Royal College of Psychiatrists
Consultation Response

DATE: 21st April 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: CQC proposals for assessing quality in 2010-11 and beyond

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was contributed to by the following faculties at the College:

- Addictions
- General and Community
- Old Age
- Rehabilitation and Social

This consultation was approved by: Dr Ola Junaid-Associate Registrar

For further information please contact: Claire Churchill on 020 7235 2351 ext.293 or e-mail cchurchill@rcpsych.ac.uk

CQC proposals for assessing quality in 2010-11 and beyond

1. <u>Aims for assessment of Quality</u>

1.1 One of the aims is to share good practice which raises questions about what is good practice, and who defines it. The regulator will be assessing risks and quality using a series of indicators. If good practice is defined by these indicators this could be disseminated, if there is agreement across stakeholders that these indicators represent quality in all domains. It is extremely important that the indicators are valid, accurate and precise and reflect shift in the clinical services that are commensurate with improved quality of care as defined by patients and clinicians. These do not necessarily map onto the CQC definitions which may pursue organisational fitness irrespective of quality in care processes. Problems may arise if the indicators are not sufficiently precise or valid but have been used as a screening tool. There is a risk that a regulator removed from provider experience and service user experience will distort the delivery of care in a direction that moves it away from sustaining quality of services developed over a long of period of time. It is important that the different purposes to which the indicators are put are commensurate with their objectives and aims. We would suggest that the sharing of good practice as an aim may be over ambitious and should be managed by agencies such as NICE or commissioning agencies or strategic health authorities and by providers. The regulator might look more to address safety, investigate serious incidents, and ensure financial and legal compliance.

1.2 Equalities and Diversity and addressing social exclusion are omitted from the current aims and objectives. It is extremely likely that whatever generic system is put in place it will not be sensitive to the needs of socially excluded groups. A dominant system may serve the needs of the more prominent and vocal communities, whilst those less able to assert their needs are overlooked. The homeless, ethnic minorities and other socially excluded groups need

special measures and indicators to assess their needs as existing indicators may not be sensitive to these. There are a few national data sources that might be used to supplement these profiles. A generic approach to regulation needs to be adapted for each of the key socially excluded groups.

1.3 The focus on outcomes is welcome but it does raise the problem of whose outcomes are to be assessed. Those defined by service users, those defined by provider, or outcomes to ensure regulation of spend and/or reduction in critical incidents and risks. Or are we to aim for reducing clinical symptoms or are outcomes to be focussed on improving positive mental health and wellbeing at a population level.

1.4 The commissioning/provider split should be lessened. A regulator being involved in matters formerly dealt with by commissioners or providers might further complicate the matter by introducing a further layer of organisational interfaces and divergent imperatives that override the effective functioning of service providers to deliver care to the public. The integration of social care and health is to be welcomed but regulation of that, in the absence of responsibility and agency remaining with the key partners involved risks adding a further layer of organisational impediments to progress. Certainly, indicators of effective integration may be very valuable and indicators of effective commissioning may be helpful.

1.5 There will be a challenge to balance national regulation frameworks with local priorities and problems in service delivery and unique scenarios and situations in terms of deprivation. In the urban centres, for example, almost certainly we're likely to encounter particular problems and applying a national framework of regulation which assesses quality may not be appropriate. The same might apply in rural communities. To some extent even more stringent indicators of equality may need to be applied, which are very specific to the populations that are served.

1.6 Any indicators used should be transparently valid and not to reliant on values judgements about which risk profiles and quality profiles are worthy of attention. The dynamic appraisal of quality over time needs to be defined or operationalised further; it could be too unmanageable, inconsistent and subject to value judgements.

2. <u>Value for Money</u>

2.1 Certainly this is important both for the CQC and for services. This seems to be a role for the CQC which was formerly assigned to health authorities and MONITOR. It would seem ambitious and perhaps diffuse to extend the CQC role to this also, although measures in place for assessing value for money in a balanced score card might be reasonable. There is a need to have consistent metrics applied across disease areas which are found to have validity for different stakeholder groups, clinicians, service users, carers and the public. This introduces, inevitably, value conflicts between those who desire quality of care and those who would need to restrict particular services based on expense. The matter is likely to become more of a difficulty with the harsh economic climate. CQC being separately involved or accommodating MONITOR risks CQC confusing its role and expanding its role rather than acknowledging the challenge of integrating the diverse roles that already exist, and consolidating these to work efficiently and effectively with minimal cost.

