NURSES ARE to be handed a crucial role in ensuring that care providers are up to standard, with the introduction of a new hospital inspection regime in England. The Care Quality Commission (CQC) sees nurses’ input, along with that of patients and junior doctors, as central to the redesigned inspection procedure. According to the regulator, nurses are vital to collecting and providing information about hospital performance. As a result, they are an important component of the new, larger inspection teams.

Whereas, the regulator previously focused on themed inspections centred on 16 standards, such as nutrition and infection control, the new teams will look at the whole patient pathway. This means that inspections will involve eight care areas, such as emergency departments, children’s services, end of life care and outpatients. Each of the 20-strong inspection teams may include as many as six practising or retired nurses, as well as doctors and other healthcare professionals.

The changes come after publication in July of a review of the 14 hospital trusts with the highest mortality rates by NHS England medical director Sir Bruce Keogh. The new chief inspector of hospitals, Sir Mike Richards, says his involvement in the review opened his eyes to the important role staff on the inspection teams can play. ‘One of the things that really stood out was the ability of nurses and junior doctors to connect with staff working in hospitals,’ he says.

We need to make sure we have this expertise on the inspection teams.’ Professor Richards says the way to find out the views of staff will be through focus groups, which he wants to be held away from the eyes and ears of bosses. ‘My experience from the review is that we find out a lot that way. We need to create these safe environments so people can tell us what is happening.’

To help achieve this, he wants to recruit a ‘small army’ of part-time inspectors who can be called on when needed. Recruitment started over the summer in time for the launch of the new inspections system, which began last month.

Detailed picture
Four inspections have been carried out so far, at: Airedale NHS Foundation Trust, West Yorkshire; Croydon Health Services NHS Trust, Surrey; Royal Wolverhampton NHS Trust, West Midlands; and Taunton and Somerset NHS Foundation Trust. There have also been public listening events.

The new inspections will take longer than before, with those at the largest trusts taking up to a week to complete. ‘These new-style inspections will allow us to get a much more detailed picture than has been possible before,’ says Professor Richards. ‘Part of the difficulty with basing it around a group of, or individual, essential standards is that it does not allow us to look at the whole pathway of the patient.

‘I want to see what happens when patients come into A&E, when they go on to a medical assessment unit and then perhaps a general ward, and on to a ward that cares for the frail elderly.’

The revamped system
- Inspection teams are likely to comprise more than 20 people, including practising and retired nurses and doctors.
- Inspections will always cover emergency care, maternity, children’s services, acute medical and surgical pathways, care for the frail elderly, end of life care and outpatient departments.
- A surveillance tool, which uses 150 indicators, such as patient surveys, death rates, complaints, never-events reporting and avoidable infections, will identify high-risk, priority trusts.
- Trusts will receive school-style ratings of ‘outstanding’, ‘good’, ‘requires improvement’ and ‘inadequate’ from next January.
- Where concerns are noted, follow-up inspections will be carried out. Targeted spot checks will also be deployed alongside the routine programme.
The CQC is aiming to inspect the first 18 trusts by the end of the year, and to have inspected the remaining 161 by the end of 2015. The first wave of trusts has been identified using the CQC’s new surveillance tool, which analyses data such as death rates and patient surveys, to see which providers should be prioritised.

Six of the 18 have been chosen because they have high risk ratings, six because they have low risk ratings and six because they fall in between. The spread will enable the CQC to review its programme once the inspections of all the trusts are completed.

RCN management and leadership forum chair Jane Valle welcomes the initiative. ‘In principle, it sounds really good,’ she says. ‘The idea of getting clinicians involved lends credibility to the inspection regime.

‘If you work on a ward and are approached by someone who understands the job you do and the pressures you face, they are more likely to get to the bottom of what is happening. This should create a greater honesty in the process.’

However, she has concerns over the workload. ‘It is a big ask to get through so many hospitals in the period of time.’

Ambitious

The NHS Confederation agrees it is an ambitious programme, but one that is needed, given mounting concerns over hospital regulation.

The review by Sir Bruce, ordered after the publication in February of the Francis inquiry into poor care at Mid Staffordshire NHS Foundation Trust, illustrated the deficiencies of the previous system in that, while the review led to 11 of the 14 trusts being placed under special measures, just two of these were subject to regulatory action from the CQC.

According to the NHS Confederation, the next few months will prove crucial. The new system needs to be comprehensive, without being overly burdensome. It is thought that the first tranche of inspections will reveal any problems with processes and design, and any duplication of existing information that diverts staff and resources from care.

Nick Triggle is a freelance writer

‘Ill-informed’ debate obscuring causes of strain on emergency services

Senior staff say focus on NHS 111 problems ignores factors such as rise in number of frail older attendees, reports Nick Lipley

NHS LEADERS are warning that emergency services could experience a meltdown this winter unless the country faces up to the true reasons they are under pressure.

According to a survey by the NHS Confederation, senior health service staff, including chief nursing officers, say that services could falter if ‘decisive steps’ are not taken. They think misleading and ill-informed debate about the reasons behind A&E pressures is stopping the health service from addressing the actual causes.

Following a House of Commons health committee suggestion in May that the NHS is ‘flying blind’ about problems in emergency care, the survey, carried out in July, offered senior leaders the chance to share their thoughts on the cause of pressures on emergency care. It also asked for views on how the increasing pressures can be managed.

Nearly half the respondents said the main cause of pressure on emergency care was not the problematic introduction of NHS 111 services this year but the rising number of frail older people with multiple long-term conditions accessing services. More than one quarter identified difficulties with discharging patients or transferring them to alternative care settings.

Fewer than half the respondents said they are likely or very likely to meet the 95 per cent four-hour waiting target for the next quarter, from October to December.

Mike Farrar, who stood down as NHS Confederation chief executive last month, said: ‘We have known for some time that pressures on A&E are at their highest ever, and the honest picture is one of a service facing unprecedented demand.

‘But, as if the genuine rise in seriously ill, frail A&E attendees wasn’t putting enough strain on the system, the NHS is also struggling with ill-informed speculation about what is causing the pressures and what services they can rely on to meet their needs.

‘The knock-on effect is that the public has so little confidence in alternative options for meeting its healthcare needs that it believes the only recourse is to turn up at A&E.’

The survey asked respondents to prioritise ways of easing pressures in their organisations. More than half said giving organisations more notice about funding designed to ease winter pressures would be helpful, with one chief executive explaining that her trust received 2012/13 winter funding only in February 2013.

Other suggestions included:

- A public information campaign on alternative ways to access unplanned NHS care and treatment.
- More incentives for staff to work in emergency care, and for more senior staff to work evenings and weekends.
- A new payment system so that emergency care is rewarded fairly.

The survey results were published last month as emergency care staff across England were waiting to hear which departments will benefit from an additional £500 million announced over the summer by prime minister David Cameron to ensure they are ‘fully prepared for winter’ over the next two years.

Reference