is still underway, with responses from some hospitals inspected in April still being received.
- Observed parts of inspections for 3 acute hospitals after the pilot programme was complete, in June 2014, in order to check for differences from the wave 1 and wave 2 inspections we had already studied. For each inspection one observer attended some or all of the preparation day, a public listening event and one day of a site visit. This totalled about 5 person-days of observation.

The results of our evaluation are presented in this report across six main chapters, and are followed by our conclusions and recommendations in chapter 8. First in chapter 2 we explore the logic of the inspection model, seeking to examine how it was meant to work in order to frame the content which then follows. Then, in chapter 3 we describe how NHS trusts and foundation trusts responded to the prospect of inspection, and what they did to prepare. The next three chapters cover, in some detail, the way the new model was realised in practice. Chapter 4 focuses on inspection teams and how they worked. Chapter 5 describes the process of inspection itself. Chapter 6 examines the way that ratings of performance and feedback and inspection reports were produced. Finally, chapter 7 looks at what happened after inspections, and what early actions or impacts have resulted.

We would like to acknowledge all the people who have contributed to this research. First and foremost, we are grateful to the many staff from CQC and the NHS who were generous with their time in interviews, surveys, and our inspection observations. We would thank many staff from CQC who have helped make the evaluation possible and facilitated access to information and resources we needed, particularly Jillian Marsden and Christina Cornwell. We also thank Emmet Giltrap from the Kings Fund for his work on our on-line surveys, and Joy Furnival from Manchester Business School who contributed to one of our observed inspections. We have received many helpful and constructive comments on this draft report which we have tried to incorporate – any errors or omissions which remain are of course our responsibility.

2. The logic of inspection

2.1 Introduction

In 2013, CQC developed and began to implement an almost entirely new model for inspecting and regulating NHS acute hospitals. CQC undertook around 40 acute hospital inspections using the new methodology from September 2013 to April 2014. Though CQC has sought to adapt and improve the new model throughout this pilot period in response to learning about how it has worked, the fundamental architecture of the new model has remained unchanged. This chapter sets out to identify the reasons for developing the new regulatory model, and to delineate the key regulatory design choices within the model and their implications for practice. The narrative in this chapter is based on our documentary review and on interviews with senior CQC executives and other national bodies and regulators, undertaken in autumn 2013.

2.2 The need for a new approach to regulating acute hospitals

Over recent years there have been several high profile failures of care in NHS acute hospitals in England which have caused many stakeholders to question the ability of existing regulatory mechanisms to identify and act on poor performance. While we do not need to rehearse these events at length, their influence on CQC's new strategic direction which was adopted in 2013 [3], and on the subsequent development of its new approach to regulating NHS acute hospitals (and other health and social care sectors) cannot be underestimated.

The second Francis Inquiry [4] explicitly examined the systems for oversight, scrutiny and regulation in the NHS which had permitted the failures in care at Stafford Hospital documented by the first Francis Inquiry, and was perhaps the most important driver for change. Its many detailed recommendations reinforced the need for a systemic challenge in how NHS trusts and healthcare regulators identify and respond to variations in performance. The Inquiry triggered a system-wide debate about acceptable standards of care within the NHS, efforts to improve transparency and accountability, and the ability of the system to identify and prevent poor performance in the future.

The Francis Inquiry report made it clear that it is the responsibility of all organisations and people working in the health service to strive for a healthy organisational culture and more compassionate patient care. Interviewees reported that the report engaged people in a way that previous reports had not and was a transformative moment for the NHS:

These things [Inquiries] kind of come and go, and some of them bite, and they stay, because they actually begin to change the game about the way people think about things and conceive things. And my personal view is that I think we look back on Francis as being the one that actually put down a pretty serious marker about...a view about the importance of quality and safety in a way.

But widespread concern about the fitness for purpose of the systems for health and social care regulation predated the publication of the Francis Inquiry report. Critical reports by the National Audit Office [5], the House of Commons Health Select Committee [6] and the Department of Health's own Performance and Capability Review [7] recognised that the increasing scale and complexity of CQC's regulatory scope had led to a reactive approach to regulation with limited strategic direction. They also found that as a result, CQC had a poor external profile with key stakeholders and suggested that public confidence in the organisation was low.

The Department of Health capability review recommended that CQC should develop their strategic capabilities, strengthen their analysis of risk, improve transparency, and enhance internal and external accountability and engagement. In addition, it recommended that CQC consider the development and delivery of its regulatory model, including the use of wider sources of information (both quantitative and qualitative) and greater content expertise. This view that the existing regulatory model was not fit for purpose was echoed by interviewees:

It was my view that the CQC had not been as effective as it might be. And part of that was a basic model of regulation using a small number of generic inspectors on an acute hospital, combined with not a great deal of intelligence, or not a sufficient amount of intelligence. It wasn't an appropriate model.

My view is that the model of regulation was fundamentally flawed and wasn't sustainable.

Last year, in the wake of the Francis Inquiry report the Department of Health instituted reviews led by Sir Bruce Keogh [8] into 14 hospitals across England that exhibited a pattern of poor performance, based on their mortality rates. Following these reviews, 11 of the 14 trusts were placed in special measures [ref]. The Keogh reviews demonstrated that Stafford Hospital was not the only acute hospital with significant problems of poor quality care, but they also trialled an approach to investigating or reviewing hospitals which was very different to the existing CQC regulatory model, but appeared to be effective at identifying and diagnosing performance issues. One interviewee commented:

I think Keogh was a wake-up call. Mid Staffs was obviously a wake-up call, but at that point it was possible to say, 'is it just Mid Staffs'? The number of people I heard saying, you know, there's a bit of Mid Staffs in all of us. I don't know if you've heard that said, but I've heard it said numerous times. I think what Keogh said is, okay, they went for some high risk hospitals, but if 11 out of 14 ended up in special measures, we have a...not necessarily a system wide problem, but we have a sizeable problem, and just sacking Chief Executives and Boards is not going to solve this.

In response to these various drivers for change, CQC published their strategy for 2013-2016 in April 2013, outlining their future purpose as to "make sure health and social care services provide people with safe, effective, compassionate, high-quality care and [to] encourage care services to improve" [3]. Through internal and external consultation, CQC set about designing a new regulatory model for acute hospitals, drawing on the experience and lessons of the reviews and reports outlined above, and the approach used in the Keogh reviews.

2.3 Key features of the new regulatory model

The architecture of the new regulatory model for NHS acute hospitals has three core elements – a focus on particular clinical service areas, on defined domains of investigation and on rating performance on an ordinal scale. Taken together, these three elements form a matrix by which the performance of acute hospitals is assessed and reported.

Clinical service areas

The new approach to acute hospital inspection focuses on eight discrete clinical service areas:

- Accident and Emergency
- Outpatients
- End of life care
- Surgery
- Medicine
- Paediatrics
- Maternity and family planning
- Intensive and critical care

CQC considered these clinical areas to potentially carry the most risk within an acute hospital, and to encompass the majority (though far from all) of clinical activity. This is a move away from the previous CQC inspection models which used a generic set of essential standards and applied them to any clinical area, but tended to be focused on some quite specific and tightly bounded areas within a hospital (such as cleanliness or nutrition). It involved a relatively limited amount of actual inspection in one or two clinical area, and then extrapolated those findings to make judgements about the organisation as a whole. Interviewees suggested that the previous regulatory model had been too focused on the regulatory standards, and had missed the wider picture of the clinical service or the organisation:

If I look back to the old CQC methodology, it was very rigorous, in terms of if we're going to go and look at cleanliness, we will look at cleanliness, and we will get the evidence, we will present the evidence, and if it really isn't clean we'll slap a warning notice on. But, you can have cleanliness, you can have nutrition, you can have this...but what's the overall picture? It didn't give an overview, it went in at a level of detail. So I think what we're trying to do now is combine the overview, and where we need it, to get in a level of detail. Now, whether we will pull it off, I don't know.

These eight core service areas were chosen to represent a more complete picture of clinical activity, although it was still acknowledged that they would not cover all of the activities of a hospital and they omitted some important areas:

if we've got to go to all Trusts, on a reasonable budget, and a reasonable number of people being involved, between now and December 2015, we have to cut our cloth accordingly, and what we've done, effectively, is to say the greatest risk in these Trusts, is within the urgent care services, A&E, medicine, surgery, et cetera, and so those are the ones we are going to focus on predominantly.

However, if other data gathering activities identify an area of concern outside of these eight clinical areas the inspection would investigate that service.

If there have been a whole lot of complaints about ophthalmology, we will go and look at ophthalmology. If we hear at a patient listening event that vascular surgery is a problem area, we will make sure we include vascular surgery when we're doing surgery.

Domains

The Keogh reviews were criticised by some stakeholders for focusing on mortality as a measure of organisational performance, and in the final overview report, Sir Bruce Keogh recommended that CQC inspections should focus on a broader range of quality indicators because “poor standards of care do not necessarily show up in mortality rates” [8]. In its new regulatory model, CQC identified five overarching questions to ask in each of the eight core service clinical areas listed above – and then at the level of the hospital and the NHS trust as a whole:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

This range of domains is based on those that Lord Darzi [9] used in his definition of quality – safety, clinical effectiveness and the experience of service users. In designing the new regulatory model, CQC decided to split the domain of patient experience into two components – whether the service was caring and whether it responded to people's needs. CQC also added a new domain, concerned with organisational leadership and governance. One interviewee commented:

We've got these five domains now: safe, effective, well led, care and responsive. But I think we're about giving an account of quality in the NHS in a much more user centred way. I think the model that we had before was a fairly minimum standard, bottom up approach that tended to focus on individual [standards]... But in no way was it a real lever to improve quality across the NHS. So I think there's something about talking in terms that people understand.

CQC have articulated their definitions of these domains in their initial consultation document and subsequent guidance and handbooks [1]. In discussions around the ambition of the model and domains, there was generally consensus that these represented sensible and meaningful domains for measurement. However, there were discussions about their relative measurability, likely relationships between these domains, and the potential contribution of regulation as a means of assuring or improving performance across these domains – particularly leadership.

It [regulation] is becoming the main lever if we're not careful, and I do think that simply won't work on leadership and governance

Ratings

Another key feature of the new regulatory model was the introduction of quantitative ratings. CQC had not been rating acute hospital services since it was established in 2009, although the two predecessor healthcare regulators (the Commission for Health Improvement and the Healthcare Commission) had produced and published annual star ratings for hospitals, and the predecessor regulator for social care (the Commission for Social Care Inspection) had also produced ratings for social care providers.

CQC considered ratings to be a powerful potential driver of behaviour change – more powerful than the tools they already had available to them, such as compliance actions which held negative associations and were often seen as too crude an indicator of performance or quality:

Compliance is a dreadfully depressing way of describing care. The number of compliant services I've been into with CQC that I would not allow one of my family members to be treated in is higher than I would want it to be

All compliance did was pick up on a very small number of fairly black and white standards. It was quite a binary system, and I think as a result, it encouraged a slightly complicit approach in tolerating stuff that we said was compliant, but actually, not good.

Moving from this “binary” approach of compliance or non-compliance, the new regulatory model involved the assignment of ratings for each clinical service area, in each of the domains – ultimately providing an overall rating for each clinical service and for the hospital the NHS trust as a whole. The rating scale CQC adopted is based on that currently used by OFSTED in their inspections of schools:

- Outstanding
- Good
- Requires improvement
- Inadequate

However, OFSTED assesses each secondary school on just four domains – achievement, quality of teaching, behaviour and safety of pupils, and leadership and governance – and does no ratings at a sub-school level (for example, faculties or subject areas) so each inspection produces four ratings. In contrast, the new CQC model involves producing ratings in five domains, at service, hospital and trust level. This means around 48 ratings for a single site acute hospital NHS trust.

The use of ratings represents a departure from the approach used in the Keogh reviews, which were based on a narrative assessment and reporting approach. In 2013, the Secretary of State commissioned the Nuffield Trust to undertake a review of whether the government should introduce these OFSTED style ratings [10]. The conclusion of this review was that ratings could help to enhance accountability, allowing the system to better understand and improve performance across providers. The real impact of ratings was considered to be at a clinical service level. The review warned that hospital-level aggregate ratings would be too diluted to present timely information on patterns in organisational performance.

In adopting this approach to rating, a key concern for CQC was how they would articulate their definitions of each grade on the rating scale and how they could ensure consistency of judgement

across core service areas and across inspections. Although extreme high or poor performance might be more straightforward to rate, it might be more complex and difficult to differentiate reliably between services, hospitals or NHS trusts who were more average performers.

And the bit that I really struggle to work out, is...not really struggle, but I don't understand and I'm going to be really interested to see it in action, when we go and observe some inspections, is how you go from kind of a pile of pieces of paper and data to a judgement of, requires improvement versus good, or possibly, good versus outstanding. I think I can see...I'm sure you'll be able to differentiate outstanding and inadequate, but it's the intermediate barrier, intermediate boundaries, I think, in these ratings that I suppose we're going to find out.

2.4 Delivering the new regulatory model

To deliver the regulatory model outlined above, CQC also proposed a new approach to some key features of the inspection process itself – how the model would be enacted, who would undertake inspections, how judgements would be made and who would be making them. While CQC were designing the new regulatory model, they appointed a Chief Inspector of Hospitals to oversee the new regulatory model for acute hospitals, who brought considerable experience of undertaking reviews of hospitals and clinical services, most recently as part of the Keogh reviews.

Our interviews highlighted three features core to the delivery of the new regulatory model – bigger inspection teams, a wider range of expertise within these inspection teams, and a focus on identifying and sharing good practice alongside areas of concern for improvement in the narrative of inspection reports.

Large inspection teams

In order to assess and rate all the eight core clinical service areas across all of the quality domains, CQC decided that they needed more capacity or “feet on the ground” in inspection teams. The size of the team would reflect the size and complexity of the hospital being inspected, but they envisaged that each core service area would have some dedicated inspectors. The need to conduct fieldwork in acute hospitals across all of the core service areas, generated the question of whether it would be more appropriate to have a small team spend more time inspecting within a hospital, or to have a large team inspecting over a shorter time period:

Within two days on site, you could get a pretty good impression about what was working, what wasn't working

if you have a really big team you're on site for a short length of time, which I think is less disruptive to the Trust, in many ways, that's being visited, and it's much more realistic in terms of getting clinicians out of hospitals.

Expert inspectors and professional judgement

CQC inspections had previously been undertaken by professional compliance inspectors, assessing a hospital against a generic set of essential standards. The new inspection teams were to be large and include a wider range of expertise, including clinicians, managers and experts by experience. Judgements were to be made through a combination of professional judgement and observation, along with routine performance data.

Each inspection was to be chaired by a medical professional and led by a CQC compliance manager. Other CQC compliance inspectors would work within each of the sub-teams allocated to the eight clinical service areas. Working alongside the chair and CQC staff, the external expert inspectors were expected to offer greater insight into the operation of an acute hospital, based on their personal experience and professional judgements. External expert inspectors were intended to offer greater credibility to the inspection process, bringing technical or experiential knowledge. It was envisaged that CQC staff inspectors would provide knowledge of the regulatory framework and support other inspectors in evidence collection.

In theory we can make comments that you'd have to have a clinical background to be a good inspector in a hospital, but actually observing some people with a police background, working alongside clinicians, it works very well. So, some of us may need to change our views on that. It's not that we would necessarily send an ex police officer solo, but as part of a team, God, they're good at interviewing, God, they're good at evidence collecting. And so there is a strength in that diversity

Despite general agreement for involving experts in inspection, there was tension in how these experts would be used in practice and how their judgements would be weighed against other sources of evidence. Some interviewees were concerned that basing inspection decisions on these expert judgements could actually weaken the credibility of the process.

I've heard people say you just get a feel for the organisation, you can just smell whether an organisation... No, you can't, you can't. That's simply nonsense. All right, there might be five people on the planet that can but you can't and the you matters because it matters who's making a judgment, it matters how they're doing it. So that's quite concerning.

Some interviewees suggested that these concerns should be alleviated through a more formal or structured approach to collecting evidence.

And my personal view is that we need to have quite a clear set of rules and overlay judgement. Not start from the perspective that it's just all about judgement.

While others were much less prescriptive about the methods of evidence collection.

I'm not trying to dictate you must always look at 25 sets of notes for this or that, but a prompt list, which is very different from a tick box list, could be useful to people.

Further to these concerns, there was some debate regarding the involvement of other stakeholders from within the local health economy, such as commissioners. The Keogh reviews had involved commissioners in inspections, engaging them before the inspection and then inviting them to

observe the inspection in action. The means by which CQC proposed involving commissioners was to be much more formal – through consultation and submission of a formal response. Some interviewees argued that commissioners have considerable local knowledge that they would be able to impart more discursively, but views were mixed:

And we're actually piloting having them [commissioners] as observers on some of our corroboration sessions. So when we get all the teams back together, which we do twice a day at lunchtime and the end of the day. In [name of hospital] we had the CCG chair and one or two others in watching from the back – they weren't allowed to speak. Because it happened on Keogh and it was apparently very useful. I wasn't convinced by it

These differing perspectives demonstrate some tensions in the design of the new regulatory model which had not been resolved prior to implementation, such as the role and contribution of expert inspectors and other stakeholders, the nature of evidence and how its validity is established, and the methods for collecting, validating, weighting and combining evidence to form ratings.

Identifying and sharing good practice

Although not fully conceptualised in the design phase, CQC were keen to implement a model that was less punitive but equally focused on identifying and sharing examples of good practice.

I think part of our job is to disseminate what we learn, and that in itself, that, if you like, will be part of our improvement role. So, if we find three or four hospitals that have really cracked complaints handling, so they're not just saying, we had 300 complaints and 85 per cent were responded to within 25 days, but they're saying, this is how we learned from the complaints, this is what we've done as a result of our complaints, I think we may well be able to promote better complaints handling across the country. So, yes, that is our role in improvement, is in spreading good practice

Acute trusts were to be encouraged to highlight good practice, which would be incorporated in the final report. CQC had aspirations to share these examples as a means of improving the performance of other trusts. However, the logistics of this process were not clearly articulated.

Whether or not you end up having a separate webpage, part of the CQC ideas of improvement stuff. The difficulty is that those kind of things exist but people don't ever take the time to look at it, so NHS Improvement or NHS IQ exist but people don't use their website or use the tools they provide. So it's trying to get that balance of actually saying that we've got these problems or saying that we've got these solutions but actually putting them in a place that actually people can access them. The other option is buddying up, whether or not there should be more of that. I mean I have to admit, I'm a big fan of that, but...

Despite this ambiguity, there were a range of ways that CQC saw the new process having an impact on acute trusts and the wider health economy.

2.5 Intended impact

The new approach to acute hospital inspection was a product not only of concerns that the previous regulatory model had not been able to identify problems of poor performance, but also that mechanisms for acting to deal with poor performance had been lacking. We explored with interviewees what forms of impact they expected the new regulatory model might have, and how it might lead to or catalyse change. At the most basic level, there was an aspiration that over time the number of hospitals and service securing good and outstanding ratings would increase, and that for hospitals which performed well in inspection the process would provide useful external validation of their performance.

Interviewees also described a wider range of intermediate impacts which they hoped or expected would result from the new approach to acute care regulation.

First, they commonly described how the inspection process holds a mirror up to the organisation. Some of the feedback might be a surprise to the trust, but in most cases it would be expected to validate what they already know. Most were clear that the role of the inspection was to highlight areas of concern, identifying problems but not solving them. Although the ambition is to improve hospital performance through inspection, interviewees did not consider CQC to have a direct role in guiding this improvement.

it is not CQC's job to do the improvement, but it is...we provide the diagnosis, we provide the understanding of what's going on. Somebody else provides the prescription. [That comes from] predominantly the Trust itself. Certainly, all the better ones should be able to. But, where they can't, that is the responsibility of Monitor and TDA. Working with any others, they can bring in whoever they want. But it is very clear to me, it is not CQC's role to do the improvement. And there's a very good reason for that. Because we've got to go back and re-inspect. If it's been our job to improve them, we are going to be biased about whether they've improved, or could be biased about whether they've improved. Marking your own homework and all that.

Furthermore, some interviewees felt that CQC had quite crude and limited leverage to influence improvement or hold providers to account for addressing areas of concern raised as a result of inspection:

Our enforcement powers are not exactly irrelevant in the NHS, but they don't bite in the same way that Monitor and TDAs do. So I think that is a more credible and actually more useful set of levers that they have to bring back and prove them.

Rather, they saw this function of securing improvement after inspection, or ensuring improvements were achieved, as one that should be predominantly fulfilled by local commissioners or by other regulators, such as Monitor (for foundation trusts) and TDA (for non-foundation trusts).

What we're trying to do is also do something that can hold the system to account. Not explicitly, because we don't have the legislative authority or remit to do that, but I think the way in which we describe the problems at some of these trusts, we'll be pointing a very clear finger at the TDA. Or at Monitor or at the CCGs

Interviewees felt this expectation had been explicitly built in to the new regulatory model because it incorporated a quality summit after each inspection, at which local commissioners, regulators and providers would be gathered together to hear feedback from the CQC inspection team, see the written inspection report, and develop an action plan and timeframes for achieving necessary changes and improvements. Although there were mixed views about how and whether commissioners could be involved in the inspection process, there were seen as a key stakeholder in the period following the inspection. Interviewees felt that engaging commissioners and others within the local economy through the quality summit was useful for understanding and agreeing responsibilities about ongoing improvements and accountability.

