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Who shall inspect the inspectors?

H Cannell Consultant Oral and Maxillofacial Surgeon
Harley Street, London

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For over three years, from March 2014, I was an occasional surgical advisor to the Care Quality Commission (CQC). During that time, I was a team member for both NHS and private hospital provider inspections. My experiences led me to have real misgivings about the inspection process for the administration and management of healthcare. This article details the reasons for some of these misgivings. They concern not only recent changes to the way in which specialist advisors (SpAs) are treated and managed by the CQC but also aspects of current managerial practice in hospitals and theatre practice more generally.

It may be worth reminding the reader of the role of the SpA, as it functioned until recently. The SpA is used on an ad hoc basis for hospital inspections by the CQC. The role of a SpA is to 'provide timely, robust and objective specialist advice to CQC staff, either through verbal or written communication'.[1] The SpA accompanied staff inspectors, providing clinical input interpretation and evaluation as required. Inspections of the larger trusts were staffed by a number of SpAs and by up to 50 other CQC staff.

For all inspections, everyone in the inspecting team was issued with a warrant, active for the duration of that inspection. This allowed access to all areas of the hospital, to any records and, if necessary, to patients' notes. Briefings were given before every inspection. Deviations from a national mean in a certain area of performance indicated that the area of performance required scrutiny. The system worked well enough apart from a noticeable reluctance of the inspecting team to receive a SpA's findings in any other way than through a staff inspector and (on a few occasions) the unavailability of warrants.

From 19 September 2016, however, a revised set of terms of engagement was introduced, under the heading 'Flexible workforce'. This included a pay cut in all but name. The terms and conditions applying to ad hoc requirements for a 'casual worker' SpA were, in fact, comparable with those for peripatetic crop pickers.

Any SpA who did not accept the terms would not be selected for any further inspections. Moreover, the new terms devalued the SpAs' work. They stipulated that even a consultant SpA must work under the direction of a staff inspector. At first, I was not especially concerned about this; many staff inspectors, after all, were mature and knowledgeable ex-nurses. This view turned out to be too sanguine. The 'flexible workforce' rubric meant that newly recruited permanent staff inspectors had to become generalists, miraculously able to review any hospital department; the turnover of such appointees was about 10% per year, with roughly a quarter of those leaving for negative reasons.[2] The revised employment model exhausted past goodwill from staff, including the ad hoc SpAs.

The devaluation of SpAs' work is especially serious given some of the substantive concerns brought to light. We found surgery taking place in metal boxes (similar to those seen in container ports), masquerading as 'temporary' operating theatres. In one trust, some day-case patients had to stand in a queue between two buildings, but were not adequately shielded from the cold in winter or the sun in summer. Capture of induction data for general anaesthetics varied greatly; sometimes the data had simply been lost or apps on mobile devices used for induction records were incapable of recording changes. Patients and visitors mainly seemed to avoid using hand hygiene stands. Theatre staff were fully changed into scrubs and shod in electrostatically safe clogs for all clean areas, and yet some patients were not appropriately attired. Only one or two trusts appeared to have any idea of how to tackle this problem.[3]

Only very rarely did we have to intervene to protect the safety of patients. On one occasion it was necessary to persuade a consultant colleague to get some rest after finding that the consultant had been on shift over a sequence of busy days followed by a night on call; at other times, we had to step in and recommend tests of capacity for informed consent for some patients. The CQC's inspection reports generally failed to confront these embarrassing facts.

Of equal concern were the deficiencies in management structures and practices. Only one NHS trust I visited, in three years of inspections, had a stable middle management team. Sometimes the tenure even of senior managers was so short that they could achieve nothing. At one meeting with a senior manager of over three months' standing, we had to introduce that person to their own departmental heads. Some managerial staff appeared to have been overpromoted and it was not always clear who was responsible for what.

One especially disturbing feature of inspections was that bad news seemed to reach us only after we had been there for a few days, often during the last hours of a three or four-day comprehensive inspection. 'You are being told lies by the trust management,' clinicians might say. 'They just won't listen to us. We have tried everything. Can you help?' Or they might ask: 'Did you see the extent of out-of-hours working for elective surgery?'

We were unable to ensure that such concerns were reflected in CQC reports. The language of these reports was euphemistic. It would not be permitted, for example, to write that staffing levels for acute surgical emergencies in a trust *were* lower than in trusts of similar size, but only that they 'appeared' to be so. In such cases, the management of the trust had not wished to ease a problem (or even describe it). Still less would they accept responsibility for solving it. Even where the CQC's report did highlight a problem, the regulator's threshold

for applying sanctions for underperformance by management, curiously, was not reached. There are five questions that the CQC asks for all care services it inspects; one of these is: 'Are they well led?' One can only hope that this area will include an analysis of the costs and benefits of all managerial posts.

