

## DEFINING 'GOOD' IN HEALTHCARE

### TOPLINE SUMMARY 4: SPECIALIST AND COMMUNITY MENTAL HEALTH SERVICES

#### 1. INTRODUCTION, BACKGROUND TO THE RESEARCH AND OBJECTIVES

In April 2013, CQC published its new strategy '*Raising Standards, Putting People First*'. In this document, CQC stated its intention to redevelop its inspection methodology and the information that is provided to the public following an inspection. This change focuses not only on how services are inspected, but also the five key questions which inspectors will ask about services: Are they safe? Are they effective? Are they caring? Are they well led? Are they responsive to people's needs?

**CQC is working to develop new fundamental standards that focus on these five questions.**

As part of this work, CQC seeks to define the criteria that will be used to assign a rating to a service provider – in other words, understanding the features of a service that is considered inadequate, a service that 'requires improvement', is 'good' and 'outstanding'.

**For this new inspection model to be credible with the public, it is essential that these criteria reflect the public's expectations.** There is a particular focus on understanding what the public expects 'good' and 'outstanding' services to look like, across all care settings, and at all service levels.

**Qualitative research was commissioned to provide a clear understanding of what the public and service users think 'good' and 'outstanding' look like in Specialist and Community Mental Health services.** In addition, the research will explore what information requirements the public have in relation to inspection reports about all of the above services. The business objective is:

<p><b>To inform the criteria that are developed for rating services and to inform the development of a new style of inspection reports for each of these services.</b></p>
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## 2. SPECIALIST AND COMMUNITY MENTAL HEALTH SERVICES SUMMARY

### 2.1 Method and sample

In total, 12 face-to-face depth interviews (1 hour duration) were completed with users of specialist and community mental health services w/c 26<sup>th</sup> May and 2<sup>nd</sup> June:

- 6 x depth interviews focussing on a range of specialist services
- 6 x depth interviews focussing on a range of community services.

In addition:

- A mix of male and female was achieved;
- A mix of ages / lifestages was achieved;
- A mix of circumstances e.g. voluntary admission, compulsory admission, varying lengths of stay was achieved;
- The interviews reflected varied pathways through mental health services, both specialist and community services.

### 2.2 Care standards experienced

**The care standards experienced ranged from outstanding through to inadequate (although examples of inadequate and outstanding care were rare).** Interestingly, many respondents found it difficult to give one overall rating for their care; instead they preferred to break their care down in different ratings for different aspects.

**Only one respondent felt that he had experienced outstanding care overall.** For him, outstanding care was staff 'going out of their way' to help and the sense that they genuinely wanted to see a positive outcome. *"He really wants to help you. He will sit and listen to you and help you anyway he can."*

**For other respondents, outstanding care was characterised by the service's response to the patient's need for contact/support:**

- The speed of referral to services (within 7 days);
- Frequency of contact (to speak to someone on a weekly or fortnightly basis);
- Having number to call between appointments if extra support is needed. *"It would have been really good if there was a number to call and speak to someone and say, look I'm having a really crappy day here."*

**A good standard of care was largely defined by: the behaviour and attitudes of the staff and satisfaction with the service offered.** There were indications that these aspects of care were perceived as core (and perhaps most important). Respondents identified examples of how a service had provided good care e.g. offering the option to make an emergency appointment if required. They also identified examples of how health professionals had provided good care e.g. being thorough (asking lots of questions about medicine and how the patient is feeling); making suggestions around how the patient might approach issues differently; the ability to get the patient to 'open up' about concerns and make them feel comfortable.

**Requires improvement was the care standard which respondents generally found it easiest to define.** Once again, comments about care 'requiring improvement' can be split into two groups: the care provided by the healthcare professionals; and the care provided by the service in general.

In relation to the care provided by the healthcare professionals, respondents identified examples of care which they felt required improvement e.g. feeling pressured into having trainees present in an appointment. *"Quite often she has trainees in there and she does say 'is it OK if they stay in the room' but it's almost a bit late because you're walking in the door";* and perceived inattention of the healthcare professional and perception that they 'do not really care'.

In relation to the service in general, respondents identified aspects of care which they felt required improvement:

- Difficulty in making appointments (due to unavailability of the clinical / hospital specialist and the practicalities of booking system);
- Long waiting times (for appointments, assessment and treatment);
- Lack of contact / irregular appointments with the clinician / hospital specialist;
- Inconvenient location of the service (too far to travel).

**An inadequate standard of care was perceived as lack of (appropriate) referral to services.**

For some respondents, inadequate care overlapped with care which requires improvement when the issues are not addressed or explained. For example, one respondent was kept waiting for unreasonable amount of time for every appointment over a period of years and never given feedback on why this was happening. She classed this as inadequate care.

### **2.3 Definition of good care**

**General public priorities for safety comprised several aspects.** Firstly, 'safe' care was perceived as meeting the health needs of the patient, be this providing medicine, support, hospitalisation etc. Safety was monitoring the progress of the patient (including response to medicine and treatment). Respondents felt that a safe environment would be one in which the patient felt comfortable / at ease / safe enough to be able to disclose any issues or support needs. Safety was also maintaining strict confidentiality in relation to the patient's personal information. Finally, safety was perceived as physically protecting patients for harming themselves and others.

