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How to Boost Your CQC Rating Through Better HR

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Introduction

Just how much attention does the Care Quality Commission (CQC) pay to HR practices when it carries out inspections on healthcare service providers?

We all know that CQC inspectors base their judgements on five key criteria — safety, effectiveness, responsiveness, leadership and how caring services are. There's a lot of ground to cover — can HR really be front and centre of the inspectors' thoughts when they are assessing a service on how safe and effective it is?

Based on an in-depth review of more than 250 inspection reports, we believe that yes, the way healthcare providers manage and utilise their people is something the CQC is very much focused on when it carries out inspections. Moreover, it is our conclusion that, by making improvements to their HR practices, service providers can greatly increase their chances of achieving a good or outstanding CQC rating.

In this paper, we will use examples from a range of reports to show how CQC inspectors time and time again focus on four key areas of HR practice — Recruitment & Staffing, Documentation, Communication and Professional Development.

We will draw comparisons between examples from providers rated outstanding, good and requires improvement and make suggestions about what providers can do to improve their HR procedures and protocols ahead of their next inspection.

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Recruitment & Staffing

The CQC's inspection reports make clear links between staffing levels and the competencies of both clinical and non-clinical staff and judgements about safety and effectiveness. Phrases that crop up time and time again in the reports of 'Good' services include things like:

- Suitable numbers of staff were employed and appropriately recruited.
- There was an induction system for new staff tailored to their role.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate.
- The provider had HR systems and recruitment processes which were fully compliant with requirements.

A good illustration of how important recruitment practices and staffing levels can be to CQC judgements is found in the report of an NHS 111 call centre which was told its services required improvement on both safety and effectiveness. In particular, it was told that it must make improvements "to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in the service."

The call centre was part of a nationwide chain operated by a single provider. Staffing for all call centres was organised centrally and remotely. At this particular centre, the CQC found that there were often significant gaps in staffing rotas, with as many as 30% of clinical sessions unfilled in a single week. Inspectors judged that there were insufficient clinical staff and health advisors employed to ensure that the volume of work could be managed safely (the service handled an average of 1000 calls a day). Staff turnover was high and there was a high level of sickness absence, with staff reporting that high workloads had increased stress levels.

By contrast, the CQC praised an out-of-hours service rated 'Good' in all categories for actively planning and monitoring the number and mix of staff required from shift to shift using a "sophisticated online staff management tool". This use of technology meant there was an effective system in place for dealing with sudden spikes in demand.

A different NHS 111 call centre provider rated as outstanding was also praised for having a proactive recruitment policy, based on the NHS career framework, which appointed staff with different skill sets based on the assessment of changing service user demands. This had led the provider to recruit Dental Nurses and Pharmacists in recent times to improve the quality of advice being offered to callers.

Especially for services that deal with a wide range of medical and healthcare needs such as out-of-hours services and NHS 111 call centres, getting the right mix of staff in place to deal with demand at any one time can be challenging. The use of software to

automate and streamline rota allocations, as described above, is certainly effective. But to get staffing levels and skill mixes right, you have to have the right people employed in the first place.

Recruitment to clinical roles, in particular, can be tricky for service providers, especially when you are trying to plug gaps in provision quickly or demand arises suddenly. But to repeat the CQC's own words, 'sufficient numbers of suitably qualified, competent, skilled and experienced persons' are a baseline requirement for delivering safe, effective services.

If technology can help healthcare providers get their rotas right, it can also lend a helping hand with hiring. One of the difficulties with clinical recruitment is that there are so many pre-employment and pre-commencement checks to carry out — Disclosure and Barring Service (DBS) criminal record checks, General Medical Council / Nursing and Midwifery Council registration, right to work in the UK, professional indemnity insurance, competency under the Mental Capacity Act, safeguarding training, qualifications and more.

This creates a significant administrative burden and slows down recruitment and onboarding processes. By automating large parts of the sign-up procedure using HR software, providers can get the staff they need into post much faster and also have more confidence that the person they are recruitment is fit for the role.

Having the right staff in the right numbers will ultimately help your service improve its CQC rating.

Key takeaways

- CQC inspectors make a direct link between staffing and the ability of providers to deliver safe, effective services.
- Digital tools, such as online staff management and rota platforms, can help providers navigate the challenges of ensuring the right people are on duty in the right numbers at all times.
- Similarly, recruitment management platforms that automate key aspects of talent identification, candidate assessment and employee onboarding can help to ensure the right mix of skills available within your teams.

Documentation — Evidencing Best Practice

The issues around completing background and compliance checks on new staff quickly and efficiently raise another challenge for providers — how do you demonstrate to the CQC that staff are not just competent when they sign up, but do all the things expected of them day in, day out?

