COVER STORY

An inspector calls

A visit from the Commission for Health Improvement can be a daunting prospect. CHRISTINA BUNCE explains what you can expect to happen before, during and after an inspection

Nurses feel a chill wind when they learn that government inspectors are coming to visit. A Commission for Health Improvement (CHI) inspection is perceived by many as the health version of OFSTED inspections, which are notorious for 'naming and shaming' schools and those working within them.

Despite reassurances from the government that CHI inspections should allow nurses to contribute to positive change, there is a great deal of anxiety before, during and after a clinical governance inspection.

While nurses are used to peer review, continuing professional development, reflective practice and quality assessments, it is quite another thing to have a team of external government-appointed inspectors coming to watch you work.

Senior nurses in trusts and CHI admit that nurses feel 'extremely nervous' during the inspection process. But they are keen to stress that the clinical governance inspections should not be seen as a threatening scrutiny of nursing practice.

'These are not service reviews, we are not looking at how good the standard of care is on a particular unit,' says Liz Fradd, director of nursing at CHI. 'We are trying to test how good the systems of clinical governance are — how well they are understood by staff and how well the elements of clinical governance are supported and managed.'

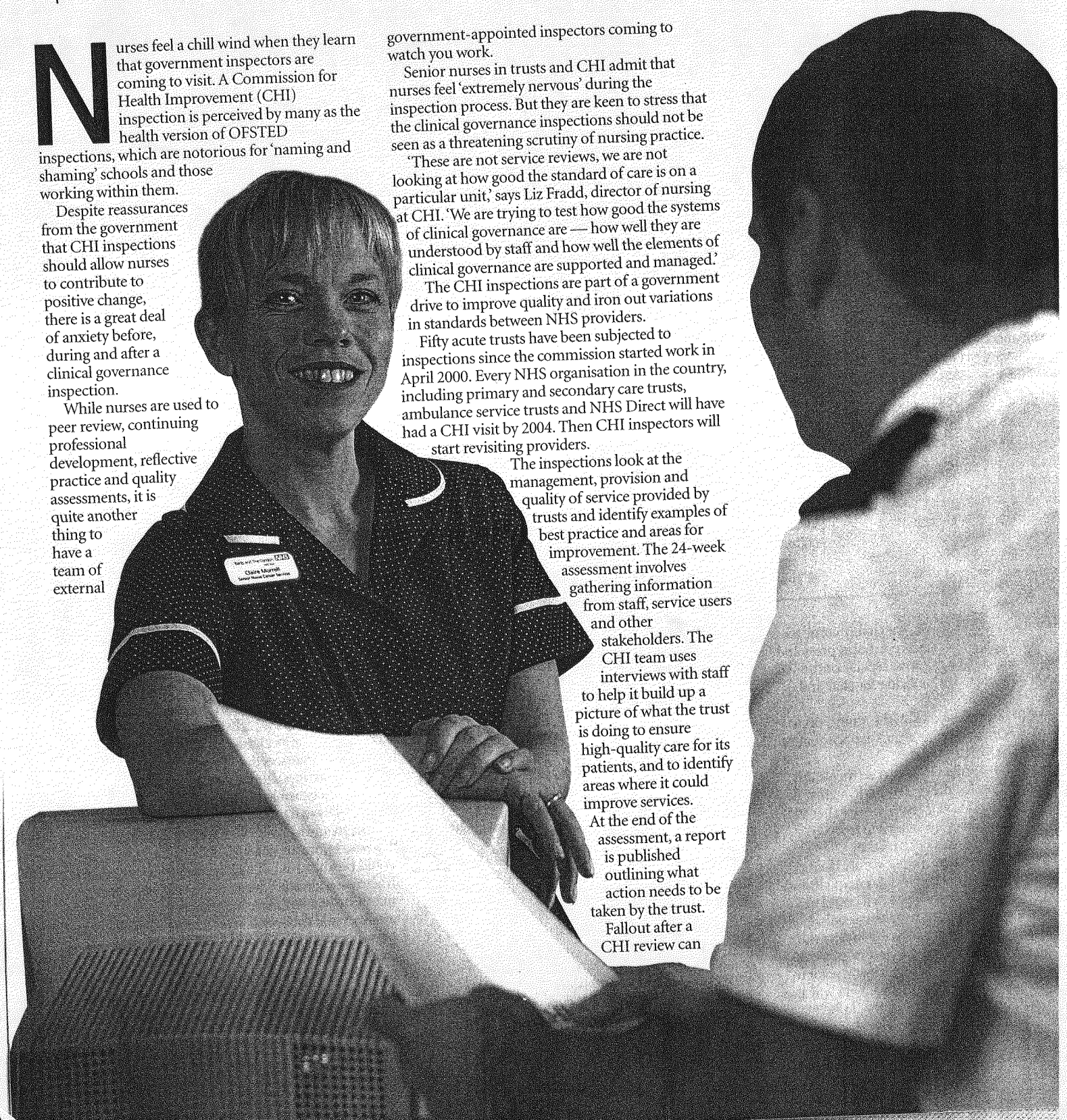
The CHI inspections are part of a government drive to improve quality and iron out variations in standards between NHS providers.