2.2 It would be important to make the collection, analysis or recording assessments not only more efficient but transparent and to provide information about factors that are modifiable. Information provided at aggregate level for providers may help at providers make decisions at locality level. There are potentially many diverse applications for the indicator data.

2.3 An overall rating is still helpful but only if valid and interpretable.

2.4 A statement of registration status alone is a broad brush statement which is helpful but doesn’t really help with understanding quality. Assessing summary scores against national priorities may also not help assess quality which may be more of a local issue and should be captured by clinicians and service users and professional regulation bodies and NICE.

3. Financial monitoring by CQC

See comments above. This seems to be a new role, formerly undertaken by MONITOR, perhaps best left to Monitor or the Audit Commission.

4. The meaning of special reviews

4.1 The parameters and terms of reference need to be set out more clearly.

4.2 Given the section largely about social care as one of the aims is to integrate health and social care and regulation, it would be important to develop a single document which addresses both.

4.3 The attention to independent healthcare is welcome and long overdue. What might be helpful is to make available the data in an anonymised form for analysis locally by providers who may wish to look at other trends and other relationships in their local services. This seems to be better use of data than leaving it in tabular form only on the web.

5. Special Reviews and Study

5.1 The responsibilities of the regulator are substantial. To take on more research functions may be a duplication of what takes place in other sectors with over stretched resources. CQC activity should be devoted to regulation and improving quality of care. Special reviews similarly should be applied in specific circumstances, perhaps where risk is a concern, or there are

unexpected deaths. Yet research work necessary to deliver existing regulator functions, for example stakeholder consultation, validation of indicators could be carried internally, only then would this be achieved at minimum cost.

5.2 Attention to pathways to dementia care is welcome.

5.3 Specific pathways are identified, perhaps pathways for specific groups are also necessary, eg the homeless, for offender patients and for Black and Minority Ethnic Groups, given the data on the Mental Health Act admissions. This surely warrants a specific attention to demonstrate commitment to understanding this and ensuring quality of care for all groups. The overall CPA review seems to be dated and emphasis here risks pursuing improvements in quality through a mechanism that has not been as effective as anticipated. Attention to children and adolescent mental health services might also be helpful, as could quality in service reform and design, commissioning and implementation.

Faculty of Old Age response

<u>Q.1 Do you support our aims for assessments of Quality ?</u>

The stated aims appear appropriate and flexible. We support the approach which will reflect the experience of those who use the services. Because there might be difficulties in accessing this experience for some groups it would be reassuring to see a firm commitment to focus on the most vulnerable e.g. those doubly stigmatised by age and mental illness. Specific reference to joint assessments would be strengthened by information on how the component parts of the CQC would now themselves work more closely together e.g. integrating supervision of Mental Health Act, Mental Capacity Act and Deprivation of Liberty Standards threads of activity in line with emergent equality legislation and reduction in age discrimination across both health and social care spheres

Q.2 What more could we do to promote efficiency and streamlining of our approach to assessments so as to reduce the costs while maintaining the benefits ?

There are helpful mentions of more pragmatic approaches and the specific commitment to information provision from projects and special reviews plus more systematic dissemination of good (and perhaps bad !?) practice should help local services address many of the main issues through clinical governance channels. The extent to which dissemination of good practice is adopted both in commissioning and in service provision should be assessed over a cycle of reviews.

Q.3 Do you support the general direction of our approach for assessing councils as commissioners ? What changes would you like to see so that our assessments are as effective as possible in promoting improvement in the performance of councils ?

The general direction of proposed travel does indeed seem correct with an emphasis on the lived experience of those receiving services to be welcomed. This latter could arguably be reinforced by an overt emphasis, perhaps via MCA and DoLS channels, on those least able to articulate their needs and concerns without appropriate assistance. An approach regarding local authority and PCT as joint commissioners should be included because many outcomes for those who use services are dependent upon the quality of cooperation in planning across the health and social care sectors.

Q.4 Do you support the general direction of our approach for assessing PCTs as commissioners ? What changes would you like to see so that our assessments are as effective as possible in promoting improvement in the performance of PCTs ?

