East London NHS
NHS Foundation Trust

# CQC Readiness Policy

## Ongoing measurement, validation and inspection of CQC standards

**Version Control Summary**

| | |
|---|---|
| Version | 2.0 |
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| Name of originator / author: | Philip Thompson, Quality Assurance Manager |
| Name of responsible committee / individual: | Jonathan Warren, Chief Nurse |
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| Target audience: | All clinical staff |

## Review and Amendment Log

| Version | Type of Change | date | Description of change |
|---|---|---|---|
| 1.0 | New policy | Philip Thompson, Quality Assurance Manager | Final |

## Contents

# 1. Introduction

East London NHS Foundation Trust (ELFT) is committed to providing high quality, evidence based care that is guided by the standards set out by the national regulator, the Care Quality Commission (CQC). The CQC is responsible for setting out and monitoring compliance with essential standards of good quality care through a programme of intelligence monitoring and onsite inspections.

In 2016 ELFT underwent a full inspection which resulted in one of the first "Outstanding" ratings for a mental health and community health trust. It is in this context that the Care Quality Commission has recently issued guidance on its "Next Phase of Regulation" which includes a new set of Key Lines of Enquiry for healthcare services.

This policy sets out how the Trust intends to align itself on a continuous basis with the latest regulatory standards of high quality care. Rather than waiting for the next inspection, the Trust will make a pro-active commitment to be Outstanding at all times, demonstrating this through assurance and inspiring confidence in staff and those who use our services. The Quality Assurance Team has therefore designed a process to underpin this commitment.

The process outlined in this policy is built on local leadership at every stage, facilitated and equipped with the necessary tools by the central Quality Assurance Team. The process relies on candid self-assessment by team managers, followed by holistic assessment of risk and concern by Directorate Management Teams, and completed by clinician/service user inspections which will use the CQC KLOEs as an impetus for improvement.

Structured around the four core types of service in ELFT – community health, community mental health, inpatient mental health and specialist – each service will receive the dedicated focus of one quarterly cycle each year. The process will also have built-in flexibility, that because of its light touch and devolved nature will allow individual teams or groups of services to opt in to the process based on specific concerns or intelligence through the year.

# 2. Purpose

The purpose of this process is:

- to develop systems that enable the Trust to meet the relevant regulatory framework
- to enable the Trust to demonstrate how it takes account and complies with CQC regulation
- to set out clear roles and responsibilities in the measurement, validation and inspection of CQC readiness
- to establish assurance processes to monitor the impact and effectiveness of

these processes

# 3. Explanation of terms

## 3.1 Care Quality Commission (CQC)

The CQC is the independent regulator of health and social care in England. They monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and they publish findings, including performance ratings to help people choose care. Across all services, inspections are structured along the domains: safe, effective, caring, responsive, and well-led.

## 3.2 Key Lines of Enquiry (KLOEs)

Each of the five key CQC questions ("Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?") are broken down into a further set of questions. These are known as key lines of enquiry (KLOEs). When the CQC carry out inspections, they use these to help decide what they need to focus on. For example, the inspection team might look at how risks are identified and managed to help them understand whether a service is safe. The CQC is currently consulting on a unified set of KLOEs covering all health sectors.

# 4. Duties

## 4.1 Duties within the Organisation:

### 4.1.1 Chief Executive

- Ultimate responsibility for the implementation, maintenance and monitoring of compliance with CQC standards across the Trust.

### 4.1.2 Chief Nurse / Quality Committee

- In practice, this responsibility is delegated to the Chief Nurse and the Quality Committee through the Associate Medical Directors for both Mental Health and Community Services who will assess the ongoing compliance with the process and will review and decide on responses to any major systemic risks or concerns brought to light by the CQC Readiness process. In addition the decision on initiation or and amendments to this process rest with the Chief Nurse and Quality Committee.