Then there's the report phase, at the end of which we have a quality summit the day before the report's published. That's a chance for us to stand up and say what we've found which is wrong is x, y and z. But then the TDA if it's a non foundation trust, or Monitor will be there, as will the CCGs and the trust, and we'll be expecting them to be equal partners as is appropriate, depending on our findings, to explain what they intend to do about it.

2.6 Conclusion

This chapter has mapped out the key features of the new acute hospital regulatory model, and sought to explore how it was expected to work through the views and perspectives of interviewees. As the new model was being developed and piloted, CQC put in place arrangements for trying to gather learning from early inspections and to revise the model and some aspects of inspections as piloting continued. The aim was to see all acute hospitals inspected using the new model by the end of 2015, and to have completed piloting by April 2014:

It's been a very compressed process really, and that's why Wave One is very much about us testing approaches, building things. Wave Two will be much more like 80% of the final model. From 1 April, it'll be a hundred percent of our version one

I think we have changed this after every single visit, and so we should. I'm unapologetic about that, we've got to learn from experience

The rest of this report examines how this new regulatory model has played out in practice, and how the features of the model have worked – such as core clinical service areas; domains of investigation and ratings; large inspection teams incorporating a range of professionals; inspections that integrate professional judgement and observation with routine performance data; and the process of reporting and action planning that highlights good and bad practice and engages others within a local health economy to support improvement.

3. Preparing for inspection

3.1 Introduction

In this chapter we consider how NHS trusts and their staff prepared for CQC inspections, how this influenced the conduct of those inspections, and how it impacted on pre-inspection service improvement. We also explore the interactions between CQC and trusts in advance of inspections, and draw some conclusions regarding the key issues affecting preparation for inspection. Much of the detail in this chapter is drawn from interviews and surveys with trust staff from the first wave of inspections.

Trust staff reported that prior to their inspection they were generally positive about the new CQC approach to inspection, and there was a willingness to engage with and prepare for the process. Trust staff were largely confident that the inspection would focus on issues of importance to the trust and provide an opportunity to gain useful learning about those issues.

We thought, maybe, this was going to be a more effective form of evaluation, because it would be a bigger team with more time, the ability to scratch below the surface, and the ability to have a sensible conversation about issues, rather than a fairly superficial judgement about what was going on (Trust staff)

This meant that NHS trusts took their inspections seriously, investing significant resources in ensuring that the organisation and its staff were adequately prepared.

3.2 Preparing trust staff for being inspected

There are a number of ways that NHS trust leaders prepared their staff for the CQC inspection. Some of this activity was aimed at reducing anxiety about the process. Much of the information that is collected by inspection teams is gathered through interviews with trust staff and observation of hospital activity. The prospect of being interviewed and observed could produce feelings of anxiety amongst staff prior to the inspection visit. They may be concerned that their service is being unduly scrutinised, that they may not know answers to questions they are asked, or that they could share overly negative information.

People knew that we were on the list [of Trusts to be inspected], they wanted to understand why we were on the list, was it because we were a bad hospital or anything like that (Trust staff)

Staff become very frightened about letting the organisation down (Trust chief executive)

This anxiety may have related to experiences from previous inspections. Some staff said that they had felt intimidated by inspectors during previous CQC inspections, because of practices such as aggressive questioning, or over-long interviews that took them away from caring for patients.

In order to alleviate these anxieties and otherwise prepare for the inspection, trusts undertook a range of activities. Table 3.1 outlines the range of pre-inspection preparations reported by trust staff

in our survey of wave 2 inspections. The most common activities were to provide information to staff about the forthcoming inspection, and support for those staff who were feeling anxious.

Table 3.1. Pre-inspection preparation activities undertaken by NHS trusts

Answer	Response	%
Provide staff with information about what to expect during the visit	331	95%
Provide support for staff who were anxious or had other concerns about being inspected	289	83%
Gather together service and performance information to give to inspectors	254	73%
Provide staff with guidance about how to respond when inspectors ask questions, observe practices or request information	243	70%
Identify good practice examples to tell the inspectors about	223	64%
Review performance and where feasible address issues found	214	62%
Learn from previous "new approach" inspections E.g. seeking advice from colleagues in other hospitals, joining inspection teams	182	52%
Conduct "dry run" inspection exercises	167	48%
Bring forward actions to address known issues	162	47%
Identify particular staff members to attend CQC focus groups during the visit	117	34%
Other preparations	43	12%
Change staff rotas for the announced visit period E.g. to increase staffing levels, ensure the best staff are on duty	24	7%
Take actions to reduce bed occupancy during the announced visit period	8	2%
Delay actions to address known issues	8	2%
No particular preparations were made	7	2%

Respondents could choose more than one option

Staff briefings

All of the NHS trusts where we undertook interviews reported that they had developed strategies to formally brief staff about the process of the inspection visit. There did appear to be significant interest from staff to know more about forthcoming inspection visits. Some of our interviewees reporting holding many sessions that reached several hundred staff, even in relatively small NHS trusts.

Particular efforts were made to reach frontline staff from the areas to be inspected by CQC, typically through holding a series of open meetings at which a senior manager responsible for coordinating the Trust's activity around the inspection would provide information and answer questions. These frontline staff would be likely to interact with inspectors during the visit, however it appeared that many had little awareness of what to expect. This lack of awareness was particularly noted among junior doctors.

Staff briefings tended to involve explaining the inspection process and how it would be different to past CQC inspections, in order to reduce anxiety and instil confidence; informing staff about how they should behave towards inspectors; and encouraging staff to feed back concerns about services to trust management prior to the visit, primarily so that there would be “no surprises”, but also in case immediate action might be taken to tackle issues.

Briefings about the inspection process outlined key aspects of the new model, such as the domains, the large teams containing NHS specialists and the greater emphasis on identifying good practice; and the various methods of gathering information. This meant that staff could then ask informed questions for further clarification as necessary. Some NHS trusts outlined the sort of things inspectors might look at, and the sort of questions that they might ask; with a few NHS trusts going further, by indicating the key issues that they believed inspectors would be likely to focus on with regard to each service (see below). In some of these briefings, staff also received instruction about their trust’s internal processes around the inspection. For example, one trust asked staff to feed back by email to the trust coordinator during the visit about what inspectors had been asking, so that main messages and an impression of how the inspection was going could be circulated to staff at the end of each day and help to relieve their anxiety.

Many trusts also briefed staff on how to interact with inspectors, with an emphasis on being open and honest, seeking to impart what they know to inspectors, so that the inspectors can get a complete picture of the service.

I know they [the inspectors] appreciate that because it means they’re not trying to extract information from people who are defensive and distant (Trust staff)

You should feel free and able to say how it feels, not to be coerced into saying what you think people want to hear, that’s not how we learn (Trust staff)

Some trust executives were concerned that staff may sometimes tend towards negativity, for example if their service has a history of being criticised. On the other hand, staff should also be honest about the issues that do exist, rather than feeling that this is letting down an otherwise good organisation. Trust executives briefed staff to also focus on examples of good practice as a way of limiting their anxiety and tendency towards negativity.

Sometimes it’s not that staff don’t know it, but if we don’t give them confidence to be able to articulate the answers, then it can come across as if they don’t know it and I think as well, I mean, it’s quite easy for ground floor staff to see an inspection and view it negatively (Trust staff)

Some Trusts saw this as best being achieved through staff going about their work as they would at any other time, being open about issues and concerns rather than trying to hide them.

As much as we try to resolve things [in A&E] we were still very very busy. ... we’ve put extra beds up on the wards to cope with the volumes of patients, and that causes a compromise to patients’ privacy and dignity. We knew that the CQC would pick up on that and the staff were going, ‘oh god should we mention the escalation beds?’ ‘Yes, of course mention the escalation beds’. That is an example which was a big thing in the organisation, and everybody knew that the CQC would not be very happy about that (Trust chief executive)

Alternatively, others believed that a “take us as you find us” approach risked inspectors seeing or perceiving performance that was lower than average. Some interviewees were concerned that performance does fluctuate from day to day depending on circumstances, and staff needed to be given the confidence and information to enable them to provide full, rounded, considered responses that reflect overall performance.

When the staff had been questioned by the inspectors [on a previous inspection], they said, ‘oh we don’t have enough staff, and it’s all too difficult here, and we can’t cope’. And we thought, ‘actually why did they give out that message, when actually we knew that we’d employed 68 new people, and so on and so forth? So, what we tried to do, with that one, as an example, was we did some PowerPoint slides for our ward areas, and we said, ‘don’t forget, we’ve appointed all these new nurses’, and they started on these dates, and these new healthcare assistants started on these dates, this is where we’ve still got vacancies, and these are our plans. Just so that the staff had the information to their fingertips instead of ... staff just blurt out the answer, because they think they have to give an answer (Trust staff)

Some trust managers used this pre-inspection briefing as an opportunity to outline the potential benefits of inspection. If staff have a positive attitude towards the inspection then this could bring subsequent benefits.

A CQC inspection can be a very good tool for clearly articulating standards that are expected, but also enabling staff to celebrate when they achieve those standards and kind of, build up the morale of the workforce (Trust staff)

Some managers built further on this theme of positivity and confidence by using the briefing process to encourage staff to be similarly open and honest with their own organisation about any service issues in advance of the inspection, rather than whistleblowing to the inspectors; and to generate energy among staff to actually address small issues that were within their control.

We would rather share with them [CQC] where we felt we didn’t have reliable systems or services rather than them hold the mirror up and show it to us (Trust staff)

The amount and quality of preparation of frontline staff did appear to vary between Trusts. More than one comment suggested that staff in frequently inspected trusts would be less likely to prepare thoroughly for inspections, because they believed they were accustomed to being inspected and were already sufficiently ready.

It felt to me anyway, in the Trust it was like inspection fatigue, and people were saying, when it’s coming or announced, because we have so many interventions in our own team, we’re well used to inspections. But actually, my throwback was, you’re well used to them, but you’re not well used to preparing for them (Trust staff)

3.3 Pre-inspection improvement actions

Some NHS trusts set up task forces or groups of varying sizes (some small, one a very large group with wide involvement from across the organisation) to identify “quick wins”. Respondents to our

survey reported that they spent an average of eight days each on preparing for the CQC inspection (though there was very wide variation). One of the main areas of focus during this period was cleaning and tidying up the estate.

Sorting out a few things which frankly have been a bit irritating for quite a while. It certainly got the place a bit tidied up and holes fixed and just some stuff done that actually had been around for a while and they hadn't sorted out (Trust chief executive)

Despite the efforts to brief staff regarding how and what information to share with inspectors, interviewees generally stated that their Trusts did not make any significant changes or improvements to services in the run up to their inspection. One of the beliefs underpinning this was that it would be sufficient to demonstrate to CQC that the organisation had identified the key issues that it needed to address and was in the process of addressing those issues.

We felt, well, we know where our problem areas are; we're trying to address them. We've got nothing to fear (Trust staff)

Higher performing trusts in particular were more confident that the inspection would not expose any significant issues that they were unaware of. Rather, the inspection was an opportunity to receive assistance in diagnosing these issues and to help the trust identify improvement actions. One trust described how they decided to explicitly highlight issues the inspectors might not otherwise be aware of, so that there would be an opportunity for the organisation to learn from the inspection.

We're going to have to tell them a few things [in our Trust presentation to the inspectors] and make the inspection worthwhile for us. So we raised every issue that we had any concern about at all (Trust staff)

Although trusts did not undertake any new pre-inspection improvement activities, they did commonly review their governance processes, risk registers and such in order to reassure themselves that they were aware of their key issues, and that any concerns arising from previous CQC inspections had been addressed.

Did we try and dot the 'i's and cross the 't's? Absolutely ... we took the decision that we would be reviewing the risks in the board assurance framework before the CQC came ...we brought our review of those risks forward (Trust staff)

The prospect of the inspection also gave increased focus and impetus to existing quality improvement initiatives.

That was a programme of work that we were doing [already] because we'd been directed to do that by the Chief, but it definitely gained traction because of people thinking they were going to be asked about it [by CQC inspectors] (Trust chief executive)

We already do executive walkabouts here, that's one our tools that we use. But what we did in that five weeks [before the inspection visit], was we made sure we always did them, because it's one of those things that often slips out of your diary, so we did make sure we always did them (Trust staff)

Some NHS trusts produced their own data packs of indicators, sometimes commissioning Price Waterhouse Coopers (who were assisting CQC to prepare the inspection data packs) to do this, in order to predict what issues the inspectors might focus on. This then informed the briefings provided to staff, gathering of further information about those issues, the explanation that the trust would give to CQC about the issues, and decisions regarding feasible actions to resolve any outstanding issues in the time before the inspection.

Is there something we can do in the next five weeks to change those that would make a difference, or do we just need to fess up, actually we don't do very well, and these are the plans that we've got already in place to make a difference? (Trust staff)

However, trust staff were also concerned that superficial attempts at improvement would set a bad example to staff and risked showing managers in a bad light. Managers were concerned that the large, more specialist inspection teams would identify such attempts, so they only initiated improvement efforts that could achieve results in the time available before the inspection.

Our chief exec was very clear that if you're planning to make a change just because the CQC are coming, you should already have made it. So we didn't take the approach of 'oh god, quick, they're coming, we've got to do things' (Trust staff)

This was different [to previous inspections], by the sheer number of people ... they're all over like a rash ... you can't hide anything from a number of people when they're coming in droves (Trust staff)

We'd rather be hung for something else than hung for trying to fiddle something (Trust staff)

We are aware of only one Trust that initiated what it regarded as major improvement efforts in the run up to an inspection.

The chief nurse launched a campaign... getting people to think about what was excellent care and how do you show people that you're delivering excellent care, ... and it was really constructive and really got people energised and interested in what they were doing. So, on the nursing side, they focussed on things like getting quality boards up in the ward with all the data about pressure ulcers and falls...and making sure that every single patient had a board at their bed with their named nurse on it and their consultant and anything else about them that people should know about (Trust staff)

The rationale in this trust was however similar to that in others.

We didn't manage to cure it completely but ... the staff could see that a lot of work was being done to resolve this, which was really important because one of the things we wanted our staff to be able to say to the inspectors when they came round was, yes, we know this is a problem, but we have escalated it and something is being done about it (Trust staff)

3.4 Interactions and information sharing between CQC and trusts in advance of inspections

NHS trusts had significant work to do in advance of the inspection to organise the logistics required, including providing on-site facilities for the inspection team (room, refreshments, guides, internet access, and so on) and scheduling meetings, focus groups and other inspection activities. Making these arrangements was made more difficult by requests being made at short notice, such as the number of inspectors to accommodate or which members of trust staff inspectors wanted to interview.

We didn't even get the six weeks' notice for the dates, let alone individual requests for people. So we couldn't change rotas in that time and patient clinics (Trust staff)

Interviewees generally felt that they would have appreciated more information in advance from CQC regarding the scale and intensity of new style inspections. A national meeting for some of the NHS trusts inspected in the early waves had been useful, but trusts only had basic background information at the time the inspections were scheduled. This was partly because of the emergent nature of the new approach to inspections.

In advance of the inspection, NHS trusts did interact with the leaders of the inspection team (lead, chair and planner), although there was some confusion regarding who they should direct their questions to. The amount of contact appeared to vary from one inspection to another, as did the amount of input from the NHS trust into planning. Most trusts also gathered intelligence about what to expect in the inspection from contacts in other trusts that had been inspected previously (initially there were only Keogh reviews to learn from) and from their staff who had acted as inspectors on other new style inspections.

More of a blank canvas ... the information was very limited, and so we were left, you know, just like other Trusts, trying to find out what the inspection would concentrate on, how it would run, what kind of things they would be looking at. With the logistics, I was probably left to try and find a lot about the logistics from other organisations as well (Trust chief executive)

The experience ... was really quite variable in what they [CQC] 'd done and they were interested in, and a lot of the myths that circulate about what happens on these visits, and that probably was not so helpful. And then, of course we did prepare in some ways, which were a bit of a waste of time in the end (Trust chief executive)

Some trusts had understood from CQC that they were participating in a relatively low key, light touch, pilot exercise to test out the new methods of inspection. But the inspections were actually more formal and official than they had perhaps expected. There was significant media coverage – which did not highlight the pilot nature of the inspections – which concerned some of the trusts that had agreed to participate in the pilot stage. Some of the pilot ratings were also unexpectedly published.

Actually, it didn't turn out anything like that at all. It assumed a much higher profile internally and externally than was intended. And I think that was very unfortunate. I think they should have tried it out beforehand (Trust chief executive)

We thought we'd be totally rating free, until we saw the release on the website where they had lots of reds and ambers and greens. It was a bit of a shock for us (Trust staff)

Trusts were surprised at the amount of information that was requested by CQC prior to the inspection, and there was a lack of clarity about exactly what information was wanted and at what level of detail.

We had been told that they wouldn't ask for loads and loads of policies and procedures, like they used to with the CHI visit. Although, in the end quite a lot of information was asked for (Trust chief executive)

We got a, sort of, shopping list from the CQC, which was then sent out to the various divisions, and we all interpreted it slightly differently (Trust staff)

Following submission of the information which they had been asked for in advance of the inspection, NHS trusts received a draft data pack for review. While trusts did find this to be helpful, it sometimes revealed data quality issues. The final data pack was only being released shortly before the inspection and this did not facilitate trusts being able to provide comprehensive answers to questions it raised.

The fact it was released so close to the visit felt like it was trying to catch you out a bit (Trust staff)

3.5 Conclusions

Overall, NHS trust staff had a more positive expectation in advance of the inspection than they had for previous CQC inspections, and they were confident that the process would provide a more thorough evaluation of their organisation and services. This positive attitude drove much of the preparation activity – as there was an enthusiasm to support the process, alongside a pressure to adequately prepare. Some trusts did allocate considerable resources to preparing for inspection.

However, trusts were concerned regarding the lack of information they received in advance of the inspection and their ability to plan accordingly. Trusts' preparation efforts were somewhat hampered by a lack of timely or sufficiently detailed information about inspection processes and expectations. Some aspects of preparation, such as understanding the inspection model, are likely to be less of an issue once trusts have experienced a new style inspection, provided that the nature of the model does not change significantly before their next inspection. Other aspects, such as the specification, production and sharing of performance and organisational data may require action if they are to be made productive.

Many trusts did not feel that they had adequate time to prepare, to review data packs and other materials, and that expectations (interview requests and inspector numbers) changed with little advance notice. These practicalities and logistics made it very difficult for trust staff to feel confident that they were presenting the image of their organisation that they would have wanted to. Future inspections might benefit from a longer lead in period, with structured timescales that are agreed between the inspection team and trust.

4. Inspection teams and how they work

4.1 Introduction

As outlined in chapter 2, the new approach to acute hospital inspection uses larger inspection teams that involve a range of regulatory and clinical experts. This represents a departure from the previous regime that predominantly relied on focused judgements from CQC-employed compliance inspectors. This chapter describes the composition of these new teams – particularly recruitment, selection and skills matching. We also describe team preparation and inspector training. Based on our observation of inspections and interviews and surveys of inspection team members and trust staff across the first two waves of inspection, we offer some overall conclusions and reflections.

4.2 Inspector selection and recruitment

A key feature of CQC's new inspection model is to bring together large inspection teams, with a range of external professional expertise alongside CQC inspectors – thus combining skills in regulation with professional judgement. Inspection teams typically comprised:

- CQC-employed inspection lead
- Inspection chair – typically a senior doctor
- CQC - employed compliance inspectors, who lead each sub-team
- Doctors – including board members, consultants and junior doctors
- Nurses – including board members, nurse managers and student nurses
- Managers
- Experts by experience – including patient representatives
- CQC-employed data analysts
- Inspection planners

CQC undertook a range of recruitment activities to build these teams and ensure that the range of professional groups and sufficient CQC staff were represented across all scheduled inspections.

Table 4.1 describes some of these methods of recruitment, as reported by inspection team members.

Table 4.1. Methods of recruitment to inspection teams

CQC inspectors	Number	%
It is/will be a responsibility of my job	44	37%
I was asked by another CQC staff member	41	34%
Other route	4	3%
I volunteered	49	41%

External inspectors	Number	%
Formal advertisement/recruitment process	50	22%
Personal request from someone at CQC	41	18%
Other route (please give details)	54	24%
Had already done work for CQC	102	45%

Respondents could choose more than one option

CQC staff interviewees described how CQC had advertised for expressions of interest for CQC staff and external representatives. Most CQC staff involved had volunteered or were asked by their manager to participate, though some did report a tension between doing this new work and sustaining their existing inspection portfolios. Given the numbers of CQC inspectors required, many of these inspectors had backgrounds in inspections of other health and social care sectors and did not necessarily have much experience either of inspecting NHS acute hospitals or of previously working in the acute hospital sector:

We have calls for expressions of interest across the country, saying there is an opportunity for you to put in an expression of interest if they wanted to lead one of these inspections (CQC inspection lead)

To recruit external inspectors or inspection chairs, senior CQC staff had used professional contacts and formal and informal networks (such as royal college affiliations) predominantly, rather than the open recruitment advertising process. One interviewee claimed that ‘my recruitment process was Mike Richards badgering me until I said yes’ (Doctor, CQC inspection team). Others reported that they had been approached because of their prior involvement in the Keogh review teams.