Fifty acute trusts have been subjected to inspections since the commission started work in April 2000. Every NHS organisation in the country, including primary and secondary care trusts, ambulance service trusts and NHS Direct will have had a CHI visit by 2004. Then CHI inspectors will start revisiting providers.

The inspections look at the management, provision and quality of service provided by trusts and identify examples of best practice and areas for improvement. The 24-week assessment involves gathering information from staff, service users and other stakeholders. The CHI team uses interviews with staff to help it build up a picture of what the trust is doing to ensure high-quality care for its patients, and to identify areas where it could improve services.

At the end of the assessment, a report is published outlining what action needs to be taken by the trust.

Fallout after a CHI review can



WHAT HAPPENS DURING A CLINICAL GOVERNANCE INSPECTION?

Trusts are selected for inspection randomly or on a recommendation by the English regional NHS offices or the Welsh National Assembly

Who conducts the inspection?
An inspection team is appointed which will normally include a doctor, a nurse, a professional allied to medicine, a pharmacist, a therapist, a lay member, and a manager. The team's make-up may vary according to the clinical areas that will be under review. The team members will normally be seconded from their permanent positions and perform up to two inspections a year. Team members will have had no previous association with the trust that is under review.

The inspection process
The inspection normally takes about six months and has three stages:

Weeks 1–5
Pre-site preparation
- The trust will nominate a trust coordinator to act as a focal point and point of contact for the inspection process;
- CHI will seek the opinions of patients, staff, relatives and related organisations to try to identify relevant themes of public opinion. CHI will request various types of data and reports. This information will be used to identify specific therapeutic areas for the review team to look at during its visit;
- CHI will meet management teams at the trust to explain the review process and answer queries;
- A start-up meeting will be held, usually during the third week of the inspection. Up to four people from CHI will attend the meeting with senior trust managers, including the director of nursing.

Week 16
Site visit
The team of CHI inspectors will spend a week visiting the site, meeting staff, observing the day-to-day working of the units under review, and then interviewing groups of staff and patients. Interviews with nurses will often be on an individual basis, either by appointment or chosen randomly during the working day. Individuals are not named in the report, although comments may be quoted.

Weeks 17–24
Production of the report
- The inspection team drafts a report outlining its key findings, examples of best practice and areas for improvement. This is then discussed with the trust, which comments on its factual accuracy;
- CHI's final summary and report is published;
- The trust then begins work on an action plan in response to the report, working with CHI to set objectives to implement necessary improvements.

REVIEW SUMMARY: HOMERTON HOSPITAL NHS TRUST

The review looked in depth at arrangements in three clinical teams which provide care for general medical patients, patients who are admitted for general surgery, and those who require maternity and neonatal care.

FINDINGS

EXAMPLES OF NOTABLE PRACTICE
- The health advocacy service and the health information shop demonstrate the commitment of the trust to working with patients. The trust has made considerable efforts to work with local communities to try to ensure their cultural needs are met. CHI welcomes this approach and this is evidence of good practice;
- There is a very good working relationship between the executive and staff at all levels. The executive has clinical credibility and is seen by clinical staff as being in touch with their issues;
- Staff at all levels felt supported and encouraged to report untoward incidents and near misses so that lessons could be learnt and systems improved. There is evidence of changes to practices as a result of incident reporting. A no-blame culture exists;
- The trust has an outstanding commitment to training with a good training programme and opportunities for staff at all levels.

KEY AREAS FOR ACTION
- The admissions process for all patients, but especially for those suffering strokes and broken hips, should be further streamlined to ensure that the patient experience is improved;
- Urgent action is required by the wider health community to collectively address the causes of the high neonatal mortality and stillbirth rates and to find ways to reduce them;
- There is more work needed to develop a process that systematically looks at the effectiveness of the procedures the trust's clinicians carry out, with a view to assessing whether the best evidence-based practice is adopted;
- There is progress and development at a strategic level in IT and information management, but it is difficult to find evidence of how these systems support improvements in patient care. Action is required to ensure a cohesive approach to the use of information and to involve clinical staff and the public in determining how information is gathered and used to enhance the patient's experience.

e substantial. Nursing issues inevitably come to ıe fore during the review process. Local press and ıedia often pick up on negative aspects of the :port, which can be demoralising for staff and 'orrying for patients.

For staff to be protected from the aftermath of ıe review, it is important that they are adequately repared for the visit.

Liz Fradd says: 'While I wouldn't advocate any ırmal preparation for the review itself, a great deal anxiety can be reduced if trusts ensure that staff nderstand what the review is aiming to do. ıdeed, if staff are anxious because they ıisunderstand the nature of what we are doing, at in itself is indicative that the system of clinical)vernance is not working as well as it could be.'

Along with other health care professionals, ırses working in areas on which the review team focusing will be asked to attend interviews with embers of the CHI team. The team will want to e nurses from all grades. Team members will also end time on each unit observing the daily utines and chatting informally with staff on duty.

Ms Fradd believes that a 'business as usual' attitude is the most appropriate and that there is little point in nurses trying to swot up on issues they think they will be questioned on.

