Being Ambitious for End of Life Care: The CQC’s perspective

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Chief Inspector of Hospitals
National Council for Palliative Care
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Overview

- CQC’s role and purpose
- Our new approach to hospital inspection
- What we have found in year one
- Being ambitious for end of life care
- How CQC can drive quality improvement
Our purpose and role

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care
We ask these questions of all services:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well led?
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<thead>
<tr>
<th>Question</th>
<th>Description</th>
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<tbody>
<tr>
<td>Safe?</td>
<td>Are people protected from abuse and avoidable harm?</td>
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<tr>
<td>Effective?</td>
<td>Does people’s care and treatment achieve good outcomes and promote a good quality of life, and is it evidence-based where possible?</td>
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<tr>
<td>Caring?</td>
<td>Do staff involve and treat people with compassion, kindness, dignity and respect?</td>
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<td>Responsive?</td>
<td>Are services organised so that they meet people’s needs?</td>
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<td>Well-led?</td>
<td>Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?</td>
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A new approach: Why?

• Previous CQC inspections
  • Missed important problems
  • Focused on compliance vs non-compliance
  • Did not give a picture of overall quality of care
  • Were undertaken largely by ‘generic’ inspectors without expert clinical input
  • Did not command confidence (e.g. from providers)

• But … had good elements (e.g. evidence gathering)
3 Phases

1. Pre-inspection:  
   Selection of trusts  
   Planning  
   Datapack  
   Recruitment of teams

2. Inspection:  
   8 core services  
   5 key questions  
   Large team (30+ people)  
   Visits to clinical areas  
   Public listening event  
   Focus groups  
   Interviews  
   Announced and unannounced visits

3. Post-inspection:  
   Report writing  
   Confirmation of ratings  
   Quality Summit
• The following 8 core services will always be inspected:

1. Urgent and emergency services
2. Medical care, including frail elderly
3. Surgical care, including theatres
4. Critical care
5. Maternity and gynaecology
6. Children and young people
7. End of Life Care
8. Outpatients and diagnostic imaging

• We will also assess other services if there are concerns (e.g. from complaints or from focus groups)
• We rate each service on each of the five key questions (Safe? Effective? Caring? Responsive? Well led?)

• 4 point scale: Outstanding ★★ Good ★ Requires Improvement ★★★ Inadequate ★★★★
<table>
<thead>
<tr>
<th>Trust X ratings grid</th>
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<tbody>
<tr>
<td><strong>Hospital location A</strong></td>
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<tr>
<td>Accident and emergency</td>
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<tr>
<td>Medical care (including older people's care)</td>
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<tr>
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<tr>
<td><strong>Overall</strong></td>
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</table>

**Overall provider rating**

<table>
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<tr>
<th>Trust by key question</th>
<th>Safe</th>
<th>Effective</th>
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<th>Responsive</th>
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<th>Overall trust rating</th>
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<tr>
<td>Requires Improvement</td>
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What have we done so far?

- 75 acute trusts inspected (over 40%)
- 12 mental health trusts and one large independent MH provider
- 8 standalone Community Health services, and several which are managed by acute or MH trusts
- 2 ambulance trusts
• Sept-Dec 2013: 18 ‘Wave 1’ inspections. These were selected to include 6 “high risk”, 6 “intermediate risk” and 6 “low risk” trusts

• Jan 2014 onwards: 51 further trusts/FTs. These have included:
  • Mainly “high risk” trusts or those with local concerns
  • Some FT aspirants
  • All 14 Trusts inspected in 2013 for the Keogh review
Variation

• The degree of variation between the best and the worst is large and unacceptable

• There is variation
  • Between trusts
  • Between services within a trust
  • Within individual services (e.g. one ward may be inadequate, while others are functioning well)
### Basildon University Hospital

<table>
<thead>
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<th>Service Type</th>
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Key Findings: Compassionate care

- Compassionate care is alive and well in the NHS in all trusts inspected.