Many experts by experience were recruited through having already worked for CQC as an expert by experience in the past, or through the various patients’ associations or other representative bodies, such as Age UK with whom CQC had established working partnerships.

I was approached. I think that they were looking for – as part of the transition process – to get someone who had experience of caring and/or being involved in the Keogh reviews in order to try and inform the process that Mike’s trying to put in place (Inspection chair)

I applied. I saw the advert in the CQC newsletter...looking for specific health, social care professionals who were interested in becoming specialist advisors. So I applied and was successful (Allied Health Professional, CQC inspection team)

Motivations for participation

Those who volunteered or agreed to join an inspection team were motivated by a wide range of reasons to do so, as table 4.2 shows.

Table 4.2. Motivations to participate as inspection team members

CQC inspectors	Response	%
Personal or career development	51	43%
Opportunity to decide whether I want to work in the Acute Sector with CQC	63	53%
Opportunity to learn about the new inspection model	78	66%
Recognise the potential of the new model and want to support it	47	39%
Other motivation	9	8%
It is/will be a responsibility of my job	36	30%

External inspectors	Response	%
Personal or career development	127	55%
Opportunity to identify good practices to improve services	188	82%
Opportunity to learn about the new inspection model	121	53%
Recognise the potential of the new model and want to support it	121	53%
Payment	29	13%
Other motivation	39	17%

Respondents could choose more than one option

For both CQC and external inspectors, there was a mixture of extrinsic and intrinsic motivations. For example, some spoke of their support for the new model and a desire to contribute to its development; or a wider sense of responsibility to contribute to improvement or evaluation of hospital services.

I think we have a duty as senior clinical leaders in the system to share across the system and share our expertise (Inspection chair)

Other inspection team members had more personal motivations – seeing participation as useful to their career development within CQC, for example, or as an opportunity for them to find out more about the new inspection model and decide which health and social care sectors they might specialise in for the future. Some external inspectors were motivated by the opportunity to gather intelligence about the inspection process, collect examples of good practice to take back to their own organisation, or to better understand what organisations needed to do to meet CQC's future standards for compliance. Inspection team members frequently reported a combination of these motivations.

As a medical director I was encouraged to become involved and my trust was anxious that I should do so, given that we were about to have our CQC inspection ourselves of a similar kind and we were anxious to get some intelligence about that (Doctor, CQC inspection team)

Some CQC staff seemed to feel that they had little choice about whether to participate or not, either because they felt a sense of responsibility if they were a compliance inspector for the area that the trust being inspected was within and they had prior knowledge to contribute, or because they had been asked to take part and felt unable to refuse. CQC staff usually continued to perform their 'day job' (as compliance inspectors for instance) alongside their role in the new inspection regime, and some were not particularly enthusiastic about taking on this new inspection role:

Whilst the CQC pays me on the 19th of the month I'll do what CQC wants me to do (CQC inspection lead)

I was sort of requested to by CQC and didn't get out of the room or think up an excuse quick enough (Inspection team chair)

Since the first wave of inspections in late 2013, CQC has appointed eight Heads of Hospital Inspection (HOHIs) to lead each hospital inspection and four Deputy Chief Inspectors of Hospitals to chair inspections across acute, community, mental health and ambulance services. These appointments may assist in establishing greater continuity and expertise in inspection leadership. These chairs and HOHIs will continue to work with a pool of CQC and external inspectors. It has also put in place processes for recruiting and interviewing external expert advisors on inspection teams.

In the longer term, there may be challenges in maintaining a pool of suitable and willing external inspectors. Although our survey found that very few (1%) external inspectors would be unwilling to participate in another inspection, and most (81%) estimated that they would be willing and capable of undertaking at least two inspections per year. It is worth noting that those who said they would not be able to commit to any (or less than one-per-year) future inspections were all doctors.

Our interviews suggested that any reluctance to participate in further inspections was largely driven by the time commitments involved, the pace and intensity of the workload of inspection, the limited advance notice given of inspections, and the likely difficulties of combining this with their normal working responsibilities and commitments. Most interviewees did not suggest that they were unwilling to participate further because of any particular disagreement with the new approach to hospital inspection.

4.3 Team composition and matching

There was considerable variation in team size and composition across observed inspections, largely driven by the size of the hospital being inspected and availability of inspectors. Inspection teams were divided into sub-teams, in accordance with the eight clinical core service areas being reviewed. Each sub-team generally consisted of varying combinations of a CQC inspector, doctor, nurse, expert by experience and manager. Outside of these sub-teams, the inspection was supported by the CQC lead, chair, data analyst(s) and inspection planner(s). The size of the overall team was scaled up to deal with multi-site trusts. Inspection teams averaged approximately 30 members for a single site acute hospital NHS trust, with teams for large multi-site trusts comprising up to 80 members. The sheer scale of these teams presented some important challenges for those trying to manage the inspection process:

I think it was too big. I think it made it incredibly difficult for me to manage all those people. At times I just felt overwhelmed, because people just wanted you. And I had a queue of people waiting for me, and I just never had time to do the things that I really needed to do – like have time with my sub-team leaders – just by the sheer volume of people really. And dealing with such trivial things – which you have to do, I know you do – but because there were so many people there, it was just such a big scale really (CQC inspection lead)

Over time, we saw reducing numbers of inspection team members across observed inspections. Whereas earlier inspections involved this full spectrum of sub-team membership, sub-teams of later inspections often comprised only some of these representatives. For instance, earlier inspections may have had an expert by experience allocated to each of the eight sub-teams while later inspections may have involved only two or three experts by experience in total (who might then work across a number of sub-teams during the inspection).

We also saw that over the period from September 2013 to March 2014, there was some decline in the seniority and expertise of external inspectors on inspection teams. It appeared that earlier inspections had more board level doctors and nurses on the inspection team while these senior professionals were less well represented on later inspections.

In practice, there were varying levels of experience within and across inspection teams. Whilst CQC inspectors did have experience of compliance and regulation, they were themselves adapting to a new approach to hospital inspection or had been recruited from other health or care settings and were less familiar with acute hospitals. External inspectors had backgrounds in a variety of clinical settings (such as general practice, radiology, anaesthetics) and were generally matched to appropriate areas in the inspection team. It seemed that there had been little selection of inspectors – that the pressure of the inspection schedule meant CQC had needed to accept onto teams those who were able and willing to take on the role:

Well, people put their names forward, to CQC, and I think they just submitted a CV, and as far as I understand it, it was almost like, 'yes okay you're on', sort of thing. I'm not sure that we've really tested out people, and I think that's a huge risk, and I think we've done CQC staff a disservice as well, because it's not that long ago that we were being criticised big time because some of our staff were police officers and stuff like that...and yet, there are some inspectors...I mean I'm a nurse for example, and I think I've got as much if not more experience as some of those – they haven't touched a patient for donkeys years either, so I think we need to be very careful about that (CQC inspection lead)

There appeared to be little explicit matching of skills or experience to particular inspection teams. Potentially due to recruitment challenges, inspection teams were built around pragmatic considerations (such as availability) rather than a considered matching of skills.

I'm not sure that we're checking people out properly. I'm not sure who's making the decisions about what skills people have got really (CQC inspection lead)

Over multiple inspections, CQC inspection leads (and now HOHs) were starting to develop an idea of the team composition needed to undertake a comprehensive inspection. HOHs saw that it was important to have a balance of clinical knowledge alongside skills in regulation and gathering evidence. However, under the current selection process and timescales HOHs receive limited advance information regarding inspection team members. Because inspection leads are unaware of the skills or experience of their team in advance, they frequently expressed concerns regarding their ability to match members to relevant clinical areas or tasks.

I didn't know who I was putting with who when I was planning it, so it was a bit of a guess as to whether we had the right skills. I could identify we had gaps in skills from the team that were provided to start off with, so it was trying to minimise those gaps (CQC inspection lead)

At one stage, three or four days before the inspection we were Googling the names of our clinicians to see if we could work out what they did, so we could see where to put them (CQC inspection lead)

All I knew was somebody was a doctor, or somebody was a nurse, or somebody was a junior doctor – and I didn't have the biography so I didn't really know what specialisms they had. Therefore, putting them in the teams that I put them into was a bit of good luck really more than anything (CQC inspection lead)

Both inspection team members and trust staff felt that the specific composition of the inspection team (particularly the representation of clinical specialties) should be driven by any concerns identified in preliminary data gathering or routine monitoring. However, it has been less possible to put together this ideal team composition in practice.

When I got the data pack it was quite apparent that there was an issue with neonatology, and we didn't have a clinician with that background. In fact, we didn't even have a midwife. So, if I'd have got the data pack earlier I would have liked to have made sure that we've got a neonatologist or an obstetrician or somebody with that background that could look at that for us. We only had two surgeons and one physician and I would have liked another physician (CQC inspection lead)

4.4 Training and preparation

CQC staff involved in these inspections have taken part in a one day course to help them become familiar with the new inspection framework, and external inspection team members have had access to webinars and team teleconferences prior to the inspection visit. Each hospital inspection was immediately preceded by a training or preparation day, where team members came together for the first time as a group to get ready for the inspection. This training or preparation day comprised several elements: learning about the new inspection model and the inspection skills and techniques it requires; becoming familiar with the hospital being inspected; reading and understanding the data

pack on the hospital; planning for the inspection activities to take place over the coming days; and building relationships with other team members.

Earlier inspections classed this initial day as a training day, with the intention to ensure inspectors were all equipped with the skills and knowledge to undertake inspection activities. However, in practice relatively little training took place and this first day has become termed a preparation day. The early part of the day does involve a routine presentation that outlines some of the features of new inspection model and the core principles of the approach (such as domains, ratings, evidence collection, and so on). However, there is no time available to learn, develop and practice skills in inspection (such as facilitating focus groups, undertaking interviews, doing record or pathway audits, and so on) and the pressure of preparation activity needed for the inspection itself rather limits the opportunity for inspection team members to interact and build relationships.

So, the training day I had very little involvement with. I was basically told what we were delivering. Certainly some of the feedback I've had from some of the team since then is they felt it to be insufficient. They're grateful for what they got, but they'd have liked a bit more please (CQC inspection lead)

Not surprisingly, interviewees often reported that they did not feel well prepared for taking on the role on the inspection team, though inspectors with more experience of past inspections (not just with CQC) tended to report more confidence in planning and undertaking inspection tasks. For example, those inspectors who were previously involved in the Keogh reviews often felt that they were more prepared for the CQC inspection they took part in. However, this confidence in the applicability of past inspection experiences could be somewhat misplaced, since the other forms of inspection will have had different objectives, processes and methods.

I think at the end of the [preparation] day the inspection team were reasonably prepared. I think people who'd done the Keogh reviews – some of the feedback was actually that they felt more prepared. Which to me was a bit of a surprise really, because I think I felt less prepared than some of them. People were at different stages (CQC inspector)

Team members therefore primarily gained the skills and competencies to undertake inspection activities through experience, rather than through training. They began inspections with variable levels of prior experience, as shown in Table 4.3. This survey data was collected across the second wave of inspections (approximately six months into the programme) so many CQC and external inspectors had taken part in earlier hospital inspections – only 14% of respondents, reported that this was their first inspection of any kind.

Table 4.3. Prior experience of inspection

	Response	%
None	47	14%
Other "new approach" CQC inspections	147	42%
"Old approach" CQC inspections of acute hospitals	153	44%
Keogh reviews	53	15%
Royal College inspections	32	9%
Others	73	21%
"Old approach" CQC inspections of other health and social care providers	140	40%

Respondents could choose more than one option

As the inspection programme has taken place, the balance of inspection team members with and without prior experience has shifted, and although there appear to be ongoing concerns regarding skills and training our more recent inspection observations suggest that inspectors with some experience of past inspections tend to be more confident and to expect an increasing pace of planning and undertaking inspection tasks. One effect of this could be that new inspection team members without prior experience, now very much in a minority, are more able to be supported and mentored informally by peers, but it could also be that the development of their skills tends to be overlooked.

4.5 Team dynamics

Teams come together on an inspection for a short period of time and need to be able to work professionally and collectively. Quickly building a relationship between members of the inspection team is important to identify skills and expertise; divide tasks up among the team; compare and corroborate findings and reach consensus. This is particularly important for team members undertaking their first inspection. The preparation and planning day is the main opportunity to build these relationships.

Inspection chairs and leads recognised that this team-building function was needed, but tended to feel there was too little time to address it on the preparation day and instead relied on teams building relationships as the inspection progressed:

Having been a manager of teams for a lot of years, getting a team to work together effectively as a cohesive team is not something that is easily done in a very quick amount of time. Usually in most situations if you're working with a team, you've got weeks and months to build a cohesive team and I was aware that I was going into a situation where I've got this team coming together who didn't know each other at all and within the space of half a day I'd got to make them a team – not individuals, but a team that were cohesive. And so for me, that was the biggest challenge I think (CQC inspection lead)

Some inspection leads found this more facilitative role challenging, particularly because they had not previously met the members of the team and did not necessarily have any information about their background or inspection experience. This was especially difficult for large, multi-site teams. Sub-

team inspection leads also highlighted the importance of building relationships and dealing with teams dynamics and ensuring that members understood their relationship to the lead.

In my team I had a couple of board level nurses, I had senior consultant surgeons there. And it's about saying 'I'm the leader, you're an inspector, I'm leading this team and this is how I want this inspection to go'. Because when you get to the report writing stage, if you've not had that level of control over how the inspection has gone I don't know how you would write the report (CQC inspector)

The relationship between the inspection lead and the sub-team leaders was also essential for validating and corroborating evidence across clinical areas, and building consistency across different parts of the inspection. For example, an A&E team might ask a medical team to validate their hypothesis that long waits are due to bed shortages on a particular ward. The inspection lead also had to feel confident that sub-team leaders could undertake inspection activities with minimal supervision.

4.6 Team roles and responsibilities

In general, team members seemed to have a good understanding of their own and others' roles on the inspection team. Overall, external inspectors were essentially providing input based on their content knowledge or experience – whether from a patient, clinical or managerial perspective. CQC sub-team leaders understood their role was to provide regulatory expertise, to manage their subteam, to ensure that the inspection fieldwork covered the necessary areas of investigation, and to undertake their own inspection activities and compile parts of the final report. As mentioned above, inspection leads relied heavily on these sub-team leaders to undertake this role.

I think one of the things I would do differently is put more emphasis on the role of the compliance inspectors [sub-team leaders] within the inspection programme, and the responsibilities that they have. Because they are in effect sort of mini team leaders of those teams. And they have quite a key role. And I think that what I either didn't get – or it was a bit late – it was a bit further on in the process before I realised how key those people are actually (CQC inspection lead)

However, there were some areas of confusion regarding the breadth of the role of external inspectors. Some responses and observations suggested that these representatives were tasked with a specific focus within their area of expertise. For instance in some inspections an external inspector with a background in nursing would focus solely or mainly on issues concerning nursing across the five domains. Or, an expert by experience would concentrate on how services were experienced by patients. However in other inspections, or even in other subteams within the same inspection, these role definitions would be much less clearly bounded, and external inspectors collected evidence and made judgements on a broader range of issues. For instance, an expert by experience would participate in interviews with ward staff, or a doctor inspector would be involved in gathering views from patients.

I know one or two of the lay reps [experts by experience] came up to me and said they felt that they had been held back by the CQC inspectors. So they felt they hadn't been able to give as much as they would have liked (CQC inspection chair)

It would have been good to have had a lay person in on the strategic stuff (CQC inspection chair)

We appoint experts by experience and they are lay people who are bringing a perspective as members of the public and/or users of the health service, service users or people who have an interest in health. I think because some of them came from professional backgrounds they thought that what they were there to do was to bring their professional background into it. If somebody had been a management consultant say, then it was almost like they wanted to bring their management consultancy skills into the inspection (CQC inspection chair)

Furthermore, some CQC inspectors had different views on how much they were to involve the external inspectors in making what they regarded as regulatory decisions – for example, in determining ratings for service areas. Some seemed to see the external inspectors as one source of evidence, there to offer their thoughts or judgements alongside other data sources (such as the data pack, and documentary review). In this model, the CQC inspectors as sub-team leads and team leads were clearly in charge of taking final decisions about ratings, and would not necessarily generate conclusions through corroboration with these external inspectors. However other sub-team leads took a more collaboration and less hierarchical approach, and saw corroboration with external inspectors during the inspection as a collective endeavour across the whole team.

On some occasions, there was confusion regarding the relationship between the CQC inspection chair and CQC inspection lead, who often acted somewhat interchangeably during inspections. Some inspection chairs were content to leave the effective leadership of the inspection to the CQC inspection lead, while others played a more visible and operational leadership role. The distinction between these two roles was not always clear, though we observed little overt friction or contention. The chair and inspection leads were not assigned to subteams, and we observed that they often took on a range of tasks where there were gaps in the inspection team, where they were less unable to disengage from their 'day job' and where support staff were not sufficiently capable of the task. For instance, inspection chairs were observed to take on the role of a clinical expert inspector (undertaking observations within a clinical area), or the inspection lead took on the role of a planner (arranging transport and dealing with other logistics). Although there might be valid practical reasons for this, it could create a gap in inspection leadership.

4.7 Conclusion

The new acute hospital regulatory model is highly reliant on the recruitment and deployment of large expert inspection teams. Our research suggests that both CQC staff and people working in the NHS have been mostly willing volunteers and enthusiastic about participating in the new large inspection teams, but it also suggests that the effectiveness and sustainability of this model deserves some reconsideration. Recruitment, selection, training and team formation all require significant

and careful attention and resourcing, and there are significant development needs in each of these areas. The larger the inspection team required, the more difficult some of these issues may be to manage. We note that even over the short period of the pilot programme we have seen some indications of changes in recruitment that might suggest the current team size and structure will be difficult to sustain in the longer term.

Some of the features of the inspection process itself, which are discussed in the next chapter, affect the inspection team and its recruitment. The intensity of the inspection workload, the short timescales and limited time for preparation, and the challenges of balancing inspection team participation with people's existing work roles and workloads may all be factors in external inspectors' decisions about whether to volunteer to participate in future inspections.

The inspection team – and individual inspectors – are essentially the face of CQC as far as the hospital being inspected and their staff are concerned, and their credibility, knowledge, attitudes, actions and behaviours all help shape stakeholders' perceptions of CQC, as well as being important determinants of the quality and effectiveness of the inspection process. Therefore, it seems likely that resources invested in a much more substantial initial and ongoing training and development programme for inspectors, outside the setting of inspections themselves, would be worthwhile.

Having involved a large number of CQC and NHS staff in the inspection programme to date, CQC is now well placed to develop and maintain a more established pool of inspectors, and to have more detailed information on inspectors' backgrounds, experience, qualifications and prior inspection performance to support inspection team selection and deployment. It should be more possible in the future to identify inspection team requirements in advance and ensure that inspection teams have the necessary specialty, professional and managerial expertise to hand.

5. The process of inspection

5.1 Introduction

The new model for acute hospital regulation described in chapter 2 is in most respects a complete departure from CQC's previous approach. The new approach to hospital inspection employs a much wider range of data sources and a far larger and more expert inspection team; it involves much more varied and detailed inspection fieldwork with greater reach and coverage across eight core service areas in the hospital being inspected; it uses a variety of new inspection tools including an extensive data briefing, listening events, staff interviews and focus groups, designated key lines of enquiry and unannounced inspections; and it produces a much more detailed narrative report with quantitative ratings of the hospital in five domains at service and hospital level.

This chapter explores how these new inspection processes have actually worked in practice across the first two waves of inspection, mainly through our own observation of six hospital inspections and both 1:1 interviews with and online surveys of CQC inspection team members and hospital staff.

5.2 Logistics: organising inspections

Involving anything from 30 to 80 people in the inspection team and many more from the hospital, each CQC inspection has been a formidable exercise in planning and logistics for both CQC and the hospital being inspected. The practicalities of assembling and coordinating the inspection team, providing transport and working facilities, scheduling and organising inspection fieldwork, and keeping track of all the information being used and produced were very challenging. However, in most cases people reported that the inspection had been run well and professionally conducted, and although it was undoubtedly a literally intrusive exercise, the great majority of trust staff (83%) in our survey reported it had caused little or no disruption to patient care processes or service provision.

