**Satisfaction Guaranteed?**

Not many of us go to work to do a bad job.  Most of us hope that we do the opposite – but how do we know if we are?  How can we tell if the service we provide is a good one and whether the work we do makes a difference?  Working out whether the services we and our teams deliver is up to scratch is not an easy task.  As a clinical academic I can point to papers published, or the results of the torment visited on us every few years known as the Research Excellence Framework, but even there a paper published can vanish into thin air, leaving no trace behind, and the judgement of our peers (which is basically what these assessment exercises are for) can be flawed.

And the situation is just as complex for clinicians.  We could and frequently do measure whether or not our patients are satisfied with us and our services. That’s no bad thing, and it is better to have a satisfied patient or relative than an unsatisfied one.  But measuring satisfaction alone is, well, unsatisfactory.  Some doctors get high satisfaction scores because they are polite, charming and give you just what you want – but they may simply be promoting snake oil. Studies show that patient satisfaction with their local hospital is significantly influenced by the availability of parking – important yes, but no reflection of the standard of care.

The RCPsych has been working quietly for years to help answer exactly these questions – how do we provide a good service?  [The College Centre for Quality Improvement (CCQI)](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement.aspx) is the part of RCPsych that aims to help members assess and improve the quality of care they provide.

When I took over as President I have to confess that I knew very little about the CCQI.  That’s all changed now, and the more I learn about it, the more impressed I have become.  But talking to others I find that my lack of awareness of one of the most important parts of the College was by no means unique.  So for the rest of this blog I have teamed up with Professor Mike Crawford, who has been Director of the CCQI since 2011  to fly the flag for CCQI.  If you don’t know what it does, then please read on and you might be pleasantly surprised.

Let’s take two areas in which standards matter - good prescribing practice, and improving the physical health of our patients.  We know that prescribing drugs for too long and at too high a dose can be dangerous.  We also know that we have as a profession neglected the physical health of our patients for too long, with serious consequences.  Frankly, we have to accept responsibility for this. It’s not the fault of Andrew Lansley, the GMC, local councils or any other person or organisation that we often tend to blame (sometimes with good reason).

The ‘CCQI’ has been running audits like the [Prescribing Observatory](http://www.rcpsych.ac.uk/quality/quality%2Caccreditationaudit/prescribingobservatorypomh/templatehomepage.aspx) and [National Audit of Schizophrenia](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/nationalschizophreniaaudit.aspx) for over 10 years.  There is good evidence that their focus on things like high dose prescribing and physical health are making a difference. Fewer patients are now prescribed antipsychotic medication above BNF limits and more patients are starting to have regular assessments of their physical health. However, access to psychological treatments remains poor and the speed with which services respond to mental health crises is still very patchy. A recent audit of Early Intervention in Psychosis services showed how long some people still have to wait before being taken on by a specialist team.

Finding out that services are not delivering high quality care is one thing; doing something about it is another. This is where our quality improvement networks come in. These programmes support services to conduct a self-review against national standards. This is then followed up by a visit from colleagues working in a similar type of service, along with service user reps and staff from CCQI.  The team discusses what they find compared to the results of the self-review with the local service and highlight strengths and weaknesses. Most of the CCQI’s quality improvement networks offer services the option of applying to be formally accredited by the RCPsych.

Now I know what you thinking, that is just a voluntary version of the CQC.  And we know the CQC is, well, not the most popular institution in the country.  When a service is informed that the inspectors are calling, the reaction is rarely  “jolly good, what fun - this is something that I am really looking forward to”.  We can put to one side the question as to whether or not they do a good job - that’s for others to answer - but we can say with some confidence that the job of a regulator is not to be popular.  Just ask the GMC.

But our quality improvement networks operate differently.  For a start, they are voluntary. They work with individual clinical teams rather than descending en masse in an attempt to assess a whole trust. But most importantly of all they provide structured feedback about specific strengths and weaknesses in a service as well as tailored support and advice about what other teams have done to improve when they have faced similar types of problems. Services that take part also have access to discussion groups and learning events where members identify areas they are struggling with and share good practice.

