CQC Strategy consultation

Royal Pharmaceutical Society Response

1. People and communities

We want to be an advocate for change, with our regulation driven by people's needs and their experiences of health and care services, rather than how providers want to deliver them.

This means focusing on what matters to the public, and to local communities, when they access, use and move between services. Working in partnership, we have an opportunity to help build care around the person: we want to regulate to make that happen.

1a. To what extent do you support the ambitions set out in this theme?

We agree with all of the ambitions set out under this theme, but clarity is needed as to how they will all be achieved without adding significant bureaucracy into the system.

In addition, as well as looking at the people who are accessing the services there is also a need to support the people who are delivering the services. The mental health and wellbeing of the staff members must also be considered as part of CQC assessments. If individual staff members are suffering from poor mental health and wellbeing, they are more likely to make errors which will have an impact on patient safety.

1b. Please give more details to explain why you chose this answer.

The CQC state that "We want our regulation to be driven by people's experiences and what they expect and need from health and care services".

There is a big difference between what people expect and what they need. The NHS and social care have limited resources and it is not always possible to provide people with what they expect. Expectations must be managed and the CQCs needs to be careful not to raise unrealistic expectations with the public. Clearly some level of expectation is important e.g. NHS constitution, but some expectations are more "wants" rather than "needs". The CQC needs to respect local decisions if they think they are acceptable.

2. Smarter regulation

We will be smarter in how we regulate. We'll keep pace with changes in health and care, providing up-to-date, high-quality information and ratings for the public, providers and all our partners.

We'll regulate in a more dynamic and flexible way so that we can adapt to the future changes that we can anticipate – as well as those we can't. Smarter use of data means we'll target our resources where we can have the greatest impact, focusing on risk and where care is poor, to ensure we're an effective, proportionate and efficient regulator.

2a. To what extent do you support the ambitions set out in this theme?

We agree with the ambitions set out under this theme

2b. Please give more details to explain why you chose this answer.

There needs to be greater clarity as to how CQC will work with other regulators. In particular the General Pharmaceutical Council who have responsibility for inspecting community pharmacies who are part of the overall system. In addition, whilst the GPhC inspect community pharmacies and the CQC inspects NHS trusts and general practices where pharmacy services are run, it is possible to

provide a service to the NHS which nobody regulates because neither organisation thinks it's their role e.g. a warfarin monitoring service provided by a company.

As community pharmacy evolves and develops more care services that are integrated with the multidisciplinary health and social care services then the CQC and GPhC are going to have to liaise and plan out who inspects which part of pharmacy services.

3. Safety through learning

We want all services to have stronger safety and learning cultures. Health and care staff work hard every day to make sure people's care is safe. Despite this, safety is still a key concern for us as it's consistently the poorest area of performance in our assessments.

It's time to prioritise safety: creating stronger safety cultures, focusing on learning, improving expertise, listening and acting on people's experiences, and taking clear and proactive action when safety doesn't improve.

3a. To what extent do you support the ambitions set out in this theme?

We agree with the ambitions set out under this theme and it is good to see consideration given to leadership qualities, the culture of the organisation, how they deal with and learn from incidents and reporting of errors and how they encourage and support personal development of their staff. However, we have some thoughts below.

3b. Please give more details to explain why you chose this answer

The CQC state that "There's no national agreement on what we mean by safety in different health and care sectors and services. We'll work with others to agree and establish a definition and language that explains what we mean by safe care and how this could apply in different services".

We do not necessarily believe that it is the role of the CQC to define safety across health and care settings. CQC need to define who they mean by "others".

The CQC state that "We'll share the learning from our insight on themes, trends, and best practice to help services and systems improve their safety. "Clarity on who this learning will be shared with and how it will be shared is needed. Is this local learning shared with the local providers or is this shared nationally? How will the learning that is shared help with change for the better i.e. what will be the mechanism for supporting behaviour change at an individual and organisation level? Simply sending out a newsletter, for example, would not achieve the aims of real shared learning.

It is important that organisational culture includes the provision of working environments that are conducive to good mental health and wellbeing and that organisations support their staff members to speak up and voice their concerns relating to mental health and wellbeing. Employers should ensure that all of their members of staff (whether employed or locums) have access to mental health and wellbeing support services whether provided at a national or organisational level. Access to these services should be highlighted and promoted by the organisation.

The use of medicines is the most common intervention made in healthcare. It has been estimated that 30-50% of medicines prescribed are not taken as intended and the cost of wasted medicines is around £300 million per annum in England, with at least half of that being avoidable.