Inspection team members – both CQC staff and others – described the inspection process as all-consuming, exhausting, intimidating, intense, and very demanding, and some doubted the wisdom of expecting such workrates from people and the sustainability of such ways of working:

“...the days were very long and tiring; I'm a medic, I'm used to long days... but I found it very tiring, it was a bit like doing a couple of half-day exams each day, running from – I remember one day – very early in the morning, I mean from six in the morning till eight at night, just before nine at night is a pretty long day; and you are thinking for a lot of that time. So it was tiring.” [Doctor, CQC inspection team]

In a sense this intense way of working was designed into the inspection process because the number of core service areas to be covered, number of fieldwork activities required, amount of data to be reviewed and volume of feedback and rating required it. The schedule had been intentionally packed with fieldwork, corroboration meetings and other activities and very little space had been left for reflection. Inspection team members often reported running out of time for fieldwork. But

some thought that it would have been possible to organise the process to make it more selective and less demanding, and to allow more space for analysis and reflection:

“I think the long hours were perhaps not quite as necessary, but I think we might have done a better job had we had more shorter days.... I think we got caught up a bit in the drama of it if I am to be really honest. “ [CQC inspection lead]

Hospitals had generally assigned a number of staff to manage or coordinate the inspection, supporting the CQC inspection team and providing liaison and communication assistance while also monitoring and reporting back on the inspection to senior leaders as it went. From the perspective of hospital staff, the inspections were often reported to have been more lengthy, intrusive and detailed scrutiny than they had previously experienced or had perhaps expected.

“I think really there’s no hiding place, so if the inspection is carried out thoroughly, there’s not a lot you can hide from it, it was far broader than anything I’ve experienced..” [Trust chief executive]

There were some complaints about the short notice provided by the CQC inspection team when it asked to access information or people in the hospital, the amount of time spent by inspectors in some clinical areas and the sheer impact of having 30 or more people visiting different clinical areas across the hospital at once, but most hospital staff seemed to think the process had been quite a productive one:

“It felt like a full on week, obviously it was a week out of our working lives that was pretty much dominated by it, so it was a big week in that respect. But actually it was very positive, the staff really enjoyed it by and large, you know, the feedback was there seemed to be a buzz around the place, ... The staff felt they were being inspected by peers, people who understood, they enjoyed showing what was good, what they were proud of, they felt they were talking to people who understood them. I’d say during the week it was a pretty positive feeling actually.” [Trust chief executive]

5.3 Using data in the inspection

Inspection teams were provided with a data pack – often of over 100 pages – providing a single summary of key data about the hospital, organised and presented around the five domains. We found that both CQC inspection teams and hospital staff thought the data pack was in itself an impressive achievement, bringing together as it did data from diverse sources to present a “snapshot” of the organisation. Inspectors talked mostly about using the data pack to frame or set a baseline for the inspection, get an understanding of the hospital and identify some key issues or areas for investigation. Rather fewer inspection team members said they had used the data pack during the inspection, in conjunction with their other fieldwork.

The main strengths of the data pack seemed to be that it provided a single summary of performance data, which was generally accurate and clearly presented and was organised around the five domains of assessment. But interviewees also identified a number of problems in using the data pack, particularly that it was insufficiently specific or granular at core service area (many thought it should be organised around core services), that the data sometimes lacked currency, and that the

pack told them little about the hospital organisation and how it was structured and governed. A more practical problem was that the data pack was often not available (or not looked at by inspection team members) until just before the inspection.

“...so the data pack gave some useful information background about the trust size; you know, some of that, kind of, demographic data and some of the issues that they had had; and that’s useful. But it didn’t – as I said, it didn’t reflect the governance structure, which was critical – it didn’t tell you how the trust ticked, or how it was meant to tick” [Inspection chair]

Some inspection team members spoke very positively about their use of the data pack, but others felt they lacked the quantitative skills to interpret the information it contained, to work out what was and was not significant, and to use it to initiate lines of enquiry. Some thought that the CQC data analysts on the inspection teams should be providing that kind of analytic support but in practice they were usually more involved in managing data and getting access to it than with actually using it.

“...unfortunately, the data team were a bit too shy to participate. But I think that’s the dynamic of it, you know. And data is really valuable, you don’t always know what you’re going to want, so you can ask for an awful lot. But if it’s live and analysed, rather than just dumped, then it’s usable. So it’s great having lots and lots of data, but it’s much, much more important having it analysed and presented and live.” [Inspection chair]

“..it used a lot of jargon in there that I didn’t understand, you know ...things like z-scores... and things like that I’m just thinking, oh I don’t understand. You know, and really as a compliance manager it’s not my job to understand that because there’s people already employed in CQC, I just need people to tell me whether that’s good or bad or...so that I can work out what questions I need to ask. We had the...we had a couple of analysts with us who...I’m sure this is, and I don’t want this to sound personal but I think I expected them to be a bit more knowledgeable about the data pack and be able to stand up and say, right, the data pack is telling us that A&E is really good, maternity is really bad, in that kind of language, but they were just in data mode, and it’s the interpreting bit that’s the important bit with the data pack.” [CQC inspector]

Before each inspection, hospitals had been asked to provide quite a lot of information in advance, including documents, policies, meeting minutes and the like as well as more quantitative performance information. In some inspections, hundreds of such documents or items of information had been received by the team. In addition, during the inspection hospitals received many further requests for information, initiated by the inspection team members through fieldwork. It was not clear how, or how well, this large volume of heterogeneous qualitative and quantitative data was being used.

“ It certainly seemed like a lot of information, and a lot of it they already had. And then even when they came on site, during the...I know you’re trying to keep with the pre-inspection, but during the inspection they would ask for more information that they’d already been sent, once or twice. [Trust CE]

“You couldn’t have anticipated the amount of material that they needed... for a few days after the inspection, literally all I did was sit at my desk and upload documents that have been approved for ...when they pick up something they’re not happy about, they then interrogate it further and then they ask for more documentation and then more documentation, so it’s like an un-feedable beast, if you like [Trust staff]”

5.4 Knowing what to look for: key lines of enquiry

Inspections are structured around a set of “key lines of enquiry” (KLOEs) in each of the five domains of assessment. In early inspections, these KLOEs were essentially very brief lists of prompts, but over the pilot inspection programme they have evolved and in the acute hospitals provider handbook currently out to consultation they now consist of a numbered list of broad questions in each domain, with for each question a tabulated list of characteristics representing “good” performance and a list of prompts for issues to consider. They are generic, rather than being specific to particular core service areas.

Inspection teams were encouraged to customise the KLOEs to each inspection to some degree, with subteams developing more specific KLOEs for the core service areas they were going to inspect at that hospital based on their own knowledge and the data pack and other information. We observed teams trying to do this, in the very limited time available at the outset of inspections, and some CQC inspectors had spent time before the inspections in preparing such KLOEs for their subteams.

“...I mean it was, wasn’t it, actually, it was missed at the training day, we didn’t really have time to go into the KLOEs, and I think we were meant to. And I think possibly a...maybe it’s just me, a better understanding of the KLOEs overall would have been helpful.” [Inspection chair]

As with the data packs, we observed inspection teams using the KLOEs as a framing or baseline device much more than they used them during the inspections themselves as a structure for fieldwork or data collection. Inspection teams did not usually seek to work through the KLOE framework systematically to assess performance, but did often use it in planning their fieldwork and afterwards to check whether there were areas or issues they had missed.

“So it was...it wasn’t used as sort of an exhaustive list to kind of tick off, I’ve asked this question, I’ve asked this question, I’ve asked this question, but it was something that team members sort of bore in mind as they went out. ..” [Inspection chair]

Interviewees were sometimes critical of the KLOEs as they stood, but for a mixture of reasons which sometimes conflicted. There was a quite widely held view that the KLOEs were expressed at too high a level to be operationalised, that they were duplicative across domains, and that they needed to be more specific and measurable in order to achieve consistency within and across inspections:

“You know, you can say, well, there are some basic things that we need to look for and there are...if any of us was asked, what are you going to look for, we’ll all come up with half a dozen of our own favourite things that we want to go and have a look at... But you need to make sure that all areas are looked at in a certain area. So I think there is a consistency that

the KLOEs can help people achieve, but I think the current KLOEs are too high level, too high falutin and almost excessively aspirational really.” [Inspection chair]

However some inspection team members also emphasised the importance of allowing flexibility in the KLOES and space for inspectors to use their professional judgement and to respond to what was being found in each inspection:

“I think we didn’t officially alter the key lines of enquiry but I think they evolve, and I think this is why it’s best to not be too prescriptive because as the inspection continues, the key lines of enquiry evolve and that high level question you don’t know in what direction that’s going to take you. So it’s...so I quite liked that organicness about it, because I felt then we were not being rigid in where we were going, we were allowing it to develop so that we could get a true picture of what was happening at the trust.” [CQC inspector]

5.5 Fieldwork: observation, interviews and focus groups

Inspection teams used a variety of approaches to gathering information during the inspection themselves – primarily a combination of direct observation and engagement with staff and patients, alongside more formal 1:1 interviews with selected staff and focus group meetings with groups of staff, usually in particular professional or occupational groups (for example, consultants, junior doctors, therapy staff, administrative staff, and so on). Some inspection teams also made use of informal records audits, pathway tracking and other forms of documentation review.

Observation was perhaps the largest (in terms of time spent) and most variable component of fieldwork. Inspectors went to wards, clinics and departments for anything from a few minutes to a few hours, and both observed clinical care directly and spoke informally to people. This fieldwork was directly focused on the core service areas. There was little structure or formal guidance on how to observe, but this was probably the form of fieldwork in which inspectors felt most confident about their prior skills, knowledge and abilities, and many inspectors spoke about how important observation had been to getting an authentic and realistic understanding of the hospital:

“Observation is very important, looking and seeing what’s going on I think was very helpful. If I can give you an anecdote – and obviously is a, in inverted commas, scientist one is always worried about anecdotes – but it’s very interesting that we were watching a handover in one particular area and there was a group of us doing that, it was very obvious to myself and the other clinician doctor who was from HEE, that the process we were watching wasn’t a usual process, shall we say, it was very obvious to us just because we were looking at the body language and knowing how doctors behave, so I think observation can be very helpful and very useful. [Inspection team clinician]

However for hospitals, the direct observation of care was perhaps the form of fieldwork that was seen as most intrusive – and where the CQC inspection team was most visible to the wider hospital staff, who were not perhaps as prepared for or used to such scrutiny as senior leaders. Some people commented adversely on the CQC inspection team members and some individual attitudes or behaviours towards staff, but more generally the process of scrutiny was felt to be much more intensive than in past inspections:

“And actually our staff found the observing the harder bit. So the equivalent of an Ofsted inspector sitting in the corner of a classroom observing a lesson. ...They found that nerve racking and we didn’t prepare them for that is what I meant. ...one of our matrons was followed for two hours. Someone just followed her around the hospital for two hours to see what she did and she was a bit of a nervous wreck at the end” [Trust staff]

More formal interviews were held with many hospital staff – particularly senior leaders at board level, but also commonly with service leaders in the core service areas such as clinical directors, matrons and service managers. There was little guidance about the interview content and process, and teams tended to develop their own broad frameworks of questions often to pursue issues identified through observation or other fieldwork.

“I think the individual interviews were...I personally was involved in the executive team, they were interesting in terms of the...knowing where...well I think how to word it really, in terms of sometimes what you didn't hear was as important as what you did hear. So I think being able to be good at doing that process you get a lot more out of it.” [Inspection chair]

Focus groups were convened in staff professional or occupational areas (such as consultants, junior doctors, ward nurses, student nurses, therapy staff, ancillary staff and so on) rather than in the core service areas, and an effort was made by CQC inspection teams to have focus groups led by inspection team members in those staff groupings – for example, junior doctor focus groups were usually led by a junior doctor on the inspection team.

In general staff seemed quite ready to speak openly at focus groups, though there had been some effort on the part of hospitals to select who was invited, and some focus groups were attended by more senior staff whose presence could have deterred others from speaking openly. The “rules of engagement” concerning the confidentiality of the process were often not explained. Focus group discussions were broadly structured, but usually covered what the hospital was like as a place to work, what staff were proud of, and what things they would like to improve. Some staff (both across and within groups) were more willing to express their opinions than others, so discussions were sometimes dominated by a small proportion of attendees.

Inspection team members varied in how skilled they were in facilitating focus group discussions, enabling people to contribute and managing the dialogue appropriately, and had usually been chosen for their professional background rather than their facilitation skills. Common difficulties included inspection team members finding it difficult to get discussion established, expressing their own views or experiences, allowing discussion to be dominated by a few individuals, and allowing discussion to go off-topic to unrelated areas. Because focus groups (and some interviews) did not focus on particular core service areas, it was less clear how the data collected was then to be used in assessing performance (see chapter 6).

5.6 Hearing from patients and the public

At each inspection CQC had organised and publicised at least one “listening event” for patients and the public, where they would be able to come and speak to members of the inspection team.

Peoples' understanding of these listening events seemed to vary – some had expected them to be public meetings when in fact they were generally structured into small group or 1:1 discussions. Interviewees generally felt that the listening events had been worthwhile, though some of the arrangements were problematic – with venues and timings that were less than ideal – and the turnout varied greatly. Some were well attended (with 70-80 participants) but most attracted fewer people than that.

“My reflections on that and reflections as to what happened at our listening event is that I’m not sure how good it is at getting a good overall picture because both at our listening event and at the listening event that I went to in Xxxx there were really two types of people who turned up, ...you’re not going to get people who are slightly disgruntled or slightly happy, you’re going to get people who are either very happy or very disgruntled; now it’s not that you can’t learn from that, clearly you can, but one needs to think that that’s what’s probably going to happen for the most part” [Clinician inspector]

A number of practical issues emerged like how to deal with particularly angry or upset individuals, whether to admit journalists to the event, how to sustain appropriate patient confidentiality, and how to deal with serious individual issues being raised at the event. We observed one listening event where individual stories were retold to the plenary with no advance notification or consent from attendees. For the inspection teams, listening events were usually in the evening after a full day of inspection and were an important cause of the sense of intensity of workload referred to earlier. Many suggested that the listening event would be better held before the inspection, for reasons of workload and to allow it to inform the inspection.

“I’m not convinced whether the timing of the listening event is ideal, it’s quite...that first day is a really long day and I think that was quite gruelling for everybody and if you’ve got any more information from the listening, we only had the next day left to follow that up, whereas, perhaps if we’d have had that before we started the inspection that may have been better, I think that’s something we need to think about. “ [CQC inspection lead]

We did observe that some listening events on my recent inspections were scheduled at the end of the initial preparation day in order to spread the intensity of the workload.

5.7 Gathering and synthesising information: note taking and corroboration meetings

Throughout the inspection process, inspection team members were asked to record their findings from their fieldwork on a note taking template. The same template was used for all forms of fieldwork, and the proforma has evolved somewhat and currently asks the person to record details of the hospital/service being inspected and the form of fieldwork undertaken, and then allows space for free text notes which inspectors can also cross refer to the statements in the KLOE guidance, and categorise as positive or negative findings. Subteams reviewed their notes during corroboration meetings, and then passed them on to the CQC data analysts who were responsible for sorting and filing these sheets for future use in reporting. In practice it was difficult to maintain the discipline of record keeping because of the intensity of fieldwork, and the size and diversity of the inspection team:

“... it just was a real challenge to get them to write it down, and actually hand in something afterwards that the inspection could actually use to write up their specialist area. .. Some inspectors really worked around it in so far as they constantly spoke to the specialist, and if they'd done something separately they would ask them about it and what the key points were, and they almost wrote it down for them. In others, and this is the area which slightly dived in my inspection, which was the area they were covering surgery and critical care, where the inspector just didn't really compensate at all for the lack of comprehensive note taking by the external specialist. And, consequently didn't really have much to write about when he had to write up particularly his specialism about critical care.” [Inspection lead]

During the inspection, the inspection team gathered twice a day for a “corroboration meeting” which was an opportunity for the subteam for each core area to discuss their findings from fieldwork, and for a plenary reportback and discussion across the whole inspection team. This was also the place in which provisional ratings of hospitals were discussed and agreed within subteams for each core service area and collated across the inspection team. The aim was for corroboration meetings to provide opportunities to share information, compare and contrast findings, identify common themes or areas for further investigation, and challenge.

In practice, subteams often found it difficult in the time available to cope with the sheer scale and heterogeneity of the information they had collected, and to synthesise it into a rating. The issues of rating and reporting are covered in the next chapter, but the use of corroboration meetings as part of the inspection process is discussed here. Most inspection team members thought the corroboration meetings were an important mechanism for sharing information, triangulating or challenging findings, identifying lines of enquiry to pursue, and building a consensus view of the performance of the hospital.

“I think corroboration sessions are vital, probably the most important part of the whole exercise, because then people come back twice a day, they rebase, they recalculate, they go off and do again. Everybody's heard what everybody else has seen. And that flavours what they themselves go and look at, so everybody has in their head, to some extent, a greater or lesser extent, have a sort of view in their head about what the whole of the Trust looks like” [Inspection chair]

However, the reality of corroboration sessions was sometimes less than ideal. The practicalities and logistics were often particularly problematic. Meetings did not start on time, or some teams were not back from fieldwork or ready to feed back on time. With eight subteams to report back, in an hour, each had only a few minutes to speak. Some feedback was inaudible, and flipchart notes unreadable because of room size and layout. Some subteams continued working or doing other things like eating and using phones during others' feedback, making for a distracting environment. Some feedback was seen as excessively anecdotal or too driven by one team member's views. Some plenary corroboration meetings became more like a series of bilateral meetings with each subteam lead and the inspection lead/chair. It seemed that not all inspection team members saw corroboration meetings as an essential part of their role – some seemed to view them as a distraction from their core task of fieldwork. But others clearly valued the peer support and challenge received in corroboration meetings, particularly where they were well led and facilitated.

The requirement to rate each core service area and the hospital as a whole, on five domains each scored on four point scale, led many inspection leads and chairs to give primacy to collecting ratings during each corroboration session. That seemed to have some advantages as it focused feedback and provided a clear common structure, but it could come to dominate discussion and mean that issues other than ratings were not discussed.

Some interviewees suggested that there could be fewer corroboration meetings (perhaps once per day) with more time allowed for discussion and reflection, and that the collation of ratings could be dealt with bilaterally, leaving the plenary meeting free for a discussion focused on emerging ratings. On more recent inspections, we observed some efforts to solely gather sub-team leads for full mid-day corroboration. This method allowed for a quicker and more efficient corroboration meeting whilst also allowing external expert inspectors more time for observation.

5.8 Unannounced inspections

In CQC's prior inspection model, most inspections were unannounced on the basis that providing notice of an inspection allowed the provider to make preparations to give an unduly positive or unrepresentative view of the organisation to the inspection team. However, it was clearly not feasible for the large and complex new inspection process to be put in place without much advance planning and liaison, so hospitals had several weeks or even a few months notice of the dates of the inspection. To counter the concern about representativeness, every inspection was followed by an "unannounced" further inspection on a smaller scale, usually involving a few people from the main inspection team, focusing on one or two service areas identified by the main inspection, and often taking place out of normal office hours (at evenings, nights or weekends). They were not truly unannounced as hospitals knew there would be a further unscheduled inspection soon after the main inspection, though they did not know when or where it would take place.

Most unannounced inspections were carried out by CQC staff with a few of the external members of the inspection team – often it was logistically problematic for those external members to return to the hospital for a later unannounced inspection. They usually took place within a fairly narrow time window after the main inspection, because of course the report writing process was already underway. They seemed in practice to serve three purposes – gathering further information about areas where the main inspection had suggested there were problems or issues; gathering further information about areas which had been missed or not well covered in the main inspection; and gathering information about service performance outside of normal working hours (evenings, weekends and nights).

5.9 Usefulness of and confidence in using inspection components and methods

Through our survey, we asked CQC inspection team members about which methods or components within the inspection process they had used, and how useful they had been, and the results are shown in tables 5.1 and 5.2 below. It can be seen that inspection team members particularly valued the key lines of enquiry (KLOEs), corroboration sessions and data packs, and pre-inspection planning and preparation. They saw some other inspection components, such as listening events,

information requests during the inspection, the NHS trust's presentation to the inspection team and the forms for recording evidence as less useful.

CQC inspection team members were most confident about their own abilities in the more qualitative forms of data collection such as talking to patients and carers, interviewing staff on wards or departments, and observing activities on wards or departments. They were less confident about some more quantitative methods such as reviewing Trust data reports, undertaking interviews with senior leaders, and recording evidence/note taking.

CQC inspection team members who were on their second or subsequent inspection in the new acute hospital regulatory model were asked whether they felt their confidence in their own skills had changed since the last inspection they took part in, and we found that 81% felt their skills had increased (38% by a lot) while 15% felt they were unchanged and only 4% felt their skills had reduced.