**Although all agreed with the description of 'safe', the elements from which respondents identified as particularly relevant to their needs were:** *'the people using the service, those close to them and staff are protected from abuse and avoidable harm'; 'when things go wrong the provider is open and transparent, incidents are investigated, learning is communicated and action is taken to improve'; and 'staffing levels are set and reviewed to keep people safe and meet their needs and at all times the practice / service is open'.*

**General public priorities for ‘effective’ were associated with good outcomes for the patient.** The general public felt that an effective service would make the patient ‘feel better’ and ‘move forward’, whether this was the result of support, medicine or therapy. However, respondents acknowledged that, in the sphere of mental health, ‘feeling better’ or ‘moving forward’ is very difficult to measure. They acknowledged that patients do not always make progress and this may not be related to the quality of care they have received, but simply a product of their condition.

**Although all agreed with the description of ‘effective’, the elements from which respondents identified as particularly relevant to their needs were:** *‘discharge, transfer and transitions to other services are planned and involve a holistic assessment of people’s on-going needs’; ‘people receive care, treatment and support that achieves good outcomes, promotes a good quality of life and is based on the best available evidence’; and ‘staff are appropriately qualified and competent at the right level to carry out their duties’.*

**General public priorities for caring were closely associated with the personal qualities and attitudes of healthcare professionals.** Caring was defined as staff behaving in certain ways (being supportive, empathic, sympathetic, understanding and non-judgmental), the sense that they were genuinely concerned about the welfare of patient and the level of the contact received (*“they don’t just sit there and then go, I’ll see you in 3 months”*).

**Although all agreed with the description of ‘caring’, the elements from which respondents identified as particularly relevant to their needs were:** *‘feedback from people who use the service, those who are close to them and stakeholders is positive about the way staff treat people’; ‘staff respond compassionately to pain, discomfort, emotional distress in a timely and appropriate way’; and ‘staff are kind and have a caring, compassionate attitude and build positive relationships with people using the service and those close to them’.*

**General public priorities for responsive were around patients receiving the care they needed within a reasonable timeframe** e.g. timely referral to services, appointments, assessments. Responsive care was also seen as healthcare professional responding to what

the patient is saying and the way the patient is feeling in an appropriate and person-centred way.

**Although all agreed with the description of 'responsive', the elements from which respondents identified as particularly relevant to their needs were:** *'people receive care which meets and is responsive to their needs'*; and *'people wait as a short a time as possible for services, treatment or care'*, *'there is an effective and proactive approach to managing referrals, assessments, allocation and appointments and minimising cancellations. People have the information they need whilst they wait and risks are managed in the meantime'*.

**General public priorities for 'well-led' were communication and feedback, both between patients and staff but also between frontline staff and management.** An example of being 'well-led' was healthcare professionals thoroughly explaining treatment, procedure and progress to patients. It was also frontline staff being given the resources needed to do their job well.

**The description of well-led felt significantly less relevant to respondents than the descriptions of the other domains.** Some said that the points appeared to be for staff, rather than patients and the language itself presented barriers, e.g. *'quality drives the strategy and the strategic objectives are regularly reviewed'*.

## **2.4 Information requirements**

**Respondents did not generally feel like they had had a choice of mental health services.** Respondents were referred from other services / healthcare professionals into mental health services. Some were asked whether they would like referral, however, few felt in a position to turn down an offer of help and none were given a choice between different services. There was a sense that mental health patients might not be well placed to make choice about which services they needed and this was better left in the hands of healthcare professionals.

In this context, thinking about what information respondents would like to have about a service before use felt like a rather academic exercise. However, they were able to identify certain information requirements:

- What the service offers, e.g. in terms of therapies;
- Reassurance of the confidentiality of their information;
- Whether and how previous patients have found the service helpful, i.e. what had the service done for previous patients;
- Logistical issues, e.g. location of the service, timings of appointments, waiting list.

### **3. INSPECTION REPORTS (new style)**

#### **3.1 Report structure, content and language**

##### **BEDOC OOH Service Report**

The BEDOC report was generally well received as easy to read, well laid out, concise and containing relevant information. The report gave the impression that the service was being thoroughly monitored which was reassuring. Respondents were impressed that the inspection team was able to 'pick up' such a low level issue as 'dust'.

However there were some negative comments on the report:

- Is it 'too good to be true'? The lack of reference to any complaints being made was met with disbelief;
- Lack of specific detail on the service and the care (some of the statements felt too bland and broad);
- There was also an issue around respondents understanding who had compiled this report: was it the service? Was it government? Respondents did not understand CQC's identity (as an independent body).

## **Homerton Hospital**

As above, there were no issues with the language or layout of the report.

There was an instant preference for the ratings in this report (over a report without ratings). It was felt that ratings made the report significantly easier to use; you can see the standard of care the service is providing at a glance. Respondents felt they would be drawn to the 'inadequate' and 'outstanding' ratings because they would be alarmed or impressed and want to know why the service had been rated in this way.

Respondents felt that CQC's ratings should be structured according to the different services in relation to mental health, e.g. one rating for the psychologist, one for the group therapy work etc. They would have little interest in ratings for other services offered by the provider.

## **Gathering views on a service**

The main issue around getting patient's views on a service was fear of reprisal, therefore it is essential that there is reassurance around the confidentiality of feedback. There were several different suggestions (but no consensus) for how feedback could be obtained: paper / online / email form given whilst using the service / at point of discharge / sent to home address.