In its wide ranging report on every hospital inspected from 2014 to 2016, the CQC explained that contributions from whistleblowing staff were greatly valued.[4] Figures for the period November 2017 to October 2018 indicated an input of over 700 whistleblowing reports on average per month.[2] However, it remains unclear when and by whom these whistleblowing reports were considered. Whistleblowers could not be sure that pressing concerns raised to SpAs would be properly addressed. Despite the declarations that whistleblowers' contributions are strongly valued, this lack of clarity can hardly give them confidence.

In addition, there were other problems with CQC reports. Permanent staff inspectors were instructed not to ask for written or verbal advice from the SpAs after the inspections when writing up their reports. This led the reports to follow a straitjacket, tick-box culture. For this reason, important matters that should have been unearthed were missed.

The inadequacies of the reports may reflect wider problems within the CQC. Bullying of juniors by line managers appears to have been a chronic issue.[5] Annual staff surveys showed that a gradual improvement had been made and yet some staff preferred not to respond to the survey. It was apparent that communication and feedback were recurrent problems.[6] SpAs were invited to complete a short feedback questionnaire but this happened long after an inspection, when details had lost clarity; in any event, the questions were anodyne. Occupational health checks and appraisals for staff are now said to be available at the CQC. These have long been overdue.

A further source of concern was the inaccessibility to inspectors of work done by private providers. At one inspection in 2014, we were told that a busy unit, in an NHS hospital, was out of bounds to the inspecting team as it was administered and staffed by a private company. Such exceptions to a comprehensive trust inspection have now been abolished. From April 2018, inspections of private hospitals will have become focused on selected risk areas – presumably, after preparatory use of the CQC's intelligence data banks. The management and administration will also be scrutinised more closely, with an emphasis on improvements in patient safety.

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These are welcome changes. Previously, commercial pressures still seemed to control available information. During 2016–2017, the CQC was at last able to concentrate on private provider hospitals; most have now been inspected at least once. Unhappily, however, the private providers have been allowed to submit hospital performance data almost on a voluntary basis to the Private Healthcare Information Network (PHIN). PHIN is described as the government mandated source of information for private healthcare. Since April 2015, PHIN has been tasked with the collection and publication of data of sufficient quality to enable patients to make informed choices regarding their treatment.[7]

Data on 11 aspects of performance were collected and participation was required by every one of roughly 12,500 consultants offering treatment by private contract, but the PHIN annual report for 2016–2017 showed that 151 private hospitals had yet to submit any data.[8] Despite this, with an initial phase of light touch regulation by the CQC, no enforcement had occurred. Changes, due now, have for the first time targeted the companies that own the provider hospitals. Breaches could therefore initiate enforcement action and fines, at both the parent company and the local provider levels.

Nevertheless, gaps in information about privately funded facilities remain unfilled.[9] It may be suspected that the tardy responses to requests to fill them reflect the commercial interests of providers. Furthermore, the gaps demonstrate that the CQC, as a regulator, has been poorly advised and has failed to consider working patterns during an average surgeon's seven-day week. If missing outcome figures were supplied, this would at least make it possible to compare a minimum dataset but data should also include patient safety measures, especially those raised by newer techniques or by non-NHS recognised procedures.

CQC Insight (the regulator's new data monitoring tool) is stated to be able to help identify changes and trends in performance and quality. As with any such software, the data input (and its regulation, use and monitoring) will be crucial. Perhaps the CQC has also already chosen to place too much reliance on data gathering alone. Only when data are coupled with informed input of high quality from working clinicians, can data and artificial intelligence succeed.

Who shall inspect the inspectors? In common with other regulatory bodies, any doctors with leadership functions must be seen, on appointment, to include themselves

in appraisals and also to open their facilities for inspection to ad hoc SpAs. The CQC, however, is hardly encouraging or valuing the work of SpAs in the way it should. Ad hoc SpAs too often appear to be regarded by the CQC's core staff as a distraction from the important work of box ticking. Sometimes SpAs are treated as little more than window dressing. The CQC should not think of itself as being the 'line manager' for SpAs. Finally, the terms and conditions under which SpAs work surely require thorough revision by medically qualified clinical staff.

The CQC's currently declared focus on whether care services are 'well led' is timely – if about four years too late. At last, too, the recruitment and performance of 'fit and proper persons' as directors of healthcare services will be assessed by the CQC. To date, 'management' has been able to evade its responsibilities and to remain a serious obstacle to the efficacy of a CQC inspection. It should not have taken the events at Mid-Staffordshire to bring this to the fore. The sign of the revolving door was already there but ignored.

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