A New Start: Consultation on changes to the way CQC regulates, inspects and monitors care.

The Royal College of Physicians of Edinburgh ("the College") has 50% of its UK fellows and members working in the NHS in England and welcomes the opportunity to comment on this important consultation on the regulation, inspection and monitoring of care. Our comments will naturally focus on the hospital sector but we are mindful of the importance of effective integration between community and inpatient services and of health and social care.

Q1. What do you think about the overall changes we are making to how we regulate? What do you like about them and do you have any concerns?

The College welcomes the change of approach, particularly the focus on accessing expert clinical judgements, accountability and leadership and following patient pathways from the community into hospital and back.

The College suggests there should be recognition of those hospitals delivering teaching and training to ensure students and young doctors train in organisations delivering high quality care and with strong and effective leadership. Coordination between the regulatory role and the inspection regime and surveys of the GMC would also be important.

Q2. Do you agree with the definition of the 5 questions we will ask about quality and safety (is the service safe, effective, caring, responsive and well led)?

The College agrees these definitions and welcomes the recognition of clinical risk and avoidable harm, emphasising the importance of shared decision making between clinical teams and patients. The College also welcomes the emphasis on 24/7 inspection given the pressure for extended hours and the evidence of outcome differences (often due to staffing levels and availability of diagnostics) out of hours. The subjective nature of the questions however must be recognised so that the answered received will be comparable between organisations. The care delivered is almost certainly going to be open to debate about levels of safety, caring, responsiveness and how well led it is with disparate parameters being considered. It is not clear how judgements will be delivered consistently.

Q3. Do you think any of the areas in the draft fundamentals of care above should not be included?

No all are important and we might add that risk attached to interventions should be fully explained and patients will be kept informed at all times.

Q4. Do you think there are additional areas that should be fundamentals of care?

We might add that risk attached to interventions should be fully explained and patients will be kept informed. For example, I will understand the risks associated with my care and I will know who is treating/caring for me and what is planned/agreed. Furthermore, there should be an expectation by the patient that they will be cared for in the location most appropriate for their needs i.e. systems that have 'boarded' patients as a routine are not providing adequate care.

Q5. Are the standards of care expressed in a way that makes it clear whether a standard has been broken?

Generally yes but providers will need to make it clear which standards are applicable to their services and there may be differences of interpretation for hospital, community and social care sectors. As noted above the need to ensure that the standards are applied consistently between similar organisations is of paramount importance

Q6. Do the draft fundamental standards feel relevant to all groups of people and settings?

Yes

Q7. Do you agree with the proposals for how we will organise the indicators to inform and direct our regulatory activity?

The College agrees with the proposals to create 3 tiers of indicators to alert and prompt further investigation up to and including an unannounced emergency visit. The College welcomes the opportunity signalled in the consultation paper to work with the CQC over the development and implementation of specialty-specific clinical indicators to monitor quality and support local improvement initiatives. At present this College is focusing on the pressures in acute medicine, recognising the ability of unplanned admissions to adversely affect patient flow and subsequently quality of care across the hospital. We would be happy to share this work with the CQC in due course.

Q8. Do you agree with the sources we have identified for the first set of indicators?

The College agrees these will form the basis of indicators but national data can be inaccurate and easily misinterpreted and so strongly supports their use as “smoke detectors” only to prompt further investigation; they cannot yet be used for summative judgements in isolation. The College welcomes the consultation’s realistic assessment of information currently available and the recognition that, initially, indicators will not meet all the 10 principles identified. Many clinically relevant indicators will not be measured routinely and the College recognises that the medical specialties create particular challenges. The College also commends the results of training surveys and Deanery specialty reports to the GMC as including useful information.

Q9. Which approach should we adopt for publishing information and analysis about how we monitor each NHS Trust. Should we:

a)Publish the full methodology for the indicators?

The College agrees that in the interests of public and service confidence and transparency the methodology should be shared openly.

b) Share the analysis with the providers to which the analysis relates?

The College agrees this is essential to allow the provider to challenge or confirm the data.

c) Publish our analysis once we have completed any resulting follow up and inquiries (even if we did not carry out an inspection).

The College is concerned that publishing 100% of gathered intelligence may be counter-productive until the "smoke detectors" have indicated "fire" , triggered an inspection and the results have been assessed. Patients must have confidence in their local services and there are incidents recently that illustrate that incomplete pieces of evidence can be misleading and damage the morale of clinical staff.