Table 5.1. Usefulness of inspection components reported by CQC inspection team members

Inspection method/component	Didn't do/use it	Not at all useful	Not very useful	Quite useful	Very useful	Total Responses
Mini-corroboration sessions within your sub-team	1%	3%	4%	37%	54%	335
Pre-inspection sub-team planning session (on day 0)	4%	2%	9%	46%	40%	336
Key lines of enquiry (KLOEs)	0%	3%	11%	49%	37%	344
Whole team corroboration sessions	1%	5%	16%	41%	37%	344
Data pack	1%	2%	18%	50%	29%	344
Pre-inspection training/briefings	12%	3%	14%	45%	26%	344
Inspection framework document	6%	2%	10%	60%	23%	345
Unannounced inspection	62%	0%	2%	13%	23%	341
Listening events with the general public/patients	19%	5%	18%	35%	23%	343
Trust data/reports asked for during the inspection	11%	4%	14%	50%	21%	345
The presentation given by the Trust	2%	5%	22%	52%	19%	345
Focus groups with "hard to reach" groups	54%	1%	4%	23%	18%	344
Tools/forms for you to record evidence on	2%	6%	24%	53%	15%	344

Table 5.2. Confidence in using data collection methods reported by CQC inspection team members

Data collection methods	Didn't do it	Not at all confident	Not very confident	Quite confident	Very confident	Total Responses
Talking with patients/carers on wards/depts.	2%	0%	1%	18%	79%	344
Interviewing staff on wards/depts.	1%	0%	2%	21%	76%	344
Observing the activities of staff or patients on wards/depts	3%	0%	1%	27%	70%	343
Reviewing patient notes/records	13%	1%	2%	24%	60%	343
Listening events with the general public/patients	4%	0%	3%	36%	57%	278
Tracking/following patients	17%	1%	3%	27%	52%	343
Recording evidence/note taking	1%	1%	6%	44%	49%	342
Staff focus groups	27%	1%	1%	27%	44%	340
Reviewing Trust data/reports	2%	1%	12%	48%	38%	305
SOFI observation	46%	3%	6%	9%	37%	35
Interviewing executives/board members	35%	1%	3%	26%	34%	344
Other activities (please state)	61%	2%	5%	7%	23%	99

5.10 Conclusions

Our findings suggest that while the inspection process has developed and evolved over the period from September 2013 to April 2014, and the guidance and specifications provided to inspection teams and the experience and skills of CQC inspection teams have grown significantly, the main design features of the inspection process have remained largely the same.

Many of our findings about the inspection process bear centrally on the size and scale of the inspection. This is perhaps the most intensive and in-depth inspection process being used in healthcare regulation internationally, by some way. We estimate that each inspection has involved between 90 and 320 person-days of inspection fieldwork, in addition of course to substantial time spent in preparation for the inspection and in reporting afterwards by CQC staff, and to the time spent by hospital staff in preparing for and participating in the inspection. This level of investment in inspection fieldwork has some advantages, particularly that it has the capacity to provide a very detailed and nuanced understanding of the hospital's performance across many clinical service areas, and it seems unlikely that any significant problems or areas of concern would be missed. In that sense, it could provide a high level of assurance to stakeholders about current and future performance. But many of the more problematic features of the inspection process also flow from the size and scale of the endeavour. The challenges of managing inspection teams, maintain communication and corroboration, assuring consistency, and coordinating activity all increase (probably non-linearly) with the size of the team.

The sheer intensity of the inspection process is a key theme in our findings – and both this chapter and the previous one (on inspection teams and how they work) have raised questions about the effects of the very packed and demanding inspection schedule on the team, and on the quality of the inspection fieldwork they undertake. The inspection process leaves little time for inspection teams to engage in analysis and corroboration, both because of the pace and scale of fieldwork and the size of inspection teams. This means that inspection becomes largely a process of data collection – with much of the work of making sense of the data and producing an agreed narrative of performance postponed until after the inspection, which we discuss in the next chapter.

Although the guidance provided to inspection teams has become more detailed, this is still a process in which much is left for inspection teams, their leaders and inspection team members to determine. As a result, we observed a great deal of variation in inspection practice within and across inspection teams. What inspectors actually did was often shaped as much by their own prior experience or background, their personal interests or concerns, and their subteam colleagues as it was by the CQC guidance or by the needs of the particular service being inspected. It is of course difficult to distinguish between legitimate variation resulting from the proper exercise of professional judgement and the tailoring of the inspection process to the particular hospital or service being inspected; and non-legitimate variation resulting from inspectors pursuing their own interests, agendas or ideas.

The inspection process produces a huge volume of information – not just the data pack and the hundreds of documents and reports resulting from information requests to the hospital being inspected, but also the hundreds of completed note taking templates recording observations, interviews, focus groups, and other forms of fieldwork. Our findings suggest that the inspection process and team are more oriented towards and capable of collecting and using qualitative data sources, and are less able to make use of and analyse quantitative data sources. It does seem that far more data is being collected than can possibly be used in rating and reporting (which are explored in the next chapter). This may be a cause of concern simply on efficiency grounds – that resources are used to collect data which is not needed. But it is also a source of risk, since if the CQC inspection team gather data which they are not then able to review, there is the possibility that important findings are missed which could then bear on subsequent rating and reporting.

6. Ratings and reports

6.1 Introduction

The new model of acute hospital inspection described in chapter 2 involves the inspection team rating each core service area, each hospital and each NHS or foundation trust inspected in five domains – safe, effective, caring, responsive and well-led services. In each domain the rating is on a four point scale – inadequate, requires improvement, good or outstanding. So the inspection of a hospital will typically produce a matrix of 8 x 5 or 40 domain/service level ratings. These ratings are then aggregated to give overall core service area ratings and overall hospital level ratings in each domain, and are then aggregated again for multi-hospital NHS trusts to give ratings at a trust level.

This chapter first examines how CQC inspection teams from the first two waves used the evidence they had to agree ratings for the hospitals and services being inspected, then examines the processes of rating in domains and the use of the four-point rating scale. We then turn to explore the processes by which feedback and reporting to the hospitals was undertaken, both verbally at the end of each inspection and through the formal, written reports from inspections which were subsequently published.

6.2 The rating process: using evidence to develop ratings

The last chapter on the inspection process highlighted the very large volume of heterogeneous information which inspection teams were faced with during the inspection. Their essential task was to find a meaningful and consistent way to synthesise and integrate that data to form ratings of services in the five domains for each core service area, and then to agree ratings at a more aggregated level – for hospitals and (for multihospital NHS trusts) for the trust as a whole.

CQC inspection teams have had some guidance in the inspection handbook on the definitions of domains and ratings, though that guidance has been developing as the inspections have proceeded and current inspections have access to much more detailed guidance than those undertaken earlier in the pilot programme. For example, the appendices to the NHS acute hospitals provider handbook, currently out to consultation, contain a detailed definition of each domain, and a definition of what represents outstanding, good, requires improvement and inadequate performance for each domain. They also contain a set of rules for aggregating ratings across core service areas and across domains.

However, there is little explicit guidance on the rating process itself, which is how to take the large volume of quantitative and qualitative data and reduce it to a set of ratings. We observed subteams in each core service area during inspections discussing the evidence they had gathered and its significance or meaning and then often enumerating and counting instances or items of evidence – often using flip charts to summarise them under “positive” and “negative” headings for each domain. This discussion usually took place in the subteam meetings during corroboration sessions (see previous chapter for an account of these corroboration sessions and how they were used).

Teams tackled this task, often with a very limited time available to make their ratings decisions before they were asked to give ratings in the plenary corroboration session.

“What we did is we had flipchart paper on the walls, one sheet for each core service area that we visited, and then it was sort of marked off into each of the five domains, and then on the left hand side we asked the teams to write their key pieces of evidence, and then on the right hand side we asked them to give it a rating. And then we went around each team and they talked it through with us, so there was a bit of challenge about whether that evidence and whether that rating fitted each other [CQC inspector]

Some common difficult issues seemed to emerge from team working and discussions, concerning the categorisation/sorting, weighting/valuing, and synthesising of evidence as well as the actual process of deciding on a rating. For example:

- How should evidence be sorted and organised into the categories of the five domains? Was it alright for the same evidence to be used under more than one domain, and how should the team decide where to position or place evidence which did not seem clearly to fit a single (or any) domain?
- How should different forms and sources of evidence be weighted and synthesised? Often an inspection subteam might have routine quantitative data on service performance, qualitative data from staff and patients they had met, their own observations and results of records audits or pathway tracking, and documents from the hospital itself such as policies and meeting notes. Should each form or source of evidence have equal weight?
- How should evidence which seemed to suggest different levels of performance be weighted and synthesised? An inspection team might have data from different places or sources which seemed to suggest different levels of performance, and they often needed to decide how to combine such information into a single rating.
- How should the currency or temporal dimension of evidence be considered? Often inspection teams had evidence that related to events in the past (perhaps 6 months or 12 months or longer ago) or to events in the future (actions which were being taken and which would have a desired impact on an issue but had not taken effect yet). Should past events be discounted, to some degree, and could future events or consequences be taken into account?
- How much importance should be attached to single instances or reports of poor practice? Often, inspection teams would have found for themselves or had reported by patients and others single but significant instances of either very poor quality care or of very good quality care. Such cases often had real narrative power. How much weight should they attach to single instances of this kind, even when they were clearly significant and well evidenced, alongside broader evidence on performance from other sources?

These issues are illustrated in the quotations from a number of interviewees below.

“The question is, how do you weight those different...the quantitative versus the qualitative. And what I would say is that the weighting of information was more towards the qualitative than the quantitative. And obviously, the qualitative, even when you’re there for a week, it’s a snapshot view of an organisation. It’s not wrong, but it’s the difference between qualitative and quantitative data.” [CQC inspection chair]

“Well, I think it's so difficult because in every organisation you find pockets of excellence, and how do you put a weighting on things? So how do you...unless you start to think about giving ratings for particular clinical teams or particular clinical services, or you have some formula for averaging, amalgamating the scores, it's a very difficult exercise to do. I don't know quite how to do it.” [Clinician, inspection team]

“...when you've done a lot of inspections and you know this probably as much as I do, if you look hard enough you can find something with everything, everywhere requires improvement...” [CQC inspector]

“Well, the trouble is that within any trust you will find things that aren't right. Of course you will. You'll either see a patient not being treated... A call bell not being answered. Of course you will see those things. There may be bits of process that are not perfect. We certainly came across one particular issue which really needed to be looked at by the Trust, and the question is what does that mean” [CQC inspection chair]

I think that probably still needs some work on it, because when you've got a lot of information and then you have to decide, so do we mean that's good or outstanding or not so good? It's hard then, it's trying to not to move into subjectivity I think. ...But I think it's challenging, because particularly when you've got conflicting information trying to be proportionate, because you might have a, you know, a certain amount of information that you think, well, that's not very good that they're doing, but hen you've got this other information that's saying, but that's really good! [CQC inspection lead]

In practice, from our observations and interviews we found that teams sometimes made up rules for themselves for dealing with these and other circumstances as they went along, or reached decisions on a case by case ad hoc basis, which probably makes for substantial variation in decision making between subteams and between inspections. Overall, the rating process was an example of a highly implicit, group-based consensus-forming method in which the professional judgements made by individuals and the group dynamics of the subteam for a core service area and of the inspection team as a whole were probably very important. Discussions and decisions were often shaped by key individuals who spoke more, expressed strong views, or had (or claimed) particular expertise to which others then deferred.

When interviewees reflected on the rating process, they generally said that they had got the job of rating done with remarkably little disagreement or dissent – very few people objected to the principle of rating – but expressed some concerns about the robustness, replicability and defensibility of the decisions made:

“...we did try to rate. Just doing it like that, it actually worked. People did agree, with one exception across risk, but that was across all 40. So 1 out of 40 they disagreed with. [It] was actually amazing. But in terms of how robust that would be and if that was challenged then that's yet to be seen. It felt like it was a personal judgment, but everybody agreed, does give it some credibility I think. But equally I think if it was challenged then I don't know where we'd be with that really.... If there's going to be a process where people can challenge, which I can't see that there can't be, then I think they need to be tight. There needs to be tight criteria, which is very difficult when you've got very complex organisations. “ [CQC inspector]

Overall, this process of synthesising evidence to form ratings seemed easiest when the evidence was pretty clear, unidirectional, and pointed towards either a rating of inadequate or outstanding. It was much more difficult when the evidence was weaker, more ambiguous or subjective, inconsistent, heterogeneous, and hard to value or assess. In corroboration meetings, despite the lack of time, there was some challenge and discussion of ratings especially where concerns were expressed by the lead for the subteam (asking for views or expressing uncertainty), or where the CQC lead or inspection chair, leading the corroboration meeting, took a proactive role in asking for more information or challenging a subteam's interpretation of their evidence. This provided some element of standardisation and cross-checking within inspections, though there was a tendency to defer to the subject expertise of the subteams in their content areas.

It seemed from our observations and from interviewees that the fieldwork undertaken by inspection teams was the primary data source in making decisions about ratings, rather than for example the data pack, documents submitted by the hospital before inspection or other potential sources:

"I think that people were more interested in the information that was coming through from the actual visits to the wards and departments. I mean obviously it was linked back to the data pack, but I certainly think that the majority of it, and I thin again that was because of the limitations of the data pack, and the absence of the key lines of enquiry were very much based on these prompts which we'd developed and what was coming up actually in the wards and departments." [CQC inspection lead]

This is borne out in findings from our survey of CQC inspection team members (see table 6.1) which show that 86% of respondents saw the team's own fieldwork as very influential in making rating decisions, compared with 16% or less for three other main data sources.

Table 6.1. What data sources influenced ratings by CQC inspection teams

Data source	Not at all influential	Not very influential	Quite influential	Very influential	Total Responses
The sub-team's own observations/fieldwork during the visit	0%	0%	14%	86%	287
The CQC data pack, and other performance data supplied by the Trust	2%	23%	59%	16%	284
Data from others (Royal Colleges, CCGs, NHS England, national audits etc.)	4%	24%	56%	16%	271
Team members' prior knowledge of the Trust's services	29%	39%	22%	10%	259

Interviewees from hospitals commonly expressed some concerns about the robustness of the rating process and the way evidence was used. They pointed to what they saw as inconsistencies in

behaviour, process or rating either between areas in their own hospital or between their hospital's ratings and those of other hospitals:

"I have read other reports, and I even read one, got a report yesterday, and I think that that does demonstrate that the reports are not equally rated. And, I think that's important, because what we all want is a level playing field... It is important that the reports are calibrated fairly, and that a judgement is made in my hospital, and another judgement is made literally down the road, at roughly the same time, is the same. ...Because, you just feel like you're being exposed to a random process, which is just not fair, you've got to feel you're all playing on the same playing field." [Trust staff]

"I think as a trust, we're disappointed with our ratings. They are clearly not linear scales. They don't add up, so we've got some areas where we've got several greens and then a yellow, and then the total scores are yellow. And then there's somewhere else where we've got two yellows and two greens, and the total scores are green. And it's not very clear..." [Trust staff]

"I think there does need to be a bit of calibration of these teams, I think there has to be some guidance given about the extent to which they are at liberty or not to make qualitative judgements, the extent to which they actually need to triangulate and base on evidence, and there's probably something about how you kind of calibrate across the reports as well." [Trust staff]

6.3 Using the domains

The five domains in which ratings were made – safe, effective, caring, responsive and well-led – are defined in table 6.2 below (extracted from the acute provider handbook currently out to consultation). We observed that CQC inspection teams spent relatively little time discussing these domain definitions or clarifying or agreeing their meaning in advance – they were largely taken as read, and issues to do with the domains and how they worked were dealt with as they arose during the inspection itself, and resolved usually by informal discussion and ad hoc decision making. We saw little discussion of the domain definitions or boundaries in corroboration meetings. But this left considerable scope for ambiguity and variation within and across teams:

"I think the difficulty is that it's where to put everything I think, and there's a lot of cross [over]. Some issues seem to go across all areas, so I think that's the difficulty with that. So if something's not safe how can it be well led,..? And I can understand the domains and I think they are a useful approach, but it's difficult as well. It's hard, isn't it?" [CQC inspection team member]

"...we had plenty of evidence and, at the end of the day, we apportioned it into the five domains, but sometimes which domain the evidence would sit in was difficult. And I think, having thought up the domains, I think there is a, kind of, sense that the evidence has to be pigeonholed into particular domains; which I think is a bit artificial, I have to say. ...Because, I mean, clearly, some aspects of it are...some aspects of the evidence move across more than

one domain. And, you know, in truth, you can't have a well led organisation that has got poor scores across the rest of the domains, that would make no sense at all, it would look absurd." [Inspection team chair]

Table 6.2. Domain definitions (taken from the Appendices to provider handbook, 2014) [1].

Safe	People are protected from abuse and avoidable harm. People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse
Effective	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
Caring	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
Responsive	By responsive, we mean that services are organised so that they meet people's needs.
Well led	By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person centred care, supports learning and innovation, and promotes an open and fair culture.

It seemed that the definitions of some domains were easier for CQC inspection teams to operationalise than others. For example, safety seemed to be less problematic to articulate and assess, while effectiveness was seen as much more difficult to define and measure. It was also felt that there was much more data on which to base the assessment of some domains than of others. There were some commonly identified definitional overlaps – between for example the caring and responsive domains which some inspectors found hard to distinguish. More generally, many interviewees observed that all the domains were interrelated and it was actually hard to conceive of a service receiving significantly different ratings in different domains – in other words they expected the domain ratings to be closely correlated. The well led domain was seen as actually embracing more than just the leadership attributes which its title suggests, and to be the place in which issues to do with the organisation as a whole, and corporate and clinical governance were assigned. We also observed many discussions that debated whether a concern in the safety, effectiveness, caring or responsiveness domain also (and automatically) demonstrated a concern in service or organisational leadership. For instance, whether breaches in the four-hour A&E target demonstrated an issue with leadership and governance. And then furthermore, whether a trust could reasonably be penalised across two domains for one specific concern.

"... for many services I don't think we're very clear about what constitutes effective services. ...I mean I'm certainly not an expert, on an outpatients' clinic in an acute general hospital, but I didn't have a service specification at my disposal that would tell me the key elements of an effective outpatients' client. So I was going on...a lot of it was patient's experience, the attitudes of the staff, the physical environment, whether people were hanging around waiting, what information was available to people, whether the staff were accessing training... But the two key ones for me, the ones that really, really are important are the effectiveness of the service and the leadership of the service. And the methodology that

we've got at our disposal in terms of assessing leadership and assessing the effectiveness of the service are the weakest of those five domains." ." [Clinician, inspection team]

In our survey of CQC inspection team members we asked them to assign ten examples of evidence drawn from early hospital inspection reports to the domains, and the results are shown in table 6.3 below. Of course in actual inspections ratings are undertaken in a group process rather than by individuals, but this data provides some insight into the initial interrater reliability of ratings. It can be seen that levels of agreement varied widely, from 98% assigning "Staff left ampules of medicines in labour rooms instead of locking them away" to the safety domain, to 36% assigning "Frail elderly patients with complex needs are given additional guidance and rehabilitation to prepare for surgery" to the responsiveness domain. If we take the modal value for each example to be the correct domain in each case, mean agreement levels were 66%.

Table 6.3. Domain allocation of examples of performance data by CQC inspection team members

Example	Safe	Effective	Caring	Respon- sive	Well led	Total Responses
Interpreting services are easily accessible	5%	15%	8%	72%	1%	328
Complementary therapies are available to patients nearing the end of life to aid relaxation and symptom control	1%	13%	73%	13%	0%	325
Staff left ampules of medicines in labour rooms instead of locking them away	98%	1%	1%	0%	0%	326
Managers are developing a plan to address bullying following concerns reported in the national annual staff survey	2%	2%	0%	20%	76%	327
The children's community nursing team cannot access local authority systems to check for safeguarding issues on discharge	70%	18%	0%	9%	3%	325
Nurses undertake hourly rounds	26%	37%	24%	9%	4%	325
New medication was researched so that a patient with a very complex condition could return home to die as they preferred	1%	15%	31%	53%	1%	326
40% of staff are not up to date with their mandatory training	44%	17%	0%	2%	37%	325
Systems ensure that medical patients remain under the care of the medical team when moved to another ward	27%	49%	2%	14%	8%	323
Frail elderly patients with complex needs are given additional guidance and rehabilitation to prepare for surgery	3%	34%	26%	36%	2%	325

Of course, the actual ratings given by CQC inspection teams can be examined to test whether or not ratings in different domains are correlated. High correlations between different domains would suggest that they are effectively measuring the same underlying characteristics. Table 6.4 below summarises the correlations between domains and it can be seen that there are generally positive correlations between ratings in different domains, and that the well-led domain is the one that is most strongly correlated to other domains. This might reflect the point made earlier (that it is difficult to dissociate service performance from service leadership).

Table 6.4. Correlations between domain ratings in CQC inspections to date

	Safe	Effective	Caring	Responsive	Well led
Safe	1.000	0.405	0.300	0.415	0.556
Effective	0.405	1.000	0.380	0.460	0.540
Caring	0.300	0.380	1.000	0.393	0.492
Responsive	0.415	0.460	0.393	1.000	0.496
Well led	0.556	0.540	0.492	0.496	1.000

All correlations are significant at the 0.01 level (2-tailed)

6.4 Using the rating scale

The four point scale used for rating performance in the five domains – inadequate, requires improvement, good, and outstanding – is in part defined in the acute hospital provider handbook appendices by example, since they set out for each domain a set of examples of evidence which might lead to that rating level. For example, it says that for safety an “inadequate rating would usually be given for safety if there is evidence of one or more of the following” and then lists the ten examples shown in table 6.5.