'There is no given set of questions, and no right or wrong answers,' she says. 'Often we are not asking about nursing issues, we are merely asking for the nurses' perspective on broader aspects of how the hospital is run.'

'The inspection gives nurses a platform to highlight how they feel things could be improved'

The information required from nurses obviously varies between trusts and ties in with issues that have been highlighted for review. In one hospital, interviews centred on how nurses felt about things such as user involvement, recruitment policies and what they perceived as areas of good practice. Nurses were also asked to talk about stress, what it feels like and how they feel it affects their practice.

Pauline Brown, director of nursing at the Homerton Hospital NHS Trust, north east London, which received a good inspection report earlier this year, says that nurses should see the review as an opportunity to highlight what they see as workplace problems.

'We all have frustrations with issues that we are unable to address ourselves. The inspection gives nurses a platform to highlight how they feel things could be improved. If CHI picks up an issue then it has to be addressed. Most of the criticisms outlined in our inspection were ones that nurses were well aware of and frustrated about. It is a way of bringing them to the fore.'

This was illustrated when the review report was published.

'Most of the criticisms were of things we are ourselves critical of,' Ms Brown says. 'Where they weren't, it was often down to misconceptions based on the way data was interpreted. We were able to

REVIEW SUMMARY: UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

FINDINGS

The patient's experience
- The trust performed significantly worse than the English average in two of the seven national clinical indicators and significantly better in one of them;
- Death rates for both emergency and non-emergency admissions are above the national average;
- Readmission rates are higher than the national average and there is significant variation between individual consultants;
- The number of patients being discharged within 28 days with a fractured hip is better than the national average;
- During the 1999–2000 financial year, the trust achieved its inpatient waiting list and waiting time targets;
- Day case overstays are above the national average;
- There was little evidence of the development of clinical care pathways;
- There was an overall perception that care and treatment were provided in a competent and caring way, but there were instances where dignity and privacy were not respected.
- The emergency admissions unit was extremely cramped and needs urgent review.

Use of information
There has been worthwhile development at corporate level and some development at divisional level in the use of information about the patient's experience, resources and processes.

Clinical risk management
- There is some development at corporate, divisional and clinical level in implementing clinical risk management;
- A just culture, in which staff would not be blamed unless they had recklessly made errors, is rarely evident;
- Clinical risk management is seriously undermined by the fact that some senior medical staff feel intimidated when reporting clinical risk;
- The practice of putting five beds in bays designed for four is unacceptable and should cease immediately;
- The current configuration of A&E and the emergency admissions unit may put patients at risk and an immediate clinical risk assessment is required;
- The trust has developed a clinical risk management strategy but this is not consistently applied throughout the trust and there are few feedback mechanisms as part of the reporting process.

Clinical audit
- There is some development at corporate and divisional level in clinical audit;
- There is some effective clinical audit and subsequent service development and change, but audit is not embedded in all areas of the trust and some areas undertake no clinical audit.

Staffing and staff management
- The trust has some staff management procedures and policies but they are not always followed.

Education, training and continuing personal and professional development
- There is strategic grasp and substantial implementation in education and CPD with alignment across corporate, divisional and clinical teams.

EXAMPLES OF NOTABLE PRACTICE
- The work of the chaplains to ensure a multi-faith service is notable. The trust clearly acknowledges the diversity of need of individual faiths and beliefs;
- The GP out-of-hours cooperative at the Hospital of St Cross is an example of integrating other care with A&E;
- Patient diaries are a notable example of patients being involved in their own care;
- Opportunities for experience in specialist clinical areas for trainee doctors and CPD, particularly for nursing staff, are notable examples of staff development.

WHAT IS CLINICAL GOVERNANCE?

A CHI inspection looks at the effectiveness of an NHS organisation's clinical governance arrangements. It will assess the management, provision and quality of service provided by the organisation and identify best practice which it will share with the rest of the NHS. It will also identify areas for improvement.

CHI defines clinical governance as 'a system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care'. It involves:
- A patient-centred approach;
- Accountability for quality;
- Ensuring high standards of safety
- Improvements in patient services and care.

Effective clinical governance should guarantee that:
- Patient services are continuously improved;
- Staff treat patients courteously and involve them in decisions;
- Patients have all the information they need about their care;
- Health professionals are up to date in their practices;
- Clinical errors are prevented wherever possible.

argue our case and provide evidence to back it up, and our final report reflected that.'

Following a CHI inspection, its report and subsequent action plan will normally be disseminated around the trust. Again, it is important to stress the positive learning aspect of the exercise, even when reports appear to be negative.

The University Hospitals Coventry and Warwickshire NHS Trust received a less than positive review, and its head of communications John Richardson admits that nurses were probably bruised by the criticisms. But he emphasises that the way forward is to be more positive.

'Any criticism is not of nurses' day-to-day work, and not of their professional ability, but of the systems in place. It is worth noting that clinical governance is relatively new and a steep learning curve needs to be negotiated before it becomes part of every practitioner's day-to-day work.

'CHI is also new and is willing to admit that the way it conducts inspections is not yet perfect. The way to look at the outcome is to see it as a baseline against which to measure future improvement.' **NT**