The CQC does not have time to observe how providers operate for long periods to check that staff consistently tick the right boxes for a safe, effective, responsive and caring service. Instead, they expect service providers to help them out by being able to evidence good practice, and make it one of the criteria of good leadership that they are able to do so. And the way the CQC expects to see that evidence is through thorough and robust documentation.

The inspection reports of 'Good' services make repeated mention of a number of different types of documentation:

- *Staff documentation such as training, qualification and professional registration records.*
- *Working documentation, such as the risk management system used by a not-for-profit community service provider which the CQC praised as "robust arrangements… for identifying, recording and managing risks, issues and mitigating actions.*
- *Policy documentation, which might cover everything from acceptable use of IT and data protection to infection control and health and safety.*

Policies demonstrate to the CQC that a provider understands its obligations and the practical expectations around delivering a safe, effective, responsive and caring service. It also shows that providers understand the importance of communicating these obligations and expectations throughout the organisation (see next section).

In addition, the CQC frequently refers positively to services using "evidence-based guidance" or guidelines in their policies, particularly in relation to prescribing medicines and other treatments. This further provides evidence to inspectors that providers are basing their own procedures and processes on accepted best practice.

Inspection reports therefore show that the CQC routinely bases judgements about whether a service is compliant, its staff competent, its leaders effective and whether its performance is in line with expected standards on available documentation. Sometimes, it uses such evidence directly to decide that a provider is not up to scratch. For example, one NHS 111 call centre service was told it required improvement partly on the grounds of call handling data that showed it was not meeting national benchmarks.

But the CQC is just as likely to penalise providers for shortcomings in their record keeping as it is for what those records reveal. A frequent complaint is that documentation is simply not kept up to date. One private clinic specialising in diagnostic and screening services that was rated requires improvement was found to have 21 out of 22 paper copies of policies out of date, ranging from local

rules documents related to an important compliance policy related to patient consent under the Mental Capacity Act.

Another common complaint from the CQC centres on providers not keeping staff training records up to date and complete. A large community interest company (CIC) formed from a confederation of more than 50 GP surgeries was told it required improvement on safety and effectiveness, partly on the grounds that it did not record all training undertaken by staff, and therefore "did not have clear and easy oversight that all staff were competent to do their role". Another provider rated 'Good' overall was told they should also make improvements in this area.

Indeed, flaws in documentation came out as a common theme for what was potentially holding 'Good' providers back from becoming 'Outstanding'. An online pharmacy was found not to have "a documented rationale" for handling prescriptions of drugs liable to abuse; an extended access and NHS 111 call centre service based in London was told it needed to review staff immunisation records as part of its infection control protocols, and also that it should review whether all of its policies "fully reflect the service's practices and sites."

In terms of outstanding practice in documentation and evidencing best practice, a standout example comes from the report of an NHS Treatment Centre specialising in surgery. The report details a number of best practice guidelines that the centre was not only following but clearly evidencing its own practice against — for example, the National Early Warning Score (NEWS) system for monitoring patient safety during surgery, the American Society of Anaesthesiologists (ASA) physical status classification system for pre-assessments, and the WHO's 'five steps to safer surgery' safety protocol checklist. Audits into things like safety management and infection control showed a 100% success rate, and the inspectors also praised the way that the centre's own policies directly referenced the national guidelines on which they were based, evidencing a clear link to standards and best practice.

More than any other area, meeting the CQC's expectations on documentation and evidencing practice can be put down to having robust and thorough administrative procedures in place. Out of date and incomplete training records, out of date policies, a lack of documentation (both policies and reporting) covering areas of practice where there is an identified risk to patients — all of these lead to services not being judged good or outstanding for safety, effectiveness and for leadership. Yet they are relatively easy issues to remedy.

From an HR perspective, there is no need to risk mandatory training for staff running out of date by relying on manual records. Excel spreadsheets containing lists of staff certification and course dates do not update themselves or flag up expiry. But nowadays, digital personnel management systems can very easily pick out the dates and create alerts in plenty of time to update training. The same applies to any kind of employee documentation — professional registrations, indemnity, DBS checks — meaning you can always evidence that staff are competent and compliant to perform their roles. Exactly the same can be done with policies, using simple automated administration to ensure your service can keep on top of evidencing that it is doing the right things whenever the CQC happens to call in.

Key takeaways

- Documentation, in the form of certification and training records, policies and reporting and auditing systems, provides a key source of evidence for CQC inspectors when it comes to making judgements about service providers.

- CQC reports make it clear that inspectors want and expect to see robust documentation arrangements in place and will penalise providers for not having them.

- A common criticism from inspectors is that providers do not keep documentation up to date, whether it is records of mandatory training or internal policies.

- A simple remedy for providers is to switch from paper documentation and manual administration to automated digital management systems. Not only does this save time, it also helps to avoid the risk of receiving a poor rating from the CQC for what boil down to clerical errors.