Table 6.5. Characteristics of inadequate rating in safety, from acute provider handbook

- Safety is not a sufficient priority and there is only limited measurement and monitoring of safety performance. There are repeated patterns of serious incidents or never events.
- The care environment, equipment or facilities are unsafe.
- There is significant negative feedback from people who use services, those close to them or staff about safety.
- Staff and others are afraid of, or discouraged from, raising concerns and there is a blame culture. When concerns are raised, the response is insufficient or too slow and there is little evidence that learning is shared and used to improve safety.
- The provider does not give sufficient attention to ensuring children and adults are safeguarded from abuse. Staff do not recognise or respond appropriately to allegations of abuse.
- There is a lack of evidence-based policies and procedures relating to safety practices and accountabilities and / or staff are not knowledgeable about them. Evidence of wilful/routine disregard of standard operating or safety procedures.
- Ineffective systems of risk identification and management in the short or long term mean that opportunities to prevent or minimise harm are missed. Changes are made to services without due regard for the impact on patient safety
- Staffing levels show substantial or frequent shortages or inappropriate staff mix which may compromise safety or effectiveness, or may results in use of inappropriate use of restrictive practices. Over-reliance on agency or locum staff creates risks to safety.
- Patient safety incidents are not always identified and reported and/or processes to review and learn from incidents are inadequate, increasing the risk of repeat occurrences or more serious harm in the future.
- The provider has not considered the outcome of national reviews and the improvements required in response

This guidance has been relatively recently developed, and was largely not available for earlier inspections. The handbook also defines briefly how inspection teams are meant to go about agreeing a rating, saying that “in deciding on a rating, the inspection team will look to answer the following questions: Does the evidence demonstrate a potential rating of good? If yes – does it exceed the standard of good and could it be outstanding? If no – does it match the characteristics of requires improvement or inadequate?” .

In our observations and interviews, we saw a fairly normative rating process at work, in which ratings were very much shaped by inspection team members’ prior experiences and backgrounds. Highly subjective definitions of terms like good and outstanding were often used or cited in discussions – for example good care was “care that you would accept for you and your family”; or outstanding care was “care that which people would be willing to travel a long distance in order to access”. Many interviewees questioned the robustness, replicability and defensibility of the rating process, and felt the need for more explicit definitions and criteria than they had to hand:

“It might be my lack of not seeing rather than it being there, but I’d not seen anything that showed what the criteria was, and therefore I felt a bit, as I said, a bit on the back foot really. Because my view of outstanding could be well different to X’s... My view of good could be well different to somebody else. Without that criteria I struggle to defend a rating” [CQC inspection lead]

One issue which emerged frequently was whether the purpose of rating was to give an absolute score based on the hospital or service's performance in that domain regardless of how other hospitals might perform, or a relative ranking based on how the hospital or service performed compared with other places. In practice, teams' rankings seemed often to be a combination of the two – with interviewees often seeking to locate their rating against an absolute benchmark but in practice using their experience normatively to place the service in a wider context:

“..the problem I think is where does the benchmark lie, and I think that was a really big issue.it was very arbitrary and subjective and where was the benchmark? How did we know where to pitch it because it was all very subjective? ...Should we be comparing trusts...so there's a normal distribution of trusts across the whole country, and should we be pitching in the middle and saying that's good, or should we be saying actually, we think the whole standard of care across the NHS needs to be improved, and pitching good somewhere a lot higher ... And maybe it's because I've not done enough inspections. But I was left thinking I'm not quite sure we've got this absolutely right to be honest.” [Expert by experience, CQC inspection team]

Distinguishing between adjacent values on the rating scale was also seen as problematic, perhaps particularly in the middle of the scale. The boundaries between good and requires improvement and between good and outstanding were often discussed, and there was probably more uncertainty about ratings in the middle of the scale than about those at either end:

“But it all kind of, I don't know, it didn't feel to me like it was that scientific if you know what I mean. Like, we found these things, and some people had views about them being of major significance. Some people were less convinced, and then we were trying to attach this value to it. Like, does it mean it's excellent? Does it mean it's good? Does it mean it needs improvement? Realistically, everything needs improvement. So, do we put that against everything? And it all felt a bit disjointed if you know what I mean. I mean, anything where the data you're collecting is very qualitative, which is obviously, the interviews we were having with people was all fairly qualitative, is going to end up with arbitrary judgement. But sometimes it felt a bit...I mean there was a lot of disagreement about what ratings should be given. And it just didn't seem a very robust way of doing things to me.” [Clinician, CQC inspection team]

“...I think 'inadequate' is pretty clear, everybody's pretty clear what that is. I think 'outstanding' is probably fairly clear, you know, sort of, if you...you know, but I think 'requires improvement', what does that mean? Does it mean, if you see anything that needs improving, it requires improvement... ..because one of the other things, I don't think when we started that process that we were exactly clear what those definitions meant. ...as I said just before, if you see that, does that actually count as 'good'? Can we call that 'good'? Or is it 'requires improvement'? That's what seemed to be most of the discussions I saw were about.” [CQC inspection chair]

In our survey of CQC inspection team members we asked them to assign ratings to the same ten examples of evidence drawn from early hospital inspection reports, and the results are shown in table 6.6 below. Again, ratings are in practice a group rather than an individual endeavour, but this survey data provides some insight into the initial interrater reliability of ratings. It can be seen that levels of agreement about ratings varied widely, from 93% assigning “Interpreting services are easily

accessible” a good rating, to 52% assigning “Managers are developing a plan to address bullying following concerns reported in the national annual staff survey” a requires improvement rating. The table shows that splits of opinion across adjacent ratings were commonplace. If we take the modal value for each example to be the correct rating in each case, mean agreement levels were 70%.

Table 6.6. Ratings of examples of performance data by CQC inspection team members

Question	Inade- quate	Requires improve- ment	Good	Out- standing	Total Responses	Mean
Interpreting services are easily accessible	1%	4%	93%	2%	321	2.97
Complementary therapies are available to patients nearing the end of life to aid relaxation and symptom control	1%	3%	60%	37%	319	3.33
Staff left ampules of medicines in labour rooms instead of locking them away	64%	35%	1%	0%	321	1.37
Managers are developing a plan to address bullying following concerns reported in the national annual staff survey	1%	52%	47%	1%	322	2.47
The children's community nursing team cannot access local authority systems to check for safeguarding issues on discharge	55%	44%	1%	0%	319	1.47
Nurses undertake hourly rounds	0%	3%	87%	9%	319	3.06
New medication was researched so that a patient with a very complex condition could return home to die as they preferred	0%	1%	38%	61%	318	3.59
40% of staff are not up to date with their mandatory training	44%	56%	0%	0%	320	1.56
Systems ensure that medical patients remain under the care of the medical team when moved to another ward	0%	6%	91%	3%	318	2.97
Frail elderly patients with complex needs are given additional guidance and rehabilitation to prepare for surgery	0%	2%	77%	21%	318	3.19

However, as table 6.7 shows, CQC inspection team members were generally quite confident about the accuracy of their rankings across all five domains, with in each case over 90% of respondents saying they believed their subteam's rankings to be quite or very accurate.

Table 6.7. Self-reported confidence in ratings by CQC inspection team members by domain

Domain	Not at all accurately	Not very accurately	Quite accurately	Very accurately	Total Responses
Safe	0%	4%	66%	30%	282
Effective	1%	5%	69%	26%	280
Caring	0%	3%	58%	39%	282
Responsive	0%	6%	70%	25%	281
Well led	0%	6%	66%	28%	280

In our survey of hospital staff, we showed them the CQC ratings of their hospital and service area, and asked them to indicate whether they agreed with the assigned rating or would have given a different rating themselves, and a summary of this data is presented in table 6.8 below. We found that overall, hospital staff respondents agreed with CQC's ratings about 77% of the time, but where they disagreed were more likely to assign a higher than a lower rating themselves (18% vs 5%). The table shows that rating agreement was highest for the effective and caring domains, and lowest for the well-led domain. Perhaps unsurprisingly, agreement was lower when CQC had given a requires improvement or inadequate rating. Though not shown in the table, levels of agreement varied between individual hospitals from 93% down to 55%.

Table 6.8. Comparison of CQC ratings and hospital staff ratings.

	Hospital staff rating higher than CQC			Agree	CQC rating higher than hospital staff		
	-3	-2	-1	0	+1	+2	+3
All ratings	0.0%	1.2%	17.3%	76.6%	4.7%	0.3%	0.0%
By domain							
Safe		1.5%	18.5%	77.3%	2.6%	0.1%	
Effective		0.7%	11.1%	81.8%	6.1%	0.4%	
Caring		0.3%	18.9%	77.3%	3.4%	0.1%	
Responsive		1.2%	18.2%	76.2%	4.3%	0.1%	
Well led		2.0%	19.5%	67.9%	9.7%	0.9%	
By CQC rating level							
Inadequate	0.8%	9.4%	60.9%	28.9%			
Requires improvement		2.9%	26.1%	68.0%	3.0%		
Good			11.1%	82.9%	5.6%	0.4%	
Outstanding				82.6%	17.4%		
By core service area							
A&E			15.9%	79.9%	3.7%	0.5%	
Medical		0.2%	17.1%	75.6%	6.4%	0.7%	
Surgical		1.9%	20.1%	72.5%	5.0%	0.5%	
ICU			18.4%	79.0%	2.5%		
Maternity		1.4%	23.3%	72.4%	2.9%		
Children			25.2%	73.1%	1.7%		
End of life	0.3%	3.2%	24.0%	70.4%	2.1%		
Outpatients		0.6%	15.1%	80.5%	3.3%	0.4%	

Note: table data based on c330 respondents to hospital staff survey to date, drawn from 13 trusts. 6 trusts are still to be surveyed.

6.5 Verbal feedback at the end of the inspection

At the end of the inspection, the CQC lead and inspection chair hold a feedback meeting with senior leaders from the hospital – usually at board level. The purpose of this is to give high level initial feedback on their findings to date, while also making it clear that further fieldwork (such as the unannounced inspection) and analysis may be needed before rating performance and providing the draft report. It is also an opportunity to thank the hospital staff and to explain the process that will be followed for drafting, commenting on, finalising and publishing the report.

It was evident from our observations and interviews that hospital leaders took this initial feedback very seriously, and often expected rather more of it than the inspection team leaders were able or willing to give.

“Everybody was really keen to know how we’ve done really. And the feedback was very limited and I understand why, but it was extremely limited. So people walked away almost a little bit frustrated. And particularly then frustrated when you get the report and there’s a lot

more detail in there that you then think oh, it doesn't feel as good as the feedback was on the day. So managing that internally has been a challenge and I don't think we saw that coming if I'm honest with you. I thought we'd get more detailed feedback on the day. ...people really want to know how have we done. People have got pass/fail mentality, did we pass? Did we do okay? And so when they're left up in the air a little bit and then by the time you get the report in for factual accuracy it feels for most staff, I mean not for senior managers, for most staff it feels a little bit too distant and oh right, what does that mean then? Did we pass? Did we fail? [Trust staff]

The CQC inspection leaders often had very little time available to prepare to give verbal feedback, and in our observations it was usually delivered from brief notes in a fairly extemporaneous fashion, without much advance scripting of exactly what was to be said. The content and form of this verbal feedback also seemed to vary considerably – some CQC inspection leaders delivered brief and quite perfunctory feedback at the end of the visit while others went into much more detail, and even gave some informal feedback during the inspection at the end of each day. These differences in form and approach are illustrated by two inspection team interviewees:

“We fed back just briefly at the end of the first day, and then at the end of the second day we fed back, and where we did have a concern about someone fed things in as appropriate, one way to raise issues. That was led by the chairperson. She gave quite positive feedback and was at quite high level. But it went well. I don't know if we were too positive or because there's lots of bits, but I think actually on reflection with the report that I'd seen it probably was right. It felt a grown up dialogue, and felt like what we were saying the trust could see that and accepted that. So I think that's the best way to describe it really, it was a grown up dialogue [CQC inspector]

“We said we wanted to go away for ten days or so, just to think about it. ... And I think if we'd just done it on the last day of the announced on-site inspection, it would have been very preliminary. And I think once you've given feedback, to some extent, you can't really change it. And I think we could have got trapped into making a superficial judgement. So I glad we didn't... And so we went back and gave feedback, by which time we had collated all the evidence. ...and we then had a, kind of, list of the issues we wanted to raise with them, both good and bad. And we, very clearly, gave them some very positive feedback about some aspects of the inspection, and also the issues that raised concerns.” [CQC inspection chair]

A number of hospital staff interviewed felt that there was some disjuncture between the tone and content of the verbal feedback at the end of the inspection and the subsequent report – usually that the report was more negative or critical than the verbal feedback. For a few, the draft report came as something of a shock as a consequence. It is difficult to know without being present at each feedback session what lay behind such disjunctures, but we think it may be that at the verbal feedback CQC inspection leaders were more tentative in their presentation of critical findings, and perhaps used more circumspect language in discussing potential areas for improvement, than the subsequent written report.

6.6 Producing the written inspection report

After the completion of both the main inspection and the unannounced inspection, the CQC members of the inspection team took on responsibility for drafting and producing the full report, to a relatively tight timescale. In essence, the CQC inspectors who had led each subteam assembled their notes and data collection forms for that area, and drafted the report section for that core service area following a general template based on the five domains. The CQC inspection lead then took those sections and brought them together, and drafted the overall report narrative for the hospital as a whole. The inspection chair was largely not involved in writing the report but had some opportunities to comment on drafts. Once the report had been drafted, it then went through an editorial and quality assurance process at CQC, before being released to the hospital in draft form for checking for factual accuracy. There then followed a dialogue with the hospital over their comments and proposed changes to the report, before the report was finalised and published in time for the quality summit. One interviewee described this process:

“I think the difficulty is the time span between doing the inspection and getting the report written is quite tight and to we’ve all had to work very long hours to, sort of, be able to go through evidence, looking at what we’ve written, you know, to pull it into a report. The inspectors wrote whichever they were...you know, whichever core service they were the core team leader of, so, for instance, the one inspector would write up the maternity and paediatric part of the report, another one wrote up the surgical and critical care part of the report, that sort of thing. They’ve sent that to me, I cut and paste it all into one report, I then have to draw out the overarching themes it, sort of, filters up, so, for instance, for each of those areas where they’ve talked about safety, then further up, higher up in the report is where I had to put in what we found about safety across the whole of the trust, yeah, you’ll see when you see the report how it works. .. So, yeah, I had to pull all that together and then obviously the challenge then is to make it look as if it’s been written by one person, not a load of different people,” [CQC inspection lead]

We observed that little or no work was done on the report during the inspection, and that the CQC inspection team turned to producing the report afterwards. Sometimes, they found there were gaps or concerns about the evidence that individual subteams had collected, or questions about the ratings which subteams had assigned, and those writing the report felt that teams had not recorded sufficient evidence to support their findings. They could and did contact members of the subteams to ask for clarifications, but as one interviewee noted, the inspection team members had returned all their notes and data collection forms at the end of the inspection and it was difficult for them to recall and comment on detailed findings a few weeks later. Inspection team members who were not on the CQC staff seemed to play a relatively limited role in the production of the report – they were generally sent drafts of appropriate sections of the report and invited to comment (see table 6.9).

Table 6.9. CQC inspection team members' involvement in report production

Answer	Response	%
Sub-team meeting at the end of the inspection visit	164	48%
Commenting on drafts of the report	146	43%
Writing a first draft of part of the report	96	28%
Answering queries from my sub-team leader as they wrote their section of the report	93	27%
Answering queries from the inspection lead as they wrote the overall report	51	15%
I had no opportunity to contribute	40	12%
Other opportunities	36	11%

All reports then went in draft to a national quality assurance group, chaired by the Chief Inspector for Hospitals where each one was discussed in some detail. This was intensive and difficult because of the timescales and time pressures, but it provided a forum in which the robustness of findings and ratings could be tested. Usually only one or two people at the meeting would have been at the inspection itself and would have direct knowledge of the hospital, one of them being the CQC inspection lead and lead author of the report. NQAG meetings dealt both with issues concerning individual reports (like the accuracy and robustness of findings, the appropriateness of ratings, and the quality and presentation of the narrative) and with issues concerning the process as a whole (such as consistency across reports and inspections, and issues of principle in relation to the definition or interpretation of domains and ratings).

The inspection reports produced by this process have been long and very detailed, with a lot of narrative content. Their structuring around core service areas and domains and progressive aggregation from services, to locations/hospitals and then to NHS trust level tend to make for long, wordy and sometimes rather repetitive reports. Although all the reports follow this basic template, there is substantial variation within that in style and presentation, as might be expected given that reports have been authored by many different individuals. The reports tend to make much more use of qualitative data – sometimes relatively anecdotal in form – than they do of quantitative data. Qualifiers or modifiers are quite often used (such as some, most, a few, many; or may, could be, might be) in ways which leave the size, scale and importance of the issues being raised somewhat unclear.

The response from hospital staff to the inspection reports has been quite mixed. In our interviews, they were generally seen as very detailed and largely accurate assessments of the hospitals being inspected, but with a number of significant problems and flaws. The importance of these reports for the hospitals concerned was repeatedly emphasised, and the impact (both positive and negative) they could have on staff, the media and the local community was often highlighted.

The opportunity for hospitals to comment on the draft report prior to it being finalised and then published was generally appreciated, though a number of interviewees did not feel their challenges to report content were addressed sufficiently. Some pointed out that this was a process of

“checking for factual accuracy” which seemed to preclude them challenging issues of interpretation of data and use of information in the report:

“... Of course in public I’m saying it’s a wonderful report and all of that, fundamentally I would have loved to be in a position of being able to say obviously this is a report I support and endorse, the bold truth is there are things in the report which aren’t right, but the process is such that you can’t really... This is clearly not the right thing to do to make a fuss about it, you just have to kind of take your medicine like a good boy.... [We provided] extensive feedback which was 85 per cent ignored. They made a few minor changes but largely ignored, really. ... To be fair, there was 80 per cent of the report which I thought was thorough, insightful, appropriate, good” [Trust chief executive]

Issues of tone, presentation and balance rather than factual accuracy were also commonly raised. Interviewees suggested there was some tendency in the report narrative to focus more on negative findings and criticisms than on areas of good practice, and that the way reports were presented and summarised tended to accentuate this. They also raised the use of modifier words (like sometimes, may be, potentially, etc) and suggested that such language could be used to allow a report to make an assertion which was not well substantiated – for example, describing a service or practice as “potentially unsafe” without quantifying the importance of the risk being described:

“So we got a copy of the draft report and were horrified, if I’m absolutely honest. There was a couple of things. Firstly, just how negatively it was written. ... Their summaries were awful. Bearing in mind the way the report was written, you had an overall summary and then a summary for each of the five questions, and then a summary for each of the service areas, so you end up with 14 summaries, all of which were just choosing a couple of negative points from each of the areas.” [Trust staff]

“But when the first report came out it bore little resemblance to the verbal feedback, and it almost looked as if...if you read the detailed report...the detailed report was littered with words, such as, good, very good, excellent, outstanding, and the detail of the report on its own made very pleasing, and positive reading. When you read the summary it was almost as if someone had gone through the report and picked out every single negative comment, and put them in the summary at the front.” [Trust chief executive]

“The other thing is that they use words...some words should be used sparingly. Unsafe is a very dangerous and powerful word, and if you’re going to say something is unsafe, you better be able to evidence it, and at the moment they don’t. They use the term potentially unsafe, or it’s unsafe, or it could be unsafe, that’s a big term, and it should be used incredibly sparingly. So, I think some words are...words are very important, words are very powerful, and some words should be used very sparingly.” [Trust staff]

Interviewees also noted that the reports were very long, and somewhat repetitious, because of the template structure they followed. Many welcomed the level of detail and the way that feedback was given for each core service area, but some questioned how well such lengthy reports would be used by all but a few highly motivated stakeholders, and thought the reports could have been more concise:

“So I think it’s...they are quite well written reports. The problem is going to be, each of them is about 60 or 70 pages, so most people will never read them! There’s a summary at the start.. which is quite helpful, because I mean, I could imagine members of staff might read

that, but a 70 page long report on each site? I'm not quite sure who they are for. ..." [CQC inspection chair]

"the report looks like it had been written by a committee, so it started off with kind of a summary and then it went into all the details and it had a summary...and some of the bits at the end of the report were the same bit as the beginning of the report. And it was written like...they'd say something really lovely about a service and then come down and say, but patients were at risk because...but in the front bit they would say patients were safe and...so there was a lot of...ballast, if you like. [Trust staff]

The use of evidence in the reports was also challenged by some interviewees. There were often concerns about the use of qualitative data, particularly individual remarks from patients or members of staff, which they thought had been taken at face value and not checked or triangulated. There were also concerns about the consistency with assessments were made and about which issues were raised or presented in reports for different hospitals. Many interviewees had read a number of other inspection reports and pointed out examples of such differences in detail.