Again, the intended direction feels right but a lack of visible focus on the groups giving rise to greatest concern at present, notably older people in general and those with dementia in particular, may mean that historical funding anomalies continue to be perpetuated in a financial climate in which progressively tougher disinvestment and commissioning decisions will become necessary in order to avoid worsening inequalities. If the work of regulation is too confined to national priorities then there is a risk that when assessing both commissioners and providers that important issues would be missed. The CQC must ensure that it has processes which allow sufficient flexibility to include special reviews which can respond to important issues as they arise, for example age discrimination or reports from the National Audit Office.

Q.5 Do you support the general direction of our approach for assessing NHS Trusts and PCTs as providers ? What changes would you like to see so that our assessments are as effective as possible in promoting improvement in the performance of NHS Trusts and PCT providers ?

Once more, the proposals seem potentially beneficial with the quality and risk profiles likely to gain in importance as they develop in maturity and detail against a background of demographically driven demand and heightened expectations of services. Nowhere is the urgency of this reflected in the language used and that is perhaps misleading given the scale of challenges faced by the CQC as an arbiter of quality and safety under progressively more difficult financial and manpower circumstances. The reasoning behind not awarding overall quality ratings

is understandable but dubious. The importance of specific service profiles is compelling but a way can surely be found to have the two co-exist

Q.6 Do you support the general direction of our approach for assessing adult social care providers? How do you think we should approach quality ratings in the future ?

The retention of quality ratings in this context appears necessary in order to empower users of services and their informal carers. Including an index of joint commissioning / working as a component of these would be useful as would clear examples of how routine or special reviews addressed problems and promulgated improvements in quality.

Q.7 Do you have any views on our approach to reporting our findings? What sort of information would you like us to publish – what would you find useful ?

Aggregated data remains potentially valuable and in need of continuous improvement but clear descriptions of how worrying situations have been "turned around" by inspection and follow up are likely to be reassuring on the one hand and informative to those tackling such issues locally on the other. When findings are reported there should be a broad indication of the likely period until the next review.

Q.8 Which of our proposed topics for special reviews and studies do you consider to be the highest priority ? What specific issues would you like us to address and how could we best do this ?

It was a matter of huge concern that the word "dementia" did not feature at all in the text until this appendix but, conversely, very encouraging that fully half of the other dozen topics listed here would fit smoothly into any examination of a dementia pathway, particularly

that part taking place in a general hospital. Given understandable limits on what can be addressed it would seem rational to focus on a topic which is currently highly visible as a national strategy and which cuts across the areas of health and social care providers regulated by CQC.. The scope for including nutrition and hydration, use of restraint, unmet need in social / domiciliary care, reducing preventable mortality (from antipsychotic usage) in hospitals, standards of nursing care and impact on carers of hospital discharge would be a bonus in terms of cohesion and efficiency.

Faculty of Rehabilitation and social psychiatry

Members of the Rehabilitation Faculty have recently visited the CQC and they have specifically requested us to suggest robust measures for commissioners which will address the issue of ending out of area placements (OATS) except for highly specialist services. This was also a feature in the commissioning section of New Horizons (p.35) following a long campaign by the Rehabilitation Faculty and the college policy unit.

Our reviewers of the plans that are outlined by the CQC strongly support a regulatory body that sets standards for services and commissioning. However in the current financial climate, where the costs of regulation, inspection and information gathering directly impinge on the available funding for direct care, there is a strong argument for leaner thinking.

The CQC has proposed a programme that seems overambitious and complex, and one which the NHS can currently ill afford. Examples would be 'the registration' of every NHS facility, 'scoring rules used to determine the grades for outcomes', 'the monitoring of services on an ongoing basis' and the need, exemplified by recent visits from the CQC to various facilities, for routine unannounced inspection visits which drill down to capture very detailed information from individual managers and mental health practitioners.

We would prefer a more collaborative approach with mental health services and senior clinicians playing a leading role in ensuring quality. An example would be the proposed voluntary scheme to accredit Rehabilitation Facilities which is being developed with the help of the College Research Unit – AIMS RU.

Another possibility for a cheaper method of regulation would be some variant of the way the GMC works, so that for instance the CQC only becomes involved when serious concerns have been expressed by patients, commissioners, management or other stake holders.

Faculty of Addictions

The Addiction faculty has a primary concern that the voluntary and independent sector will not initially be covered by inspections. We would urge that all sectors involved in care provision meet the same standards of assessment and inspection.

April 2010