### 4.1.3 Head of Quality Assurance

- Advise the Chief Nurse and Quality Committee on compliance with the CQC readiness process and raise any major systemic risks or concerns brought to light by this process
- Provide ongoing reporting on the process and significant themes arising from it
- Advise the Chief Nurse and Quality Committee on any changes to CQC standards or inspection regime

### 4.1.4 Quality Assurance Manager

- Oversee the implementation of the process
- Ensure appropriate communications, training, tools, guidance and documentation are available to support the process
- Set out timescales for the participation of each clinical specialism in the Trust through each annual and quarterly cycle.
- Support the Head of Quality Assurance with reporting and advising on the CQC readiness process.
- Ensure that feedback is provided as appropriate to all levels of staff so that learning and improvement is emphasised.

### 4.1.5 Team Managers/Clinical Leads

- Complete the CQC Readiness Self-Assessment Survey once per year, to the timescales outlined by the QA Manager
- Participate in the CQC Readiness Peer Inspection process, if nominated by the Directorate Management Team.

### 4.1.6 Directorate Management Teams

- Review data from the CQC Readiness Self-Assessments and decide improvement actions if appropriate
- Nominate the requested number of teams from within each directorate for a Peer Inspection
- Review feedback from Peer Inspections and decide improvement actions if appropriate

### 4.1.7 Quality Assurance Leads

- Support the QA Manager to ensure compliance with the CQC Readiness process in each directorate.
- Populate the Quality Assurance Tracker for CQC Readiness with actions agreed by the DMT and local teams, including chasing completion of actions through the year.

## 5. Self-Assessment

Each clinical team in the Trust is to complete a CQC Readiness Self-Assessment once per year to the timescales outlined by the Quality Assurance Team. The Quality Assurance Team will set out The Self-Assessment will be structured to reflect as closely as possible the CQC Key Lines of Enquiry. As well as reducing the central administrative burden and increasing the sustainability of this process, self-assessment has been prioritised to capture the valuable knowledge held by local teams. Local teams have strong awareness of their own strengths and weaknesses and as such are often in the best position to evaluate their own compliance to care quality standards.

The Self-Assessment will be conducted through an online survey, and will be completed during the same period as the quarterly audit data collection period. Those completing the Self-Assessment are advised to complete it based on their assessment of how confidence they are of their team meeting each standard. They should consider the evidence they can provide to confirm each response in order to guide their level of confidence.

## 6. Directorate Nominations

Each directorate is to consider the results of its teams' Self Assessments and make a set number of team nominations based on these and other data. DMTs (or other delegated committee) have a large amount of data sources and frontline experience available to them. The DMT should consider all the data available to it, as well as the harder-to-detect tacit understanding gained from frontline experience. Based on a triangulation of these sources and the Self-Assessments, the DMT (or other delegated committee) will put forward no more than the requested number of teams to the Quality Assurance to undergo a Peer Inspection.

## 7. Peer Inspections

Nominated team managers or clinical leads will organise reverse inspections of the team they are matched with to the timescales set out by the Quality Assurance Team. Detailed guidance and training will be provided by the Quality Assurance Team to ensure the inspection process is consistent.

As this is intended to be a sustainable and light-touch process, inspection teams will be kept to 2 or 3 members in order to simplify diary bookings, reduce the burden on receiving and inspecting services and emphasise that this is a light-tough inspection regime.

Where possible the inspection team will include a clinician and a service user or carer.

## 8. Responsiveness of the system to specific concerns or intelligence

The CQC Readiness process will be adaptive to specific concerns, local demand or intelligence that may arise. The Quality Assurance Team will make available the tools and guidance used in the formal process so that any staff that wish to assess their confidence against CQC standards, may do so. In addition, suitable requests for urgent additions or changes to the annual programme of self-assessment and peer inspection are permitted. Requests for these could come from senior staff, external bodies, directorate management, or teams themselves. These should be kept to a minimum to maintain the scheduled programme as far as possible. However, the Quality Assurance Team which maintains the process will endeavour to accommodate these requests where possible.

