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Consultation response to draft CQC Community Provider Handbook

May-June 2014

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RCPCH and BACCH are pleased to respond jointly to the consultation on the community provider handbook.

We have very much appreciated the opportunity to be involved with CQC's development of the inspection methodology, through representation on the Community Expert Reference/Advisory Group and involvement of BACCH officers with direct discussions on methodology.

As a medical Royal College with around 14,000 members across the UK (11,000 in England) we are keen to ensure that paediatric and child health services are commissioned and delivered to meet clear clinical and service standards and that there is an appropriate and informed process for ensuring that services are safe and of high quality.

Our formal response to the consultation follows, linked to the questions posed. If there are any areas on which you seek further clarification please contact in the first instance Sue Eardley, Head of Invited Reviews on sue.eardley@rcpch.ac.uk – 020 7092 6091 or
Dr Gabrielle Laing, BACCH Executive Committee Chair via bacch@rcpch.ac.uk - 020 7092 6082/6084

Key Principles

We agree in the selection of the right services to look at and welcome the overt inclusion of services for infants, children young people and families. We feel that it is important that your safeguarding and looked after children inspection team have actively contributed to the development of this handbook as from our members' experience they have significant relevant knowledge from inspection of community children's services to highlight gaps and priorities.

The definition of children served by community providers can vary; services may be offered up to 16, 17 18 or 19 and providers should clearly identify their provision and transition arrangements for adolescents to adult services, so there is not a 16-18 years 'gap'.

We raised in discussion with your policy team about missing out CAMHs services that are not part of specialist CAHMS, and which are delivered by community paediatricians and psychology teams in the community. This is not in the specialist mental health services handbook, so it really should be mentioned within the community handbook and mentioned in training to your inspectors.

Key Lines of Enquiry

The principle of developing meaningful KLOEs from existing and sought data is sound and we are keen to continue to work with CQC to develop the most meaningful indicators for the range of community paediatric/child health provision. Given the paucity of data and inspection history in community provision, we're presuming that once the inspection programme is established the KLOEs could be refined if evidence obtained indicated that more specificity would be helpful. BACCH in particular are continuing to develop standards and audits to help towards the refinement, and RCPCH is developing standards for ambulatory care and settings outside hospital which may be helpful in coming months[1]

The implementation of statutory requirements[2] relating to special educational needs from September 2014 will have a significant impact on provision of children's services in community settings and integrated working so we'd suggest this is mentioned within the KLOE - eg E1 prompts, and include educational needs for children in E1 characteristics of good

We'd suggest that W2 should include safeguarding under prompts on page 22

On page 25 W4 prompts; Involvement of the trust in serious employment disputes or cost and number of compromise agreements (anonymised) would be a good measure of this.

Ratings

We concur with the views expressed at the expert group meeting that an overall rating of 'outstanding' may not be helpful given the size and reach of many large providers – it is unlikely that all aspects of all services within them could be considered to be operating at this level and any areas that are not risk tarnishing the rating. However identifying specific departments or services within the whole that are outstanding or have 'outstanding features' is a positive way to recognise innovation and encourage teams.

Under the 'safety' rating it would be helpful to include an indicator around sharing information with other providers. This is particularly important for safeguarding children, where a number of agencies may be involved; both from health, education and social services, and a service cannot be good if the information does not flow effectively and securely across these boundaries. Having an interagency protocol for information sharing in place, and access to each other's databases (but in line with information governance) could be performance indicators here

For well-led the definition should also apply to departments and teams as well as the whole organisation, as there are likely to be some excellent teams within average organisations particularly given the geographically distributed sites covered by a single provider.

[1] http://www.rcpch.ac.uk/facingthefuture

[2] Special Educational Needs (SEN) Code of Practice: for 0 to 25 years

Equality and Human Rights

It is important to include more overtly in this section the rights of children in particular – and the UN convention on the Rights of the Child. Although you mention as vulnerable groups pregnant women and women with children the focus may seem to be is on the woman rather than the child in its own right. Children are too often treated as 'mini-adults' and need not just attention but often specially designed services that suit their different needs (including a right to education) and levels of understanding. It is positive that CQC has included consultation and focus groups with young people and we have been pleased to support CQC by linking with our youth advisory group and parent carers group.