Communication

Appropriate use of documentation, policies and evidence-based guidelines plays an important role in another key area on which the CQC evaluates providers — how well they communicate with staff.

In particular, this can be broken down into how well informed staff are about their roles and responsibilities, including the requirements and expectations set out in policies and guidelines, and how well leaders keep everyone up to speed with changes to the service and its strategies. The basic rationale is, if staff do not know what is expected of them, they are unlikely to deliver the standard of care required.

The CQC makes repeated reference to this in its descriptions of 'Good' services. In relation to how well informed staff are, we repeatedly saw phrases like:

- *The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.*
- *There was a clear organisational structure and staff were aware of their roles and responsibilities.*
- *The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.*

Inspectors were particularly impressed with how clear staff at one out-of-hours service were about their responsibilities in relation to infection control and medical emergencies, and how they could link their practice directly to guidance. Reports on telephone and online services rated 'Good' also regularly refer to staff being aware of the strengths and limitations of working remotely from patients, and how they are therefore able to maximise the benefits and minimise the drawbacks for patients.

On the topic of on-going communication to keep everyone fully informed about developments in the service and beyond, we often read things like:

- *The service had systems to keep clinicians up to date with current evidence-based practice.*
- *Policies were regularly reviewed and were accessible to all staff.*
- *We saw how the provider effectively cascaded learning outcomes to all staff.*

We also found that CQC inspectors regularly highlight best practice examples in these areas as evidence of outstanding leadership. For example, it praised the "well-communicated objectives" of one NHS 111 provider rated as outstanding for being "unequivocal" in how they set out expectations of staff, and for how clearly aligned they were to the CQC's own assessment criteria for delivering a safe, effective, caring, responsive and

well-led service. We can perhaps infer that the CQC views its own guidelines as offering a very clear and unequivocal description of what good clinical practice should look like. Service providers would be well advised to refer directly to these in the expectations they outline to their staff.

CQC reports also highlight effective communication as an essential part of services dealing with difficult incidents. For example, the management team at one outstanding-rated NHS Treatment Centre provider was praised for their "exemplary skills, knowledge and integrity" in relation to how they dealt with an incident where care regulations had been breached. Having requested an external audit to determine whether patient safety had been compromised (it hadn't), inspectors noted how the head of clinical services in the department concerned immediately took responsibility to inform staff of changes that would be made to prevent a recurrence, and staff reported that members of the leadership team "were visible and accessible" to help them as the changes were implemented.

On the flipside, it is clear from numerous reports that poor communication leading to staff not being fully aware of their roles and responsibilities is a major reason why services end up being rated as requiring improvement. For example, in its inspection of one GP practice federation in the south west of England, the CQC noted that staff at a number of sites were not fully up to speed with infection prevention and control and that there was not a sufficient system in place to ensure all staff were calibrating equipment correctly. This ultimately led to patient safeguarding concerns.

Inspectors noted that these shortcomings were not necessarily down to the provider lacking adequate policies, but instead were caused by the policies not being followed, understood or even read by staff. The report noted that staff had access to National Institute for Health and Care Excellence (NICE) guidelines, but some staff told inspectors they had not read them.

For the CQC, a gap between policy and practice caused by shortcomings in how policies are communicated to staff has the same outcome as not having appropriate policies in place at all — patient safety and the effectiveness of care is compromised, and this reflects badly on leadership. Management teams at providers are held to account on whether staff follow policies and guidelines, but prior to that, a first step is to ensure that everyone has read and understood them in the first place.

A simple digital 'send and sign' system for all policy documentation is one way to improve practice in this area. Staff are sent alerts each time a new document is added to the database or updated, and have to respond to say they have read it. Management therefore have clear visibility over who has and hasn't read policy changes, while the automated alerts each time there is an update or new document ensures staff are kept full up to speed with developments in what is expected of them.

Key takeaways

- CQC reports make it clear that inspectors judge services on how well staff understand their responsibilities, how well they can link their work back to current guidelines and best practice, and even how well they can articulate the CQC's own expectations.

- Policies are a key piece of evidence the CQC uses to assess how well expectations around practice are communicated to staff.

- Aside from not having appropriate policies in place, a common error made by providers is not having procedures in place to ensure that staff read and understand them, especially when policy documentation changes.

- One simple remedy for this offered by digital documentation management systems is to introduce a 'send and sign' protocol for all new or amended policies, alerting staff when there is something they are required to read, and asking them to sign to say they have done so.

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Professional and Service Development

Another factor related to effective communication with staff is having appropriate professional development procedures in place. From an HR perspective, if you want staff to carry out their roles and responsibilities to the best of their ability, you have to ensure they both fully understand what is expected of them and that they have the necessary skill sets and knowledge.