## 9. Feedback, learning and improvement

The purpose of the CQC Readiness process is twofold – to provide assurance about compliance with regulatory standards around care quality, and also to provide peer-to-peer opportunities for feedback, learning and improvement. At each stage of the process – self-assessment and peer inspection – the Quality Assurance Team will provide clear and timely feedback to teams, DMTs and QA leads. The reverse inspections by peer services will provide both face-to-face and documented feedback opportunities.

| Stage | Recipient | Purpose of feedback |
|---|---|---|
| **Self-Assessment** | Team | To provide handy prompts for managers to check where their confidence is lower and where to focus their improvement efforts. |
| | Directorate | To inform DMT discussions about which teams to nominate for peer inspection. |
| **Peer inspection** | Team | To provide validation of the team's self-assessment and to provide inspector's specific notes on areas of strength and weakness and suggestions for improvement |
| | Directorate | To provide an overview of themes arising from inspections, especially areas for improvement. To highlight any variance between self-assessments and inspections. |

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# 10. Assurance

The Quality Assurance Team will report on compliance with the CQC Readiness process to the Quality Committee on a quarterly basis via the Quality Assurance Dashboard. The Head of Quality Assurance will advise the Quality Committee on significant themes arising from the process, and raise any major systemic risks or concerns brought to light by this process.

Local QA Leads in each directorate will populate their Quality Action Trackers with agreed by DMT or local teams with actions arising out of the CQC Readiness process. The QA Leads will then assign owners to each action and chase up each action until completed.

## 10.1 Risk Register

Non-compliance with CQC standards will be recognised as a risk within the Trust and should be considered for inclusion on the organisational risk register. For CQC non-compliance that relates to a specific Directorate or service, it will be the Directorate's responsibility to raise risks of non-compliance to its Risk Register and to raise during the DMT and Quality Committee

## 10.2 Key performance Indicators

KPIs around this process are outlined below. These are subject to review and amendment by the Quality Committee as necessary.

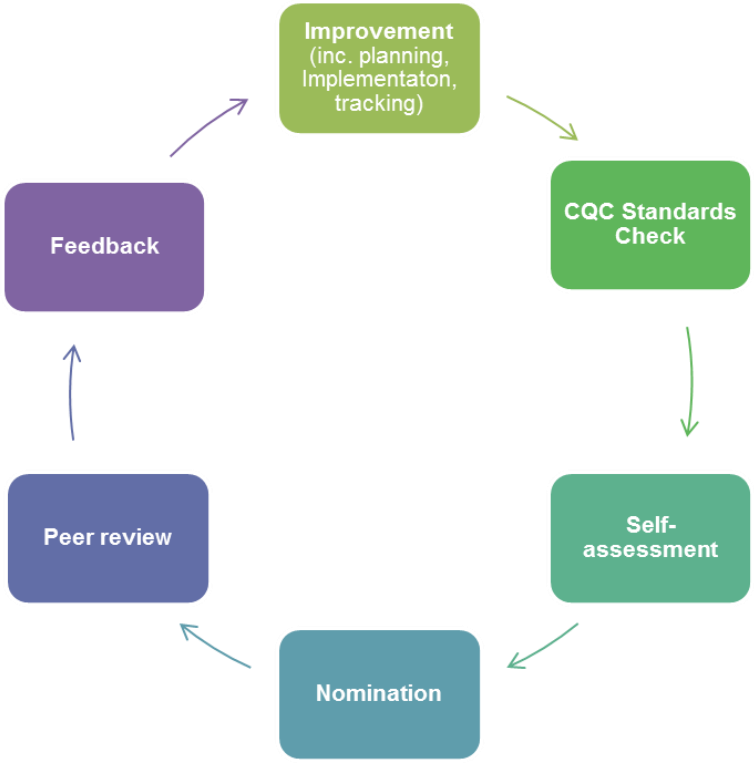
- % applicable teams with completed self-assessment
- % feedback provided within specified timescale
- % of CQC actions outstanding on CQC Tracker