No one fails, which could very well leave them open to be named and shamed in the Daily Mail.  All that happens is that CCQI work with you to improve your game until you pass, and as a result  a get a coveted kite mark.  It’s a bottom up system of quality improvement, rather than top down.  And as the literature confirms, top down inspections can detect egregious examples of the unacceptable and they are much less effective in raising general standards.

Here’s another example.  One of the first networks, ‘[ECTAS](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/ectclinics/ectas.aspx)’, has delivered big improvements to the quality of ECT services around the country - 10 years ago some of these were in a bad state. We know that ECT has a small, 'though well-defined and sometimes life-saving role to play.  But more than anything else when done badly it can give us a bad press that can take decades to overcome. It is just possible that people are starting to forget “One Flew Over the Cuckoo’s Nest”, but the reactions to the revival of Harold Pinter’s “The Caretaker”, whose emotional centre piece is Aston’s monologue remembering the ECT he had received, shows that this an area in which we have an absolute duty to maintain best practice if we are to maintain public confidence in something that we believe needs to remain available in extremis.

Other programmes like [Accreditation of Inpatient Mental health Services (AIMS)](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/whygetaccredited.aspx) and [inpatient CAMHS services (QNIC)](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/childandadolescent/inpatientcamhsqnic.aspx) have done much to help improve the quality of hospital-based care that patients receive. The great thing about these programmes is that they support teams to learn from peers, share good practice and then solve problems based on the experiences of colleagues.

But there are problems. While hundreds of services are now taking part in these programmes, many choose not to.  Some don’t because they think they are already good, and others because they know they are poor. What struggling services need to know is that the College’s quality improvement networks support teams to improve through sharing the experiences of other teams that have already been through the process. Mental health services that are not quite ready for accreditation are supported by the CCQI to reach the standards required over time and with help, most services are able to achieve accreditation.

Another problem results from the very limited use of routine outcome measures in psychiatry. This means that, while accreditation programmes can help ensure that care is delivered in accordance with recommended standards, it may still not be clear that this results in better health for patients. In response to this, services aiming for CCQI accreditation are now being asked to collect and make use of clinical outcome measures. The more services that use outcome measures, the more confident we can be that our patients are benefiting from the care we provide.

Numbers matter; they help you counter criticism when something does go wrong. It is significantly easier to be able to say that this was an isolated incident and not part of a general pattern of poor care if you have the data to back that up.  And whilst it is not the point of measuring outcomes – it can also make a difference to clinicians when it comes to applying for ACCEA points and awards.  One reason that Psychiatrists don’t do as well as, for example, surgeons is because they can point to routinely collected outcome data as objective measures of service excellence, and all too often we cannot.

All Trusts in England and Health Boards in Wales now take part in the audit programmes and staff working in the quality improvement networks went on over 500 visits to hospitals across the country last year. Methods developed by psychiatrists and colleagues at the College have been taken up outside the UK to assess and improve the quality of care provided elsewhere in Europe and beyond. At a time when there seem to be continuous ‘cost improvements’ and morale is often “challengingly”  (as you can tell, we are rehearsing our entry for the annual NHS Cliché of the Year competition) low, the quality improvement networks are doing their best to give staff something to cheer about. Taking part in the network requires time, resources and commitment, but our members consistently tell us that the benefits of belonging to a peer-led network far outweigh the costs.

The CCQI plays a vital role in justifying why we continue to need institutions like the Royal College in the 21st century. The RCPsych does indeed represent our profession, and long may that continue.  But the public can lose sight of the fact that the purpose of the profession, and therefore the College, is ultimately to improve our understanding and treatment of mental illness. And part of that must be to improve the quality of care that patients receive.  This is not a peripheral objective, but a substantial part of why we exist.

So to go back to the beginning: we know that no one reading this will go to work tomorrow determined to do a bad job.  We were attracted to psychiatry to do the opposite - to in some shape or form improve the lives of those with mental illness, both presently and for the future. The CCQI is here to help you achieve it.  Try it.

**Professor Sir Simon Wessely**

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