- In a relatively small number of individual services or wards we found that the standard of care was not as good as it should be. This largely related to wards that were understaffed especially those for the frail elderly or escalation wards.
Key Findings: Culture

- Culture may be difficult to define but relatively easy to recognise.
- The staff survey and staff sickness levels give a good indication of culture, which can then be explored at focus groups.
- In several trusts we saw a truly open and learning culture, with very positive views from staff about the leadership of the trust – these trusts generally performed well across all or most of the core services.
- In contrast, we observed some trusts with a ‘them and us’ culture between clinicians and managers.
- Staff engagement programmes (e.g. Listening into Action) appeared to be changing the culture in some trusts.
Ratings by core service

Acute ratings - overall core service level, Dec-Jun 2014

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive / critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients

Legend:
- Outstanding
- Good
- Requires Improvement
- Inadequate

0% 20% 40% 60% 80% 100%
End of Life Care: General

- EOLC has deliberately been selected as a core service to raise its profile in acute hospitals and community health services
- It encompasses care given to adults in all parts of a hospital (e.g. A+E, medical wards, surgical wards and critical care)
- It is not just about specialist palliative care, though the SPC team will always be interviewed
- It should not just be about the last days of life
• We will always ask for information about numbers of deaths for the trust as a whole and for individual locations – not all trusts have this readily to hand, though they always know about numbers of births!

• We will also ask about referrals to specialist palliative care (numbers and diagnoses) and about team size and composition
End of Life Care: Inspection (1)

- Safe
  - Completion of DNACPR forms
  - Mental Capacity Act
  - Mandatory training (?)
  - Equipment (e.g. syringe drivers)

- Effective
  - Implementation of NICE Quality Standards
  - Pain and symptom control
  - National Care of the Dying Audit results
  - Seven Day Services
End of Life Care: Inspection (2)

- Caring
  - Observation of care given to dying patients on wards
  - Potential to use VOICES Survey findings in future if results could be linked to individual trusts
- Responsive
  - Rapid discharge services
  - Mortuary services
  - Bereavement services
  - Other additional services
- Well-led
  - Local service leadership
  - Board level leadership
How can CQC drive improvement? (1)

- Influence of ratings on reputation
  - Patients/public may choose to go to a hospital with a good or outstanding rating (e.g. maternity services)
  - Providers do not like the reputational damage of either a ‘Requires Improvement’ or especially an ‘Inadequate’ rating
  - Providers will be required to display ratings in prominent places
  - Commissioners also do not like poor ratings (as evidenced by this response at Quality Summits)
How can CQC drive improvement? (2)

- **Enforcement**
  - CQC has a range of powers to drive improvement
  - During an inspection providers can be ‘advised’ to take urgent action (e.g. closure of beds where staffing levels are too low)
  - Compliance Actions: Providers must develop action plans and provide assurance that these have been implemented
  - Warning Notices: Improvements must be made within a specified time. CQC will re-inspect to ensure delivery
  - Changes to registration (including conditions or ceasing)
    - CQC can ensure that a provider ceases to function, but this is clearly difficult in the acute hospital setting
  - Prosecution
How can CQC drive improvement? (3)

- Special Measures
  - New regime, introduced in July 2013
  - Recognises that some Trusts have both
    - Inadequate quality (safe, effective, caring, responsive)
    - Leadership that is unlikely to be able to deliver high quality care (“Good”) within a reasonable time frame.
  - CQC recommends special measures to Monitor or the NHS Trust Development Authority
  - Trusts in special measures receive additional support (e.g. buddying)
  - Special measures may lead to changes in senior management
  - CQC re-inspects to recommend whether trusts come out of special measures
• 11 of 14 trusts with high mortality reviewed by Sir Bruce Keogh in 2013 were put into special measures. These were reviewed by CQC in 2014
  • 2 had already achieved ‘Good’ quality
  • 3 more were recommended to exit with support
  • 5 had made some progress, but continued in special measures
  • 1 had made no progress

• A further 7 trusts have been put into special measures in CQC’s recommendation. One has exited due to acquisition by an ‘Outstanding’ trust
Reflections after one year

• The CQC’s new approach is more robust and credible than that previously used

• Providers tell us so

  • An independent evaluation (Prof K. Walshe) has confirmed this

• We are still on a learning curve. Our recent inspections are much better than those in Wave 1.

• Consistency is the greatest challenge, particularly as judgement is required to synthesise all the evidence
How do we ensure consistency?

• Recruiting good teams (clinicians, managers, inspectors, experts by experience)
• Training
• Consistent methodology: KLOEs and subheadings
• National quality assurance group
• Factual accuracy checks
• The new inspection programme has come a long way in the past 14 months
• It is undoubtedly better than the model it has replaced
• We can and must continue to improve
• Further ideas and support on end of life care would be very welcome
To join CQC and help to drive quality improvement through our inspection programme

**Become an Inspector:**  
(Permanent or on Secondment)  
recruitment@cqc.org.uk

**Become a Specialist Advisor:**  
(Clinician)  
acuterecruitment@cqc.org.uk

**Become an Expert by Experience:**  
(Patient or Carer)  
Expertsbyexperience@cqc.org.uk