# 11. Appendices

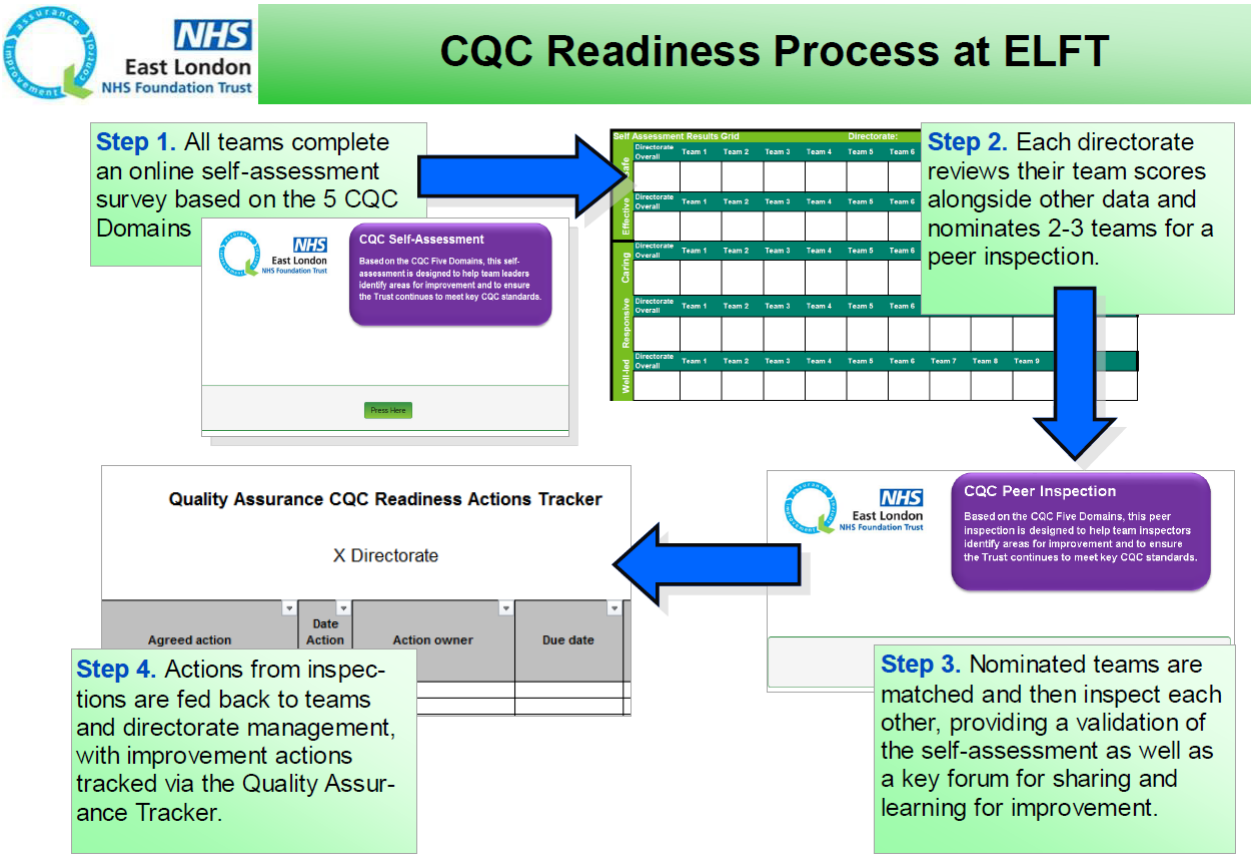
## 11.1 Additional Reading

Care Quality Commission (2017). *Our Next Phase of Regulation*
*http://www.cqc.org.uk/get-involved/consultations/our-next-phase-regulation*