"I think the report needs to be better written, that's really important. Because, there's this fantastic data pack, which is highly objective, with a vast amount of very, very useful data, and yet it is the report which gets the profile, and which people will read and use. And therefore, that report really does need to be...you know, there's a huge amount of effort that has gone into producing a data pack, a huge amount of effort that goes into having 20, 30, 40 inspectors come, not enough effort into the report itself. And so, there needs to be, I think, some further resources need to be switched to an editorial team, for example, and I do think it is very, very important that the report is not anecdotal, or uses anecdotes to only illustrate a point and not just because somebody randomly says something. But, I do think that the anecdotes are not helpful unless they are illustrative of an evidence based issue. ..#.." [Trust staff]

"So, it comes back to this question of subjectivity. For as long as their subjective people are going to feel bruised, and it's going to undermine much of the purpose of the inspection. So, it comes back to fundamentally, what is the purpose of these inspections? I think, that's a huge problem for them, because they've taken on a gargantuan task, and they don't have...because they're being subjective, and not objective, not analytical in their approach, because they have so many different teams, the whole question of regulatory consistency, which is the number one rule of any regulator to be consistent, I think, is...they don't really have a means of addressing that..." [Trust chief executive]

Interviewees rarely said that the inspection reports had raised issues or concerns which they or the hospital had not been aware of before the inspection, and some thought that if the inspection team had been able to identify such issues it would have suggested they were not fulfilling their responsibilities properly. In our survey of hospital staff, most respondents (55%) said that the inspection report had not produced any new issues or concerns, and 29% said it had raised just one or two new issues. None thought it had raised many new issues or concerns.

6.7 Conclusions

The new approach to rating performance in hospital inspections has generally been welcomed by most stakeholders, as providing a more explicit and graduated view of performance than the

dichotomous and less informative judgements about regulatory compliance or non-compliance which it has replaced. Hospitals place great importance by the ratings which they receive, and generally agree with those ratings though there are some important areas of concern.

The system for rating hospitals which CQC has put in place is largely based on the exercise of individual professional judgement by CQC inspection team members and on the use of group consensus-forming processes within inspection teams. While there is some written guidance for inspection teams to follow, it is quite limited in scope, and we found that the process of rating drew fundamentally on inspection team members' own prior experiences, expertise, and views. The sheer scale and heterogeneity of data that inspection teams have, by the end of their inspection, actually makes the task of agreeing individual ratings more complex.

The rating system also has a high level of granularity (with five domains, a four point rating scale, and ratings at service, hospital and NHS trust level). For one hospital, this involves the production of about 48 individual ratings or data items, and for NHS trusts with multiple hospital sites it produces this volume ratings for each hospital site plus ratings for the NHS trust as a whole. The more ratings that an inspection team needs to produce, the less time and consideration it can devote to each rating decision. The more points or levels exist on a rating scale, the more difficult it is statistically to achieve agreement.

These two features of the rating system combine to make it quite difficult to achieve a reliable and consistent rating process in hospital inspections – in which interrater reliability is maximised, and the consistency of the process makes it credible and defensible in the eyes of stakeholders, not least the hospitals which are being inspected.

Hospitals want feedback from their inspections as soon as possible, but they also want that feedback and the inspection reports to be as accurate and complete as possible, and there is an unavoidable tension between these two demands. Again, there has been a near universal welcome for the new approach to inspection and to the provision of both verbal initial feedback and a much more detailed and explanatory written inspection report. Both are seen as more informed, more credible and authoritative, and more useful to the hospital than the feedback and reporting that they have replaced.

Because hospitals and other stakeholders take the feedback and reporting very seriously, their expectations of CQC inspection teams are very high. By agreeing to provide verbal initial feedback at the end of each inspection, CQC places considerable demands on inspection teams and particularly inspection leaders, who have little time or space in the inspection process for reflection and analysis, and frames expectations from hospital leaders which may be difficult to meet.

Similarly, in committing to produce such long and detailed narrative inspection reports, with sections dealing separately with each core service area and then aggregating that narrative at hospital and NHS trust level, CQC has set itself a very challenging task. The analysis, writing and editorial process required to produce such reports and ensure that they are both internally and externally consistent is very substantial.

7. After inspection: actions and impact

7.1 Introduction

In chapter 2 we described the impact that CQC intended to have with their new approach to acute hospital inspections. Interviewees suggested that they would consider the model a success if more trusts were rated as good or outstanding (and less as inadequate or requires improvement) over time. They also described how they saw the new model of inspection holding a mirror up to acute NHS trusts – diagnosing performance issues, but not prescribing a solution. They intended to engage with other stakeholders (such as commissioners and other regulators) to agree solutions and responsibilities for service improvement. It was also evident that CQC hoped that the new approach to acute hospital inspection would help to improve their own reputation and credibility in the eyes of stakeholders, as regulators of acute hospitals (and other health and care services).

Our evaluation was primarily formative, focused as we noted in chapter 1 on the diagnostic purpose of inspections and the implementation of the new inspection model, but we did gather some early evidence of the impact of these hospital inspections. While the previous chapter reflected on the compilation of the inspection report and ratings, this chapter describes the trust's response to those reports – through the quality summit, engagement with CQC and other stakeholders and subsequent actions and service improvements.

7.2 Overall impressions of impact

Overall, trust staff regarded the inspection process and its outcomes positively – usually saying that it had been more helpful and robust than previous inspections. Trust staff generally reported that the inspection was an opportunity for them to reflect, set priorities and strategies, and communicate their performance and ambitions with staff and the public. Many respondents felt that the inspection did not highlight anything they did not already know. CQC inspectors similarly suggested that they would be more concerned if trusts were not aware of the issues they were highlighting through the inspection.

So they told us about staffing. Well, actually I told them about staffing but they reinforced the staffing issue back to us (Trust staff)

Reflecting CQC's intention to hold a mirror up to trust performance, trust staff saw the inspection as an opportunity to refocus on issues that have been left on the backburner, with the inspection providing the necessary momentum to make progress.

Well, I think for us, for the majority of their findings I think it was holding up a mirror to us. We wouldn't disagree, we haven't disagreed with anything they've said in the report, we've just accepted it. Part of that is because we believe what they've said and part of it is political, that it's pointless fighting over minor stuff actually; you miss the point really. So everything in there is either already in an action plan, a priority or a risk register, and therefore associated actions. What I think this does is helps put a focus on it and gets stuff happening quicker. It focuses staff attention; people don't want to be deemed to be not good. So I think it's helpful in that respect. (Trust staff)

Similarly, the inspection provided the opportunity to raise the profile of particular issues that were important to trust staff but had not received the attention of senior leaders. Sometimes trust staff had used the inspection process as an opportunity to voice concerns they had not previously articulated or that they felt had been ignored. Some trust staff and executives referred to the inspection as “free consultancy” and welcomed the opportunity to receive targeted feedback on the performance of their organisation, as a way of alerting them to areas of improvement.

Inspectors wanted trusts to see the report as a blueprint or lever for change, rather than critical or punitive. Many regarded the blend of regulation and development as an exciting opportunity – but difficult to pull off in practice. The developmental ambition was not always clear to trust staff and other regulators.

The risk is that it makes us defensive; and actually, why would we be open with CQC if Monitor then misinterprets it? And we had a fairly robust discussion with Monitor that actually, you need to be very careful that you don't use this as a, sort of, punitive review, because the whole point is, it's supposed to be developmental. (Trust staff)

There was feedback from some interviewees that the process did bring some issues into the open in some hospitals, allowing unspoken concerns to be voiced – for example, where there were problems with organisational culture, staff morale, and issues of bullying or harassment. It seemed very unlikely that the previous model of CQC inspection would have identified this kind of concern:

I think we're picking up a lot of stuff that the old CQC probably wouldn't even notice (CQC inspection chair)

Trust staff also reported that inspectors could often see issues from an external, fresh perspective that they themselves had overlooked because they were too close to the issue, or because practices had become normalised and routine. It also seemed that the inspection process could highlight the way that particular key NHS trust priorities or challenges (such as financial performance or a potential merger or service reconfiguration) had preoccupied leaders and consumed much management attention to the detriment of other issues.

Tables 7.1 and 7.2 below corroborate these findings, showing the actions considered likely by trust staff in response to the inspection and report and the likelihood of future service improvements. It can be seen that 85% of staff reported that actions would be taken on issues already known and almost half (49%) reported that actions would be taken on new issues, not previously identified prior to the inspection, a finding which is hard to square with over half of respondents saying new issues had not been identified. Only 2% of respondents thought that there would be no action in response to the inspection and report.

Table 7.1. Likely actions as a result of the inspection, report and recommendations

Answer	Number	%
Actions within the Trust to address issues <u>already known</u> prior to the inspection being brought forward or given additional impetus	277	83%
Actions to spread good practice to other service areas either within the Trust or in other Trusts	160	48%
Actions within the Trust to address issues <u>newly identified</u> by the inspection	154	46%
Actions by other organisations (eg. CCG, local authority etc.)	80	24%
Other actions	26	8%
No actions are likely to be taken	10	3%

Respondents could choose more than one option

Table 7.2. Likelihood that the report and recommendations will result in service improvements

Answer	Number	%
Not at all likely	8	2%
Not very likely	55	16%
Quite likely	145	43%
Very likely	126	38%
Total	334	100%

Many trust staff tended to suggest that even if the inspection did not identify many or any new issues for the trust, the process was still of value because it gave fresh perspective and added weight to influence and drive change. However, some other respondents were less persuaded of the value of such confirmatory findings, suggesting that it was a resource-intensive process to simply highlight issues that trusts are already aware of.

The trust perhaps hoped we weren't going to find some of these things, but I think they were inspired by the fact that we did, because I think that puts confidence in the process and in the abilities of people on the inspection. And I actually think that the profile that we've given these inspections will apply some of the pressure that's required in order for the trust to actually say we've got to get this right now. (CQC inspector)

But it is expensive and I think that it's going to be one of those things, unless we can make it...if we can make it more constructive and less punitive then people will see it as a value. If we don't I think it's going to be subjected to criticism from the host organisations and from the wider public I think. People will sit there and say bloody hell, there's 50 people with clipboards trawling round a hospital! It's costing bucketfuls of money, to tell us what we already know. So I think it's trying to really use it to make a difference. (CQC inspector)

7.3 Responses to the inspection report and recommendations

CQC generally separated their recommendations into “must do” and “should do” actions. Must do actions tended to follow a breach in regulations (requiring a warning notice or enforcement action), whilst should do actions related to other areas judged as benefiting from improvement. As the statutory regulations underlying the new acute hospital regulatory model were still being developed, ratings had no formal status and CQC relied on the language in the descriptive assessment to give the appropriate weight to the findings and level of concern. As such, the distinction between these categories was not always clear to trust staff or consistent across reports.

In the absence of a formal enforcement action (linked to a must do narrative), trusts were sometimes unclear about the action they were required to take, the necessary standard of improvement, the timescales of this improvement, and how and when they would be monitored or held to account. As mentioned above, trusts did appreciate the opportunity to reflect on areas for improvement. However, there was not always sufficient clarity around any follow up activities. This was also echoed by members of the inspection teams.

It just seems as though this has been done in such a rush, and I can understand that there was action that needed to be taken, but sometimes it's not just action but directed action and a process. (CQC inspector)

One of the other main changes to the ambition of the new inspection regime has been the emphasis on highlighting and sharing examples of good practice. Previous chapters have described how inspectors focused on gathering positive stories and examples, asking trust staff to describe what they were proud of and what activities they performed well. Some trust staff reported that seeing good practice mentioned in the report improved staff morale within their organisation.

I think it's a very positive impact. I think people here are very proud of what they do and provide, so having a regulator...they didn't give us a rating, but they gave us a very, very positive report. So what it does do is give us a fantastic launching pad (Trust chief executive)

However, there was some ambiguity around how CQC intended to use or share these examples of good practice. This was echoed in inspector and trust staff's reflections on the final report and quality summit, indicating that many of these examples of good practice were not highlighted.

Things had been extracted from this narrative when really, underneath the narrative there was a whole host of really positive stories (Trust executive)

Additionally, our interviews suggest that trust staff tended to concentrate on the critique presented in the final report – rather than any areas of praise that were highlighted. Focusing on good practice is new for both the inspection team and the trusts, and our interviews and inspection observations suggested that this was an aspiration that was not particularly realised in practice, and it was not clear how information about good practice was to be actually used.

7.4 Inspections as leverage for improvement

In interviews, trust staff discussed how they were able to use the leverage of the report to influence actions and drive change within their organisation. They also described (see chapter 3) how in the run-up to inspection, NHS trusts prepared and took some important actions to bring about

improvement. However, we also noted in chapter 2, in discussing the logic underlying the new acute hospital regulatory model, that CQC has fairly limited and formal levers for change through their enforcement actions (from warning notices through to recommending that a trust is placed in special measures). It does use those measures - in the financial year in which the new inspection regime was introduced (2013-14), CQC took 73 enforcement actions in NHS trusts, compared with 21 in the previous financial year. But of course, they tend to bear only on hospitals at the lower end of the performance range, and only on services which are clearly performing poorly. So the mechanisms, formal and informal, by which the new acute hospital inspection model might produce changes and improvements are complex. It seems likely that informal enforcement, and external and internal leverage for change, are at least as important and perhaps more important than the use of formal regulatory powers.

At the heart of the new acute hospital regulatory model is the assumption that CQC's reports will lead to improvement actions by others – that CQC's role is to “diagnose but not prescribe”, and that NHS trusts will take responsibility for actions themselves and other stakeholders will take a leading role in holding the trust to account. In particular, CQC relies on local commissioners and other regulators (Monitor and the NHS Trust Development Authority) to undertake this role. This reflects an appreciation that the issues identified through the inspection process might only be capable of resolution through concerted action by stakeholders outside the organisation being inspected.

Quality summit and action planning

Immediately following publication of their inspection report, CQC convened and chaired a quality summit along with the NHS trust concerned and other stakeholders such as commissioners, other providers, The NHS Trust Development Authority (for non-foundation trusts) or Monitor (for foundation trusts), NHS England, the local authority and HealthWatch.

The intended process was that CQC (typically the inspection chair) would present the overall findings from the inspection report. The NHS trust would then provide a response, including an outline of their action plan for addressing areas for improvement. Either TDA or Monitor would then chair the remainder of the summit, working with the group to further develop the action plan, establish responsibilities, timelines and monitoring strategies. There were some participants who generally found the quality summit to be a positive experience.

I think that was really powerful, because we had the local authority, scrutiny committee – one of the chairs there – CCGs, Health Watch. We had a whole range of our key stakeholders, and it's good for them to receive a report back from the CQC about the areas of good practice, and the areas where we need to improve. And it really did stress that it was a collective responsibility, that it was about partnership working, and that it was about ongoing improvement. So it wasn't just a sort of...these are the areas where you've been found wanting. So it was a much more helpful process, I think... You often meet stakeholders in separate meetings, I guess. The Trust will go to the overview group, the health committee, or will meet with the commissioners...or you meet to discuss a particular topic, if you've got particular issues about something. But this seemed like something quite new I think, in terms of looking at the CQC report in that very collective and partnership way (Trust staff)

It was well run, it was well structured, and I appreciated that. The exchange of information was honest and frank and open, and again that was really helpful and constructive (External stakeholder, Quality summit)

I think people ended up feeling that it had been a good occasion, a supportive occasion, that out of the other end came an action plan that people recognised and agreed with (Trust chief executive)

However, there was some variation in the way that quality summits worked. Higher performing trusts saw less value in the quality summit. In the absence of any significant concerns, there was limited attention to action planning and the quality summit was brief.

We didn't have any real concerns. It [the quality summit] didn't have a great deal of meat, actually. It was relatively benign (Trust executive)

Trusts that had received reports that highlighted concerns about their performance saw greater value in the quality summit, particularly in working with external stakeholders and other representatives from their local health economy in developing improvement strategies.

But the purpose and process of the quality summit – and roles and responsibilities within it – were not always clear to participants. Some trust representatives understood that they were to develop action plans at the quality summit in consultation with the other stakeholders, whilst other trusts brought an internally drafted action plan to the quality summit for discussion and agreement with these external stakeholders.

Well, nobody seemed to know [if we were meant to have an action plan]. That was the slightly entertaining bit. So nobody seemed to know what the agenda was (Trust staff)

It was a, well, it's a strange one isn't it – because we were there to action plan and there wasn't anything to action plan. So it should have been two or three hours and actually we were making small talk by the end (Trust staff)

Overall, trust staff and external representatives would have appreciated receiving more information regarding the purpose of the quality summit and their role in it – through a more structured briefing and agenda that was provided with sufficient advance notice. Attendees often had very limited time to review the final report before the quality summit, and so did not feel that it made the best use of their time. Many participants would have appreciated receiving the report and other information in advance, perhaps with a bigger time gap between publication of the report and the quality summit to allow them to absorb the key messages.

I don't think I'd had much written information at all [before the summit]; actually as I recollect it there was a fair bit of information that was tabled on the day, I can't remember whether I received the report immediately prior to the meeting or when the meeting commenced (External stakeholder, Quality summit)

There were also concerns regarding the balance of representation at the summit. Only a limited number of trust staff were invited to the summit (typically the chair, chief executive and other members of the executive team). Many other trust staff members that had been involved in providing information to the inspection team were concerned that they had not been informed of the inspection outcomes, had not seen the report and expressed an interest in attending the quality

summit. On some occasions, the number of commissioners exceeded the number of trust staff that had been invited.

I recognise that it needs to be measured, and sort of limited to some extent, but just having the chair, the chief exec and two of the execs probably didn't touch the people that it would have been useful to touch. So I think most organisations will have a lead for CQC, for example, and I think it may well have been useful to get that person in. And if there was a change to be made in future, I would welcome that really (Trust staff)

Some interviewees felt that the process had not fully had the desired effect of engaging external stakeholders in improvement and accountability. Quality summits appeared to be more effective and successful where Monitor or TDA understood their role and led the action planning process. This was more common where trusts had formal enforcement actions. This process also required senior commissioner and provider representation, capable of committing to these action plans.

Having the stakeholders there was very good. I did have a slight worry about there being...the people who were there being sufficiently senior to make the commitment that we were asking for because that's slightly difficult...yeah, there was several very junior CCG...well very junior, junior, more junior CCG people that didn't say a word really. And they wouldn't have been able to contribute at that level so pick your people maybe a bit better... the process and the asking people for commitment I think was very good, showed an understanding of the problems and the chair was good in pushing people to make...following it through until they'd actually made the commitment to help. And particularly that sits with the CCG and the community services (Trust staff)

I think there was confusion between monitor and CQC as to what their roles were. At the quality summit it was quite clear that monitor or the CQC don't really understand how the follow up to the summit was going to be handled (Trust chief executive)

It seems that CQC expects that Monitor and TDA would hold (respectively) foundation trusts and non-foundation trusts to account for delivering their action plans following the inspection. One of the foundation trusts reported that it seemed that Monitor was not aware of this role, and what would happen after the quality summit. Monitor also sent their apologies for another quality summit and was not engaged in the process. Our observations of quality summits reinforced these findings.

So it was very clear there's different CQC opinions in the room about what would happen with Monitor, what would happen with other things. So it demonstrated for me that actually they're making this up on the hoof, which of course isn't helpful. But respecting that actually they are in a design and build phase. (Trust executive)

I think at the quality summit there was a sense that some of these actions might be signed off by the TDA, you're not necessarily going to have another inspection in order to say 'yes, you are compliant'. So I think that's obviously an area which needs to be developed further (Trust staff)

Where inspection reports had not raised issues that were concerning enough to result in a formal enforcement action, trusts, CQC and other regulators were less clear about how they would be held to account for service improvements. Trusts had developed a range of alternative strategies.

*So in the end our CCG said they'll hold us to account for delivering on the action plan
(Trust staff)*

*We're getting on and doing what we need to do I think, and will let the CQC know what
we're doing, and how we plan to monitor it (Trust staff)*

*Speaking to our local [CQC] compliance officer, she's been made aware, well she's agreed
with ourselves, that as various actions are signed off, it's between myself and the
compliance officer, for me to send the relevant information to hopefully get signed off
(Trust staff)*

The development of different approaches to holding trusts to account for their action plans might reflect the change in inspection model with a greater focus during inspection on standards of performance (through KLOEs), service development and sharing good practice. It seemed that CQC, NHS trusts and other stakeholders are taking some time to adapt to the consequences of this change in regulatory model:

*One is old...the older style of regulatory visit, which is a regulation, you know, it's where
you're measuring an organisation against a set of regulations, and a peer review, which
is a more developmental conversation...it's partly measurement, but it's also partly
development (CQC inspector)*

7.5 Conclusion

It is evident that trust staff were generally positive about CQC's new approach to acute hospital inspection, its potential to provide a credible and thorough assessment of their organisation, and the potential to engage with other stakeholders in driving future service improvement. Furthermore, it seems that inspection reports have been useful in providing the impetus for improvement in NHS trusts, mostly by highlighting known issues that need action but also in identifying some new areas for improvement.

