



British Association of Dermatologists' Response to the Care Quality Commission's Consultation Document - 'A New Start'

The British Association of Dermatologists (BAD) is a registered charity which aims to promote, for the public benefit, the knowledge, practice and teaching of Dermatology. The BAD welcomes the opportunity to respond to the CQC's consultation document 'A New Start'.

General

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

The changes are welcome, in particular the focus on putting patients at the centre of everything that is done in healthcare settings.

We have concerns about the quality and safety of NHS Dermatology services being provided by new private/hybrid companies in some parts of England and seek clarification that these organisations will be subject to the same scrutiny as acute hospitals.

We have concerns that the CQC will not address the issue of the commissioning of healthcare and the impact that the commissioning process will have on safety, effectiveness and responsiveness of healthcare both within the NHS and the independent sectors.

We are concerned that potential conflicts of interest are not subject to adequate scrutiny.

We have numerous examples of poor quality commissioning leading to contracts awarded to inappropriate providers with compromise to safety, effectiveness and responsiveness. We also have examples of private commissioners (ie private healthcare insurers) causing delays to patient care by having unresponsive processes.

We are concerned about the effect on long established and integrated arrangements for clinical care, teaching, training and research (see Circle, Nottingham).

2. Do you agree with our definitions of the five questions we will ask about quality and safety (is the service safe, effective, caring, responsive and well-led)?

Agree with definitions.

Fundamentals of care

3. Do you think any of the areas in the draft fundamentals of care above should not be included?
4. Do you think there are additional areas that should be fundamentals of care?
5. Are the fundamentals of care expressed in a way that makes it clear whether they

have been broken?

6. Do the draft fundamentals of care feel relevant to all groups of people and settings?

Agree with fundamentals of care. No additional areas suggested. Expressed clearly. Relevant to all people/settings.

The 'Expected standards' and the 'High quality care' domains should be informed not only by NICE but also by the specialist societies. The BAD is the specialist society for skin conditions and already has a well established mechanism for defining standards of care within Dermatology. The BAD welcomes the opportunity to collaborate with CQC on such matters.

Intelligent monitoring of NHS acute hospitals

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

Agreed, provided that quality markers are also included and measured. A drop in quality (eg accuracy of diagnosis) may be the early warning about safety, effectiveness and responsiveness. The BAD can assist CQC with quality markers. However, even quality has to be measured/quantified to be ranked and compared.

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

Agreed, but would add that Tier 1 indicators including 'whistleblowing' (Domain N) and 'output from inspection' (Domain Q) have often come via specialist societies and therefore the BAD should be included in Tiers 1,2 & 3.

9. Which approach should we adopt for publishing information and analysis about how we monitor each NHS trust? Should we: – Publish the full methodology for the indicators? – Share the analysis with the providers to which the analysis relates? – Publish our analysis once we have completed any resulting follow up and inquiries (even if we did not carry out an inspection)?

In the interests of transparency the methodology, analysis and follow up should be published, but should apply to both NHS acute hospitals and non-NHS providers. This is particularly important in Dermatology which, unlike many other specialities, can be provided in non-acute settings.

Inspections

10. Do you agree with our proposals for inspecting NHS and independent acute hospitals?

Agree with proposals. BAD welcomes opportunity to provide expertise for 'peer review'.

Ratings

11. 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?

Agreed, provided the rating of individual services such as Dermatology are made with the correct indicators as advised by specialist societies such as BAD. Currently the consultation document has no detail for skin – BAD welcomes opportunity to advise.

12. Should a core of services always have to be inspected to enable a rating to be awarded at either hospital or trust level?
13. Would rating the five key questions (safe, effective, caring, responsive and well-led) at the level of an individual service, a hospital and a whole trust provide the right level of information and be clear to the public, providers and commissioners?
14. Do you agree with the ratings labels and scale and are they clear and fair?
15. 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 per year and inadequate as and when needed?

Agreed with 12-15.

General

16. 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?

Within Dermatology services there is a wide range of NHS and non-NHS providers. The inspection and ratings model should apply to all providers in order for fairness to patients and to ensure the patient always receives the correct care from the correct provider.

Duty of candour

17. 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?

The Francis Report came to the firm and unequivocal conclusion that the Government's 'contractual' duty is "not sufficient", that the statutory Duty of Candour was essential, and that it should be the responsibility of the CQC to enforce it with healthcare organisations.

We agree that the duty of candour should be introduced as a registration requirement by the CQC. The contractual duty would currently be policed by Clinical Commissioning Groups who have no desire to police it and, not being regulators, are ill equipped to do so. The BAD has extensive experience and examples of non-compliance with contracts and PCTs/CCG not enforcing the general terms and conditions of the contract. Openness and Transparency needs to be scrutinized by an outside body given potential conflicts of interest with CCGs being commissioners and providers.

18. Do you agree that we should aim to draft a duty of candour sufficiently clearly that prosecution can be brought against a health or care provider that breaches this duty.

We agree that it is essential to draft the duty of candour sufficiently clearly that prosecution can be brought against a health or care provider that breaches this duty. It should include the requirement to have qualified staff to provide services and governance frameworks in place.

19. Do you have any other comments about the introduction of a statutory duty of candour on providers of services via CQC registration requirements?

We have noted the following issues with using the contractual duty of care that reinforce the need to have a registration requirement in place.

- **Commissioners also need to be accountable for the appointment of unsuitable providers and not carrying out the necessary contractual checks. Commissioners all too frequently appoint providers who have inadequate staffing and without appropriately trained staff and governance frameworks in place for community services. Issues raised around the mismanagement of patient care and complaints are not dealt with despite issues being raised by local trusts and the BAD.**
- **The contractual duty would only apply to incidents already reported through risk management systems and so would not outlaw total cover-ups and may create a perverse incentive not to report at all**
- **Using the contractual route only would be inconsistent with how 'Essential Standards of Quality and Safety' are regulated and mean that the Duty of Candour was given lesser status**
- **Using the contractual duty alone would mean that healthcare organisations were statutorily required to report incidents to the national reporting system without having a statutory duty to inform patients – an anomaly Francis criticizes**
- **The contractual duty on its own cannot enjoy public confidence having been found by Francis to be insufficient and leading patients organisations seeing it as paying lip service.**

Impact Assessments

20. Do you have any comments on the draft Regulatory Impact Assessment?

21. Do you have any comments on the draft Equality and Human Rights Duties Impact Analysis?

No comments.

Proposed model for intelligent monitoring and expert judgement in acute NHS trusts

A1. Do you agree with the principles that we have set out for assessing indicators?

Agree with principles.

A2. Do you agree with the indicators and sources of information?

No indicators in place for Dermatology. BAD welcomes opportunity to be authoritative source of information.

A3. Are there any additional indicators that we should include as 'tier one' indicators?

Cost effectiveness. Expenditure has to be proportionate to risk.

A4. Do the proposed clinical areas broadly capture the main risks of harm in acute trusts?
If not, which key areas are absent?

It is disconcerting that there are no indicators in place for Dermatology (unlike the majority of other clinical areas (Annex p 12). The BAD welcomes the opportunity to be the authoritative source of information.

A5. Do you agree with our proposal to include more information from National Clinical Audits once it is available?

Agreed.

A6. Do you agree with our approach of using patient experience as the focus for measuring caring?

It is vital but not sufficient to use patient experience. Other sources of information including inspection/peer review by specialist societies (such as BAD) are also necessary.