### 11.2 The Quarterly Cycle - Assessment, review, feedback and action




## 11.2 Local leadership at each stage



## 11.3 Sample annual schedule

| ELFT CQC Readiness Schedule | 2017/18 | | | | | | | | | 2018/19 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q2 - Community Health | | | Q3 - Community MH | | | Q4 - Specialist | | | Q1 - Inpatient MH | | |
| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
| Self-assessments start | 3 | | | 2 | | | 8 | | | 2 | | |
| Self assessments finish | 14 | | | 13 | | | 19 | | | 13 | | |
| Self-assessment results and summaries published | 21 | | | 20 | | | 26 | | | 20 | | |
| DMT nominations close | | 18 | | | 17 | | | 23 | | | 18 | |
| Quarterly inspections start | | 21 | | | 20 | | | 26 | | | 21 | |
| Quarterly inspections finish | | | 15 | | | 15 | | | 23 | | | 15 |
| Inspection Feedback Completed | | | 22 | | | 22 | | | 30 | | | 22 |
| Change actions in Quality Action Trackers | | | Ongoing | | | Ongoing | | | Ongoing | | | Ongoing |
| Quality Committee reporting | | | | 12 | | | tbc | | | tbc | | |

## 11.4 Guidance for Peer Inspections

### 11.4.1 Guidance notes for CQC Peer Reviewers

Pre-Visit

1. The Quality Assurance team will email you details of which team you have been matched with and the deadline for completing your service reviews
2. Follow the instructions in the QA email, ensure that you have checked the Survey Link on the device you will be using (it works on phone, tablet or PC) ahead of the visit and ensure that the link is working. Any issues, contact Quality Assurance on 020 7655 4125 or QA@elft.nhs.uk.
3. Contact the matched team ASAP to agree a visit date and time. Allow about 3 hours on site for the review.
4. Try to arrange for a team of 2, including, if possible, a service user or carer to attend the review with you to make the most of the visit and ensure a wider perspective.
5. Confirm with QA@elft.nhs.uk when the visit is going ahead. If you have difficulties organising the Review, communicate this ASAP with the central team.
6. Print copies of the review questionnaire for all inspectors if you would find this useful to prompt discussion and make notes before completing the online questionnaire.

On the day

1. Announce your arrival to the named lead who is expecting you. Agree with them how you can best split your time to get the broadest overview possible of the team's work.
2. Within your team, agree how best to split your time to cover as many as possible of the following:
    a. Frontline staff interviews without senior staff present (either one-on-one or

in a group)
   b. Patient interviews without staff present (either one-on-one or in a group)
   c. Observed interventions (either one-to-ones or groups)
3. With each of these sessions, use the review questionnaire as your prompts to guide discussion
4. Ensure that you have up to an hour to go through the review questions with the Op Lead and Clinical Lead, requesting appropriate evidence as you go along.
5. Do not submit the live online questionnaire until you have met as a group to agree your conclusions
6. Ask the named lead for a room where you can meet as a Review group to go through the review questions, ensuring that you agree where possible, and note where there is difference of opinion. Take time to write down recommendations and compliments.
7. Meet the senior staff to feedback on your initial findings and recommendations.
8. Ensure that your online survey is submitted so that the Review is recorded and fed back.

### 11.4.2 Guidance notes for managers receiving an inspection

Pre-Visit

1. Arrange a suitable date and time with the inspecting team, ensuring as many as possible of the following will be available at this time:
   - Staff at all levels
   - Staff meeting/clinical supervision
   - Service Users and Carers
   - Interventions (groups or one-to-ones) that can be observed
2. Have your current caselist including RIO numbers to hand so that inspectors can check patient records
3. Prepare all the evidence you need to back up your answers to the Self-Assessment survey, including, but not limited to:
   - Staff records, including supervision, training, vacancies, sickness, volunteers/peer support, bank usage
   - Risk Register
   - Learning lessons briefings
   - Newsletters
   - Staff communication re. safety, improving practice, promoting involvement etc.
   - Safeguarding monitoring
   - Environmental risk assessments
   - Audit results and actions
   - Patient Experience results, actions
   - You Said We Did board
   - QI Project records

- Complaints
- Aim/vision statement
- Team meeting notes/minutes/actions

On the day

1. Greet the inspection team when they arrive and discuss with them how they can split their time to get an overview of the whole service
2. Set aside at least an hour to go through the evidence for each criteria with the inspectors.
3. Ensure there is a room available for the inspectors to meet privately at the end of their visit to pool their observations and submit their inspection report.

After the visit

- You will receive a full report with comparison between inspection and self-assessment as well as the inspectors' suggestions for improvement.