This forms part of a wider theme we detected in the CQC's reports focused on how effectively service providers are able to develop their operations and improve care. In relation to professional development, including training, the following statements cropped up time and time again in the reports of services rated 'Good':

- *There was evidence of appraisals and personal development plans for all staff.*
- *There was a strong focus on continuous learning and improvement at all levels.*
- *Staff had received training in safeguarding and whistleblowing and knew the signs of abuse.*
- *Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.*
- *The service's management team had a detailed understanding of the training needs of staff.*

Similarly, CQC inspectors repeatedly noted examples of how providers were demonstrating a focus on wider service development, for example:

- *There was an effective system in place for recording, reporting and learning from significant events.*
- *Clinical audits demonstrated quality improvement.*
- *The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.*
- *There was evidence of learning as a result of complaints, changes to the service had been made following complaints, and had been communicated to staff.*
- *When there were changes to services or staff the service assessed and monitored the impact on safety.*

Drawing out specific examples, one telephone advice service linked to a major health insurance provider was praised by inspectors for giving staff two hours of protected time every month for training and development purposes, and for maintaining up to date records of all skills, qualification and training for each individual.

We came across multiple examples of 'Good' service providers making use of audits to review clinical decision making, with inspectors highlighting how one GP-led walk-in centre "was

proactive in reviewing the effectiveness and appropriateness of the care it provided" via this method. An online clinic, consultation, treatment and prescribing service, meanwhile, was singled out for the way it used NICE guidance to update and improve the advice it gave to patients, for example in the prescription of contraceptives. This links back to how CQC reports tend to look favourably on services using clinical guidance explicitly in their practice.

Training looms large in reports of several outstanding-rated services. Inspectors went into some detail about how one NHS Treatment Centre provider used an online learning portal to deliver mandatory training in areas like safeguarding and risk assessment. New staff received training on a modular basis when they first joined, followed by mandatory yearly refreshers with the digitised system managing who needed to cover which aspects and when.

Elsewhere, inspectors described how an outstanding-rated NHS 111 call centre operator was promoting its proactive approach to CPD in its recruitment activities, selling the opportunity for professional development and career advancement as part of its employee proposition alongside flexible working and access to health care. It was also praised for its adoption of the government's apprenticeship scheme.

Perhaps the best example of how robust approaches to training and development can boost a service's standing in the eyes of the CQC is an online pharmacy which was told it required urgent improvement in early 2019. Inspectors raised safety concerns over management of controlled opiate and asthma medicines, and highlighted shortcomings in the way that identity checks were carried out.

The CQC carried out a return inspection later that year after the provider said it has completely overhauled its operating model in wake of the previous findings. The inspectors found their concerns had been fully addressed and rated the service 'Good' on this occasion in all categories.

Describing some of the changes implemented, the second report noted that the Superintendent Pharmacist had completed additional medicines optimisation training for certain long-term conditions and that staff training was now more firmly embedded at all levels of the service — it was a permanent item of discussion at every full staff meeting and all staff received regular performance reviews. This had helped to ensure that safer medicine management and prescription protocols could actually be put into practice day to day.

Healthcare providers rely on their people to drive through the kind of improvements in service which will see them raise their CQC rating, which is why training and professional development is so important. Investing in skills is investing in a better service. But just as the administrative side of onboarding and inducting new recruits can be a heavy burden on operators, with so many background checks and compliance documents to go through, the same applies to training.

When you consider all the various, mandatory compliance training such as safeguarding, risk assessment, infection control, resuscitation, conflict resolution and so on which have to be repeated on a regular basis, then job-specific clinical and non-clinical certification, plus whatever training the employer wants to put in place for their particular service, it is a lot to juggle.

The CQC's focus on the use of an online training portal by the NHS Treatment Centre it rated outstanding provides a clue to providers for how they can ease the load in terms of managing CPD. As with policies and documentation, digital databases can be set up for every member of staff, with all training certifications and qualifications uploaded and tools set to extract when they expire or need refreshing. That takes care of keeping compliance up to date.

In addition, modern HR software allows development pathways to be created for individual roles, managing appraisals and providing a platform for evidencing progress against targets. Some solutions developed specifically for the healthcare industry will also provide direct links to training resources, otherwise providers can upload their own courses and modules.

Ultimately, keeping on top of clinical and non-clinical skills development shares the objectives that have formed the common thread throughout this paper — ensuring providers have the right people in place in the right numbers and with the right skills to deliver care safely, effectively, responsively and with compassion. Having effective processes in place to deliver and demonstrate this will also contribute towards the CQC viewing leadership as good or outstanding.

Key takeaways

- The CQC looks favourably on providers who are able to provide clear evidence of how they are developing and improving their services.

- This includes staff training and CPD - investing in skills means investing in a better service.

- CQC inspectors frequently highlight examples of good, proactive approaches to training and staff development in the reports of high-scoring providers.

- Investing in a better approach