The quality summit provides a valuable forum for bringing together other regulators and local providers and commissioners. For trusts with performance issues or formal enforcement actions, this process was particularly valuable. However, higher performing trusts could not as easily see the forum as a useful opportunity for action planning or engaging other stakeholders. Other regulators in particular did not seem to have a clear understanding of their role in relating to trusts if there were no formal enforcement actions to manage. The quality summit seems to combine elements of regulatory enforcement, organisational development and the sharing good practice, but the mechanisms for securing the latter two through action planning are not currently clear to most stakeholders. In particular, for trusts there is a lack of clarity regarding what happens after publication of the report – when will they be inspected next; when should they show improvements; who should they tell; and to whom they are accountable. The pathway to and mechanism for impact are not clear – possibly reflecting the some ambiguities in the new regulatory model which were discussed earlier.

8. Conclusions and recommendations

8.1 Formative conclusions from the evaluation

As we noted at the outset, this evaluation was a formative one, aimed mainly at helping CQC to understand the way its new acute hospital regulatory model worked in practice. We were particularly concerned to examine its diagnostic purpose or value (what it told CQC and other stakeholders about the performance of hospitals being inspected) and the implementation process (how inspections were undertaken and how different aspects or components of the inspection process worked). In many areas of the inspection process there is no one right way to do things – regulatory design decisions involve sometimes difficult trade-offs between different aspects or characteristics like cost, rigour, timescale and consistency.

- We found that the new acute hospital regulatory model, though developed and implemented very rapidly, had been founded in careful thought about regulatory design, and the underlying logic model was clear in some key areas – particularly to do with how performance would be measured and how the process of inspection would work. It was less clear about the mechanisms for impact, and for change (improvement and spread of good practice) to be driven by inspection.
- The new acute hospital regulatory model has involved a wholesale change in hospital inspection, implemented quickly and at scale. Some of the problems we have seen in the pilot programme are a product of this pace and scale, and could be resolved relatively easily. The scale of the pilot programme has given a great opportunity for experimentation and learning in regulatory design, although the pace has allowed little of this learning to feed into later inspections.
- There has been almost universal acceptance among all stakeholders, particularly in hospitals undergoing inspection, of the case for changing the regulatory model, and general enthusiasm and support for the new approach to hospital inspection. It appears to command a high level of credibility, to be seen as a rigorous and in-depth examination which is unlikely to miss significant issues, and to be conducted well. However, there are some underlying concerns among stakeholders mainly about the costs of the process, pace and timing of inspections and preparation, the reliability and validity of ratings and reports, and the likely impact on performance and improvement action.
- The new inspection teams are a work in progress. CQC has successfully brought into the inspections a new cadre of external inspection team members, bringing much needed content knowledge, subject expertise and managerial/clinical seniority and credibility to the process. It has also changed the roles and contributions of its own staff of inspectors to the process of inspection. But the need for, and sustainability of, the “very large inspection teams” model seems questionable. The size of the inspection teams has in part resulted in or magnified the challenges of effective recruitment, selection, training and deployment which we have documented. The quality of the inspection workforce is crucial because inspectors are the face of CQC, and their performance as individuals and teams will shape stakeholders’ perceptions of CQC and the new acute hospital regulatory model.
- The inspection process itself has been a formidable exercise in planning and execution. The scale and range of fieldwork undertaken has given these inspections a depth, granularity and

range of perspective which was not present in the past, with between 90 and 320 person-days of inspection fieldwork on each NHS trust inspection. Inspections have been undertaken at an intense pace, with a focus on data collection and rather less scope for analysis, investigation, review and reporting. Although there is some guidance provided to inspection teams, there is great scope for individual and team variation, and the inspection is largely a qualitative exercise with less use of quantitative data. Each inspection produces or collates a huge volume of information, quite a lot of which is probably not directly used.

- The reintroduction of ratings has been very widely welcomed, and the use of ratings at a clinical service area level is seen as much more meaningful and relevant than past ratings at hospital or NHS trust level. Hospitals attach great importance to their ratings, and generally agree with the assessments made by CQC though they want assurance of the consistency and fairness of the ratings system. The rating process is highly implicit, relies on professional judgement, and is probably rather variable at present with relatively low initial levels of interrater reliability. The granularity of the domains/rating scales used means a large number of rating decisions have to be made on each inspection. Achieving greater consistency would require some combination of more training for raters, more guidance on rating, simplification of rating scales/domains, and ongoing testing and monitoring of reliability.
- Hospitals want immediate, comprehensive feedback after inspection, and that is very difficult to provide. Unless the inspection process can be reshaped to give inspection teams more time during the inspection for analysis and reporting, it is very challenging to expect inspection teams to give immediate verbal feedback, and the process for doing so risks setting expectations which are then at odds with the subsequent formal written inspection report.
- The new inspection reports have been generally welcomed as much more detailed, descriptive and meaningful assessments of hospitals' performance, and most hospitals have agreed with the content of their reports, though some have raised concerns during the drafting process. The new reports are very long and somewhat duplicative in structure, and some have queried who the audience for the reports is intended to be. The length and level of detail in the reports is itself a challenge for CQC, since every part of each report needs to be justifiable on the evidence, consistent with the rest of that report, and consistent with other reports CQC has produced.
- The process of inspection has had some important impacts – though our evaluation has been able to touch only tangentially on the nature and scale of impact. It seems that inspections highlight some issues of concern that NHS trusts were not already aware of, but the larger part of their impact is probably to drive change in areas where there are known problems or issues which have not been resolved.
- The quality summits were seen as a useful “capstone” to the process of inspection, but it was not clear that they were an effective mechanism for driving change and improvement. They provide a good forum for launching the inspection report and maximising its local impact, but not for action planning and securing commitment to change. The responsibility for this lies with the NHS trust, its main commissioners, and with either Monitor or the Trust Development Authority. It was not clear that these stakeholders were always fully engaged with the post-inspection action planning and change process. For this reason, the pathway to and mechanism for impact is somewhat unclear.

Overall, NHS trust staff and participants in the CQC inspection teams were generally very positive about the new approach to acute hospital inspection, and saw it as transformative in comparison

with the regulatory model it has replaced. However, they identified many potential areas for improvement, some of which we highlight in the next section.

8.2 Recommendations for consideration

We offer the following recommendations for consideration, recognising the CQC has itself been seeking to learn from the implementation of the acute regulatory model throughout the pilot programme and has already made many revisions already to improve its functioning and implementation. The pilot programme has been in many ways a large and very useful experiment – the key task now may be to identify learning from that programme and to use it both in the design of the acute hospital regulatory model and in other health and social care sectors where similar models are being developed and rolled out.

- CQC should consider making use of smaller, more expert inspection teams with a similar balance of CQC and external inspectors, but with stronger data analysis expertise. Externals could be drawn from the large pool of people who have taken part in the pilot programme, but with more selective assessment of contribution and matching to role and to specific known trust concerns or issues, and a commitment to undertaking a minimum number of inspections. It may be necessary to find new ways to enable full-time NHS staff to take time out to act as an inspector, as contributing to individual inspection visits is hard to fit around other work commitments.
- CQC should consider developing a full training and development programme for inspection team members - both those from CQC and external inspectors – which all inspectors would complete successfully before taking part in an inspection, giving inspection team members a mentor or probationary supervisor for their first inspections, and providing some ongoing development.
- CQC should consider how it can use the framework of KLOEs to build more systematic methods for data collection, analysis and reporting, so that applying the KLOEs is more integrated into the inspection process itself. That could mean having KLOE guidance at clinical service area level, structuring preparatory data collection more explicitly around KLOEs, structuring fieldwork to fit KLOEs, and using KLOEs more explicitly in reporting. KLOEs are potentially a very useful tool for securing consistency and rigour in inspection, without reducing the scope for the appropriate use of professional judgement.
- CQC should consider enabling inspection teams to undertake more preparatory work in advance of each inspection, using a more detailed and granular version of the data pack alongside a more structured data collection template from hospitals, organised by clinical service area and using the KLOEs. They would plan in advance their onsite fieldwork, and allow time during the onsite inspection for analysis and reporting. Data collection processes onsite would be more closely tied to the needs of the rating and reporting process. Because more time would be available, it would be possible to give limited and structured initial feedback at the end of the inspection.
- CQC should consider how it can best make the rating process consistent and reliable. This could involve the simplification of the domains, better definition of both domains and rating scale levels, more explicit and exemplar guidance on rating at clinical service area level, more training on rating for inspectors, and ongoing monitoring and feedback on ratings.
- CQC should consider producing shorter, more focused inspection reports in which the narrative about each clinical service area is sustained, but there is less repetition through narrative

aggregation and the report at a hospital or NHS trust level is less directly structured around the domains and instead focuses more on the corporate dimensions of performance.

- CQC should consider revising the post-inspection quality summit process to separate the functions of launching and publicising its inspection report and producing and delivering a post-inspection action plan. It could consider asking the key stakeholders responsible for implementation to produce an agreed, costed and timescaled action plan which they would sign and CQC would approve.
- CQC should consider the practical ways that the examples of good practice that are collected during inspections will be learned from and shared more widely. For higher performing trusts, part of the quality summit could be used to consider mechanisms for diffusion of learning and good practice.

References

1. Care Quality Commission. Acute NHS trust and foundation trust hospitals: framework for inspecting wave 1 and wave 2. London: CQC, 2014.
2. Care Quality Commission. Acute hospital regulatory approach – logic model. London: CQC, 2013.
3. Care Quality Commission. Raising standards, putting people first: our strategy for 2013 to 2016. London: CQC, 2013.
4. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office, 2013.
5. National Audit Office. The Care Quality Commission: Regulating the quality and safety of health and adult social care. London: NAO, 2011.
6. House of Commons Health Committee. Annual accountability hearing with the Care Quality Commission. Ninth report of session 2010-12. London: House of Commons, 2011.
7. Department of Health. Performance and capability review of the Care Quality Commission. London: DH, 2012.
8. Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. London: DH, 2013
9. Darzi A. High quality care for all: NHS next stage review final report. London: The Stationery Office, 2008.
10. Nuffield Trust. Rating providers for quality: a policy worth pursuing? London: Nuffield Trust, 2013.

Annex A.

Research methodology

Between September 2013 and May 2014 we gathered and analysed information from a wide range of sources including:

- Documents about the new regulatory model and the acute hospital inspection framework, including guidance, templates and the documents produced for the inspections in wave 1. These documents were used primarily to orient evaluation team members to the topic and to help inform the design of interview and survey questions.
- Face-to-face interviews with 18 people from CQC and some other agencies (NHS England, Department of Health, Monitor, the Trust Development Authority) about the new acute hospital regulatory model, how it had been developed and how they thought it was intended to work across all of the organisations involved. Subsequent parts of the research were designed in part to check the extent to which the envisaged model had been implemented in practice, and whether the assumptions in the model were valid.
- Observed inspections for 6 acute hospitals drawn from groups 2-4 of wave 1, chosen to provide a range of size/scale, geography and risk/performance. The observations focused on what happens during the inspection process. For each inspection two researchers attended the inspection from start to finish, observed most or all aspects of the inspection process and had many informal discussions with participants from CQC and the hospitals, totalling about 48 person-days of observation. One unannounced inspection was observed by a single researcher.
- Telephone interviews following all 18 wave 1 inspections (both those we observed and those we did not). These interviews complemented the observations by focusing on explaining what had been observed, and on the outputs and impacts from the inspections. There were 61 interviews in total: 35 with inspection team members, 25 with hospital staff and 1 with a member of staff from NHS England who had attended a quality summit.
- Attending and observing 4 meetings of the national quality assurance group which reviews reports, the quality summits for 5 of the acute hospitals where we observed inspections and 1 hospital where we did not observe the inspection, and the CQC feedback meeting for representatives from acute hospitals in wave 1. These observations aimed to understand how inspections fitted into wider organisational and inter-organisational systems, and the processes through which the inspection report findings might achieve impact.
- An online survey of members of CQC inspection teams from wave 2. This survey is complete bar approximately 15 responses that are expected to be received in early June after a final reminder has been issued.
- An online survey of a sample of senior managers and clinicians working in the wave 2 acute hospitals. We would caution that this survey is less than half complete, with staff from trusts in groups 3 and 4 not due to be surveyed until June, and not all responses from groups 1 and 2

have been received. We have therefore only conducted a basic analysis of this partial dataset, and the findings are provisional.

- Observed parts of inspections for 3 acute hospitals in wave 3, in order to check for differences from the wave 1 inspections we had observed. For each inspection one observer attended some or all of the preparation day, a public listening event and one day of a site visit. This totalled about 5 person-days of observation.

Contacts in CQC provided input at various stages in the process, including commenting on the selection of inspections to observe and on the design of interview and survey questions prior to finalisation. Emerging findings were presented at a meeting of CQC Heads of Hospital Inspection in January 2014, and an interim report was produced in March 2014 and discussed with the CQC board.

Ethics and Research Governance

Ethical approval for the study was obtained from the University of Manchester Research Ethics Committee. Permission to gather data was obtained from all Trusts in waves 1 and 2. All interviewees were provided with an information sheet about the research and completed a consent form. Participation in the study was voluntary. For all inspections and meetings that were observed, participants were notified of the presence of the research team observers and the purpose of the observation. The research team has made particular efforts to try to ensure that no individual who provided information can be identified in this report.

Interviews

Two sets of interviews were conducted: face-to-face interviews about the logic of the new regulatory model and telephone interviews about the inspection processes during wave 1. Most interviews lasted between 45 and 60 minutes, and all were digitally recorded and transcribed to facilitate thorough analysis and the capture of verbatim quotations.

The interviews to draw out the logic of the new regulatory model asked questions about the design and impact of the model, including: how it is meant to work, how it differs from previous models, the problems that it seeks to solve, any concerns, what success would look like, the expected impacts, how the impacts will be sustained over time, and how the model will work alongside other regulatory processes and organisations. A thematic analysis of the interview transcripts was conducted.

There were two sets interviews about inspection processes and its outputs – one for inspection team members and one for trust staff – each with a different set of questions. A range of inspection team members were interviewed, including chairs, inspection team leads, specialist advisors and experts by experience. Most of the interviews were conducted after the draft inspection report had been written, but before the publication of the final report and the quality summit. The questions focused mostly on the inspection process, including: the usefulness of pre-inspection preparations, whether the composition of the team was right, how KLOEs were determined, the usefulness of KLOEs, how findings and ratings were arrived at, how the unannounced and announced inspections compared, how the process might be improved, and interest in participating in future inspections.

Some interviewees were chosen because they had been involved in more than one inspection. These interviewees were asked to focus on the most recent inspection, but also to compare and contrast it with previous inspections.

Most trust interviewees were senior managers or other staff responsible for the organisation of the inspection from the trust's point of view and for liaising with CQC. These interviewees were expected to have a good overview, having been involved in all stages from planning for the inspection, liaising with CQC and staff during the inspection, the factual accuracy check of the report, the quality summit, and planning subsequent action. A smaller number of interviews were conducted with operational managers or clinicians who the senior manager believed would have particular insights into how the inspection affected their service area. Most of the interviews were conducted after the publication of the CQC report, and focused primarily on the ability of the inspection to identify important performance issues and promote performance improvement. The topics covered included: actions taken to prepare services prior to the inspection, how decisions about preparation were affected by the regulatory model, how well the inspection process worked, the accuracy of the inspection report and ratings, the usefulness of the quality summit, and the impact of the overall process on services and service improvement.

A single coding framework was devised that could be applied to all of the interview transcripts. This was pilot-tested on one inspection team interview transcript and one Trust staff interview transcript, so as to increase the reliability of coding across different research team members. The transcripts were uploaded to the Dedoose qualitative analysis website for coding, as this facilitated access by team members in different geographical locations. Once coded, text extracts were exported to Excel spreadsheets and a thematic analysis was conducted.

Observations

The 6 trusts from wave 1 whose inspections we observed were chosen so as to give a mix of Foundation and non-Foundation Trusts; CQC risk categories; being shadow rated and not rated; trusts with a single acute hospital site and multiple acute hospital sites. Two researchers observed each inspection¹ so that they could compare notes and more than one inspection sub-team could be shadowed. Each researcher stayed with members of "their" sub-team for a large part of the inspection, from the day zero preparation day onwards, so that they could gain an understanding of how the team developed and conducted its investigation during the course of the inspection. Researchers also sat in on corroboration sessions and on some focus groups, formal interviews, public listening events and trust feedback sessions. They spent some time in the base room for the inspectors so as to observe what CQC analysts and other inspection team members were doing while others were out and about in the hospital gathering information. The researchers mostly stayed in the same hotel as inspection team members, enabling them to get as close as possible to the inspection team experience.

Inspections of 3 acute hospitals were during wave 3, providing an opportunity to see the implementation of the model following revisions made in the light of experiences during the 2 pilot waves. This was a convenience sample as it was a late addition to our data collection, suggested by CQC. Most of the non-specialist Trusts in wave 3 had a troubled recent past and had been the

¹ A PhD student whose research is investigating the impact of external regulation on NHS service improvement also observed part of one of these inspections and contributed her observation notes.

subject of a recent Keogh review. We invested fewer resources in these observations because the aim was to see what had changed with regard to inspection preparation and processes since our previous observations.

A note-taking template was devised, on which the researchers summarised their observations, reflections and initial analysis. These summaries were shared and triangulated with the findings emerging from analyses of other data sources.

Surveys

Two online surveys were conducted, both using the Qualtrics™ online survey tool. The surveys were designed to take about 15 minutes to complete, although this would vary depending on the extent of comments made. Each potential respondent was emailed a unique weblink to click on to take the survey. This enabled us to monitor exactly who had taken the survey. A total of two email reminders were sent to non-respondents and to people who had started the survey but not completed it, approximately 2 weeks and 4 weeks after the initial email invitation. The final reminder gave an option of completing a very short survey about the person's background instead. A Word version of the survey was emailed to a very small number of respondents who had encountered technical problems in trying to access the survey online.

At the close of the surveys both complete and partial survey responses were analysed. The number of respondents answering each question therefore varied, as some respondents had not answered all questions. In addition, some questions or answer options were only displayed if an answer to a previous question indicated that they would be relevant to the respondent (for example, only respondents indicating that they had previously been part of a new approach inspection were asked if their confidence in their skills had changed since then, and CQC staff were not presented with an option that payment was their motivation for joining an inspection team). Qualtrics™ was used to generate basic tables and charts to include in the report. Data was exported to SPSS™ for further processing and statistical analysis, and to Excel™ to enable greater customisation of tables and charts.

The first survey was addressed to all the inspection team members from wave 2 who were engaged in on-site information gathering through observations, interviews, focus groups and the like. This excluded analysts, inspection planners and some specialist advisors, such as pharmacists and Health Education England staff, who would likely only be called on if specific issues arose during the inspection. Their inclusion would have necessitated the design of an additional survey, which was not feasible within the resources available for the project. A substantial proportion of inspection team members were involved in more than one wave 2 inspection. These team members were invited to complete a survey for every inspection they had been involved in, but were not issued with any reminders in connection with second and subsequent inspections.

Lists of team members and their email addresses were provided in advance by CQC, then where possible checked with inspection planners after the inspection, as it was known that changes in team membership were sometimes made in the days before the inspection visit. The lists used appeared to be largely correct, as only a very small number of people contacted us to say they had been invited to take the survey in error, although some team members may have been missed. Shortly before the launch of the survey, each inspection planner was asked to send an email to team members on behalf of the HOHI leading the inspection, encouraging team members to respond to

the survey. Invitations to complete the survey were issued shortly after team members had been given an opportunity to comment on the draft inspection report.

The survey was tested for clarity and ease of completion by a research team member observing it being completed by a member of NHS staff and by a healthcare management researcher who was not part of the team. The final set of questions covered topics such as: motivations for joining the inspection team, the usefulness of various tools and processes designed to support the inspection, confidence in having the necessary skills to gathering information using the various mechanisms available, the accuracy of ratings, and intentions to participate in future CQC inspections. The survey also included some short vignettes, based on actual examples referred to in CQC inspection reports, describing pieces of information about services (E.g. interpreting services are easily accessible, nurses undertake hourly rounds, etc.) , and asked respondents to allocate a domain and rating score to each vignette. The vignettes were designed to cover all of the CQC domains and ratings scores, and to vary in the ease with which domains and ratings scores could be allocated to them. This was intended to test the reliability of inspector judgements.

The second survey was addressed to general managers, doctors and nurses in managerial roles at trust-wide and service levels. The circulation was intended to include key staff both within the core service areas as designated by CQC (acute medicine including frail elderly, acute surgery, emergency department, critical care, maternity and family planning, children and young people, outpatients and end of life care) and for other key services (E.g. radiology, pathology etc.). The trust contact for the CQC inspection was asked to provide email addresses of relevant staff. If no addresses were supplied then email addresses were obtained from Binleys and other database sources accessible to the King's Fund, supplemented by searches of the trust website. Invitations to complete the survey were issued 1-2 weeks after publication of the CQC report.

The topics covered in the survey questions included: preparations that were made for the inspection visit, the ability of various inspection activities to provide inspectors with accurate information, the knowledge and skills of the inspectors, how well the CQC identifies good practices and concerns, actions likely to be taken as a consequence of the inspection, and the impact of those actions. The survey also presented respondents with relevant CQC ratings for their service area/site, and for the trust as a whole, and asked respondents to indicate what they think the ratings should be.