Q10. Do you agree with our proposals for inspecting NHS and independent hospitals

The College welcomes the inclusion of experienced front line clinicians in visiting teams and will be pleased to contribute to inspection teams. Board level managers must be required to release experienced clinicians to participate in inspection teams. Speaking to front line staff is essential but the CQC should not under-estimate the disruption to clinical services that can result from this process and must work to make the visit as time-effective as possible. Unannounced visits, particularly out of hours are necessary but will be stressful for those staff on duty and senior managers must always be informed and required to attend, not least for security reasons. Co-ordination of visits with other regulators and professional organisations will be essential to minimise disruption to clinical services.

Q11. Should the rating seek to be the "single, authoritative assessment of quality and safety"? Although the sources of information to decide a rating will include indicators and the findings of others, should the inspection judgement be the most important factor?

Ratings are proposed at a service and organisation level and patients anticipating care will wish to be assured of the quality of the particular service relevant for their needs. Broader public assurance about the quality of their local provider may focus more on the overall rating. It is important that a "good" or "outstanding" service is not undermined by difficulties elsewhere in the provider unit. Triangulation of evidence is part of all robust assessment systems and, although the inspection judgement will materially influence the end rating, due attention should be given to other information.

Q12. Should a core of services always have to be inspected to enable a rating to be awarded at either a hospital or Trust level?

The discriminating features of the ratings include the number of services within a hospital or Trust that meet or fail to deliver fundamental or expected standards. Therefore at the very least a core of services should be visited before a rating is given; this will contribute to ensuring that there is indeed consistency in rating between similar organisations. Complete reliance on data would be unwise and perhaps unfair. The College also finds it difficult to see how any provider unit could be rated as "outstanding" – i.e. no breaches and no inadequate services, if only a core of services have been inspected. Indeed the bar for "outstanding" seems very high and definition of "most" needs clarity.

Q13. Would rating the 5 key questions (safe, effective, caring, responsive and well-led) at the level of an individual service, hospital and a whole trust provide the right level of information and be clear to the public, providers and commissioners?

Ideally this would provide full assurance and indications of weak areas to target improvements but whether this is achievable, given the resources that would be required and the disruption to patient care is debatable.

Q14. Do you agree with the rating labels and scale and are they clear and fair?

Rating labels are important for patient confidence and staff morale and as most patients have little or no choice over provider the CQC should make clear to patients that all hospitals that have not been suspended or are in special measures are safe to attend. Thus it is important that the process is seen to be equitable and consistent for both the public and indeed the staff. See also response to Q12 above regarding the definition of “outstanding”.

Q15. Do you agree with the risk adjusted inspection frequency set out which is based on ratings, i.e. outstanding every 3-5 years, good every 2-3 years, requires improvement at least once a year and inadequate as and when needed?

The College agrees with the principle of risk adjusted frequency of visits but remains unclear about the trigger threshold (individual or multiple service problems) that would result in an interim visit for “outstanding” or “good” providers for whom inspection would be less frequent.

Q16. The model set out in this chapter applies to all NHS acute trusts. Which elements of the approach might apply to other types of NHS provider.

No comment

Q17. Do you agree that a duty of candour should be introduced as a registration requirement, requiring providers to ensure their staff and clinicians are open with people and their families where there are failings in care?

Doctors already are bound by their professional code to be open and honest and to report patient safety problems. The College agrees that all provider organisations should have this responsibility.

Q18. Do you agree that a duty of candour should be sufficiently clearly drafted that prosecution can be brought against a health or care provider that breaches this duty?

The College agrees that, although extreme breaches are already covered by the corporate manslaughter provisions of health and safety legislation, a breach of the duty of candour should be capable of prosecution at an organisational level for less serious offences to encourage compliance. Individual doctors have to answer to the GMC for transgressions.

Q19. Do you have any comments about the statutory duty of candour on providers of services via CQC registration.

None

Annex to the consultation:

QA1. Do you agree with the principles we have set out for assessing indicators?

The College agrees the 10 principles laid out and welcomes the recognition that some are aspirational in the short term.

QA2. Do you agree with the indicators and sources of information?

The College agrees with the indicators listed as relevant to physicians and which clearly illustrate the challenges of selecting robust clinical indicators for many of the medical specialties.

QA3. Are there any additional indicators that we should include as tier 1 indicators?

As mentioned above the presence of boarding in any acute Trust should be used as an indicator of effectiveness of care provision. There is also no consideration given to the patients who self harm, those who are subject to falls and outcomes for patients with cancer. Furthermore, there is little to define outcomes or indeed process for patients who present to hospital requiring urgent care. Such patients may form the majority of those occupying a hospital bed and there should be recognition that the processes are in place to provide high quality care at all times.

QA4. Do the proposed clinical areas broadly capture the main risks of harm in acute trusts? If not which key areas are absent?

See QA3 above

QA5. Do you agree with our proposal to include more information from national clinical audits once it is available?

Agreed.