Mental Capacity Act and DoL Standards

The detail here does not consider the assessment of children and young people's competence, i.e for those under 16 years of age where Gillick competence applies. It is also recommended that those between 16-18years are encouraged to involve their families or carers in decision making and it would be helpful to include this please. There are additional considerations about placement of young people in adult mental health wards – or even acute wards as a place of safety but this is presumably unlikely within community provider services. We would support the suggestion of suitable weighting and application of limiters including consideration of the points above.

Services provided by third party providers

Community health services for children, more than most other health interactions, are often provided by a range of different agencies, working together to form, we hope, a well-connected service (not seamless as that could be one-size, but perfectly tailored to fit the requirement). It is important that inspection, as it matures, is able to apportion judgements and recommendations appropriately to relevant providers or those which they can influence to ensure that the five elements are met for a child using the whole pathway of care. We have emphasised this issue in our various meetings and contributions at round tables with CQC staff and it has been acknowledged by Prof Mike Richards and Prof Ted baker. We understand that there is increasing 'information sharing' of interrelated inspection data across the CQC's organisation-based data packs but we have not seen evidence of this working in practice yet.

Intelligent Monitoring

There is a relatively low level of meaningful monitoring data available for community child health services, but we are working closely with CQC to identify what is available and how it might be used. Outcome indicators can be difficult to measure as much of the work is diagnosis and management of long term conditions, so proxy measures for process such as waiting times, including follow up waits which are not a national target, and medical staff turnover and vacancy/locum information can give an indication of the calibre, resourcing, and efficiency and priority of the service to the organisation. However, caution is needed in interpreting this data as many paediatric/child health teams report being "under-commissioned" and therefore struggle to provide high quality care.

Site visits, rating and reporting

It is encouraging that CQC has begun to use parents and carers as experts by experience in gathering the views of people who use services and we would recommend also recruiting young people themselves to participate. They could

be over 18 (releasing the need for chaperones) and still provide a valuable perspective around transition, approach and communications.

On page 34 there is a list of focus group categories. Whilst we appreciate that there are usually very few doctors within a community service the largest team would usually be the paediatricians and we would suggest that a medical view is also sought in a focus group either with all the doctors or just with the paediatricians. Our experience in invited reviews indicates that there is often a range of views from multidisciplinary teams and omitting the paediatricians may not give a full picture, nor engage those best placed to push improvements.

In many services but particularly community child health, the impact of commissioning can have a significant effect on the quality of services that can be provided to children and families.

Community services are block contracted by a range of commissioners and in many areas they are facing increased demand without a matching increase in resources or a reduction in both funding and the scope of service specification with no provision for the gaps which then develop in care pathways

Whilst there should be a clear responsibility on the provider to articulate these important risks in its commissioning negotiations, it is also important that the commissioning landscape should provide some context for ratings, and also that insufficiencies within the commissioned contract or service level agreement should be recognised for their impact on driving overall service quality at the post inspection stakeholder summit. We feel that the role of the CCG and service level agreements is underplayed in section 5d.

There may also be concerns raised in future over the nature of reports where privatised services are inspected, and what information may be considered 'commercial in confidence' in terms of publication during a tender period. We would presume that Monitor is working with CQC in this respect.

Encouraging Improvement

There is a range of mechanisms for promoting outstanding care, but also the caveat that services can change very quickly, especially if as a result of highlighting good care a provider is then swamped and unable to deliver the service. It is also important to recognise the impact of commissioning and the quality of care may depend upon what is funded and adequately resourced. That said, sharing positive practice is a powerful way to encourage staff, so long as the resource is maintained and out-of-date material removed.

Ratings Review

We do not have any specific comment to make on this area.

Focussed inspection

We support in principle the opportunity to invite CQC to re-inspect where improvements have been made. However given that CQC are likely to have limited resource to conduct routine inspection programme and a series of focussed inspections, perhaps more use could be made of the invited review programmes run by Medical Royal Colleges which offer an independent 'benchmark' of a service and can provide validation for CQC's inspection and rating s team as to whether a service has delivered its action plan. We would be very keen to continue to discuss this with the Chief Inspector and his team