We believe that CQC have a unique opportunity to oversee the whole system of the medicines pathway from prescribing to supply to administration, alongside all the professionals and organisations involved. CQC can ensure that there is clinical oversight where medicines are concerned by ensuring that safe systems are in place along the whole of the medicines pathway and

that an expectation is set that all organisations regulated by CQC have professional and clinical oversight of medicines.

CQC itself has stated that '*Medicines are the most common form of healthcare intervention in all care settings and are crucial to almost all care pathways. We have found, through our inspections across different types of services that where services have problems with safety, we often find problems with how they manage medicines.'*

We believe that all inspectorate teams should include a pharmacist who will have professional and clinical oversight of medicines issues. Having a pharmacist as an integral part of the team will mean they will notice any medicine issues which could potentially be overlooked if they are not present. We would also expect the inspection teams to make a judgement on how the organisation / pathway being inspected was providing leadership for medicines (systems, processes and medicines optimisation), recognising the importance of medicines and their use across the organisation/ pathway. This should include a review of the systems that are in place for the transfer of medicines information when the patient moves between different care settings, ensuring that there is a process to minimise medicines related risk.

The remit/scope of the CQC and GPhC needs to be clearly defined so that its clear which regulator governs which part of the medicine's journey. There is scope for the regulators to continue to collaborate and share expertise.

The elements and principles of medicines optimisation should also be used as part of the assessment process to ensure that the organisation / pathway is delivering safe and effective care where medicines are concerned. This should include assessments that ensure the organisation involves patients and their carers in decisions about their treatment and that patients are at the centre of decision making about their medicines and that their medicines are optimised to reduce risks and side-effects. Organisations should also be assessed to ensure patients receive appropriate and equal care for both mental and physical health conditions.

Accelerating improvement

We will do more with what we know to drive improvements across individual services and systems of care. We'll use our unique position to spotlight the priority areas that need to improve and enable access to support where it's needed most.

We want to empower services to help themselves, while retaining our strong regulatory role. The key to this is by collaborating and strengthening our relationships with services, the people who use them, and our partners across health and care.

4a. To what extent do you support the ambitions set out in this theme?

We support the ambitions set out under this theme

4b. Please give more details to explain why you chose this answer.

The CQC state "We'll make sure we understand changes being developed to the way services deliver care. We'll then work with health and care services and other stakeholders to understand how these can improve the quality of people's care. When we do this, we'll consider where using new technology might disadvantage some people and what services need to do so that nobody is left behind. "

This is a massive task. It overlaps significantly with the roles of other organisations such as the ICS, AHSN and NICE and we are unsure of this is solely the role of the CQC. It would be good to understand why there is emphasis on the introduction of new technologies disadvantaging some

people as this almost suggests that CQC want to restrict change in case others are disadvantaged in other parts of the ICS/country. It would be more understandable if the CQC were to look at why an organisation is good at adapting to or using a new technology and spread this learning to others.

Each provider organisation within a complex system is interdependent on the quality of care provided by other providers in the system. This new way of regulation must not lead to a blame culture, where one provider who is perhaps not doing so well is targeted by other providers in the area. It should ensure a supportive system is in place to help any provider that is struggling. There needs to be good engagement with all the providers in the local area in order for the quality of care across a place to be properly assessed and this would include liaison with other inspection regimens such as that for community pharmacy. CQC would need to co-ordinate with other regulatory organisations, such as GPhC for community pharmacies, to gain a true picture of the whole system

Overall comments (general)

The aims of this change in strategy are laudable but potentially too ambitious in terms of practicability and deliverability. WE are aware that the CQC struggle currently to do inspections and taking on new aims such as a remit for safety or accelerating implementation of improvements is potentially too large.

Also, other organisations do some of these functions e.g. NICE and the AHSN might have a role in looking at implementation of new technologies, medicines safety etc. Other organisations have a role in identifying safety issues and trying to implement learning to reduce risks if a similar issue occurs in the future.

The CQC need to define more clearly

1. their remit
2. how they will spread good practice and improvements across the health and social care system and not just within one organisation they are inspecting
3. how they work with other organisations that have a similar remit and not try and duplicate what is being done elsewhere.
4. how they increase the expertise within their own organisation when they struggle currently to have experts working for them.
5. how they genuinely support providers rather than simply inspect and criticise them.
6. how they will do all of this without increasing the costs to those organisations that are obliged to register with the CQC.