

The Muslim Council of Britain

Response to The Healthcare Commission's Consultation process

21st February 2005



Assessment for improvement: Our approach

The Muslim Council of Britain (MCB) is an umbrella organization with over four hundred national, regional and local Muslim bodies and associations including mosques as its affiliates. It aims to enable the Muslim community to realise its full potential by participating in and contributing to the mainstream society.

Our response to this consultation document considers how the Muslim community (the largest non-Christian faith community in the UK) will benefit from the assessment process that endeavours to achieve the objectives that:

- *Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.*
- *Public Health: Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.*

Introduction:

Will our proposals ensure that we engage effectively with patients, the public and healthcare professionals? Are there other or different steps we should be taking?

- The proposals outlined in this document are laudable and are indeed relevant to those who use and work in healthcare. Unfortunately there is a category of individuals who either do not use the healthcare services optimally or are not aware of what the healthcare system is striving to offer them. Certain minority groups - faith groups and refugee and asylum groups fall in this category.
- Communities differ in their ability to organise themselves and to articulate their views. With regard to healthcare we know that the communities most vulnerable to health inequalities are least likely to participate in and respond to such consultation processes.

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- In a resource-restricted atmosphere, such communities may also be seen as 'resource-consumptive' - competing for the limited resources available for mainstream communities.
- It is likely, therefore that if the process is not appropriately focused there may be a widening of the inequalities gap.
- While the NHS and healthcare providers have a real desire to minimise inequalities and improve access for such communities it is clear that special efforts must be made to reach and engage these communities. It is important therefore to ensure that arrangements to address inequalities are robust and include all sections of the 'disadvantaged communities'. This requires attention to capacity building within these sections of society. How does the Healthcare Commission propose to ensure that the interests of this section of the community are not overlooked in the assessment process? We suggest an auditable assessment template (see Appendix)

Are we measuring what really matters for patients and the public; for clinicians and for different types of healthcare organisations?

Most individuals' personal experience with healthcare is with their general practitioner. Based on this experience individuals will form their own opinions and assessment. While NHS Trusts (Acute of th, Mental Health and Primary Care Trusts) undergo comprehensive assessment of their performance there is little that one hears of the performance of individual surgeries. Many surgeries have reformed the way they provide services. Is there an objective method of assessing this most important interaction between the public and the NHS. Are there national standards for GP services? If so, are they in the public domain, easily accessible to patients to make informed choice? Who makes objective assessments and publishes star ratings for individual general practitioner sites in a given PCT?

Is there anything else that should be included in our proposals?

Healthcare workers need to be aware of the diverse cultural, religious and social needs of the various communities they serve. This is a necessary pre-requisite for provision of cultural and faith-sensitive services.

How often should we present our findings and what format would you find most useful?

This should be on an annual basis. It is important to note progress and see it maintained. This does not preclude investigation and publication of specific information on different themes.

An annual report has the advantage that adverse comments or findings in one year may be rectified by the following year. Consumers would be reassured to know about this. Equally, having made improvements healthcare providers will be anxious to ensure that information on improvement has been disseminated.

Guiding Principles for the new approach to assessing performance

Will our proposals identify failings in the provision of healthcare and lead to appropriate steps to address these?

If robustness of arrangements for the 'disadvantaged' communities is included in the assessment process, we believe failings in the provision of healthcare to these communities will be identified.

Will our proposals offer sufficient support to healthcare organisations' continuous efforts to improve their services?

Healthcare organisations are always anxious and enthusiastic about improving their services.

It has now become customary for healthcare organisations to be asked to make significant changes without providing the resources to accomplish the new targets. As the 'goal post' changes, healthcare providers may concentrate their efforts on achieving new targets, often at the expense of other areas where improvements may have been made in previous years.

Do you believe that the assessments that we make will be fair?

Yes.

Do you believe that we will make assessments transparently?

Yes

Overview of the new approach:

Do you have any concerns about the phased approach?

Healthcare organisations respond to changes that are assessed for star ratings. Thus aspects that formed the focus in previous years are likely to be ignored.

Can you suggest better ways that we can use information? How can we help to assure and improve the quality of information available to us?

The changes to assessment system should result in greater participation of the public – the end user of the services. An increasing participation of and feedback from the end user is the best indicator that the quality of information has improved indicating that general public understand the report and are in a position to participate in the deliberations.

Will the proposed approach achieve the right balance between effective assessment without undue burden on those assessed?

We hope so.

Healthcare organisations taking responsibility for their own performance and effective independent assessment

A very significant proportion of health service is accessed through primary care.

Often the services provided at primary care determine the pattern of use of secondary care services.

What arrangements exist to audit the services provided by general practitioners?

Would it be appropriate to use patient experience and patient journey in both primary care and secondary care as a tool for measuring adequacy and appropriateness of services?

Getting the basics right

Is the process by which we are proposing to assess compliance with the core standards, in particular, the intended use of a trust's declaration that incorporates the views of other organisations is the local healthcare community?

Could this lead to Trusts diverting their energies and resources in preparing impressive and possibly 'creative' reports?

Experience of Control Assurance – a tool for assessing locally standards of quality within the trusts, shows differences in approach – either as a result of differences in interpretation of the requirement or applying a different standard when responding.

How can we be confident that self-declaration is appropriate and honest? Would sanctions further damage the healthcare provided to the local community?

Should trusts be asked directly to state which of the core standards, in their opinion are not being met and what action is proposed to achieve them. How can you ensure that the self-assessment is proper and interpretation of standards and the Trusts' interpretation of their compliance with standards is applied uniformly?

Annual performance ratings

We note that while there will be an annual review and report in relation to each healthcare organisation, the elements that will apply to each organisation will vary with time and from year to year. Would organisations know which element is being looked at before the review? Will the element looked at in a given year be the same for all organisations within a given category?

Recognising improvement: important, Examples of good practice and how it has been achieved could be publicised and presumably available for other organisations to share and emulate!

What comments do you have on our proposals for:

- **Making information publicly available, in particular, the possibility of publishing results as they become available within an annual cycle of review?**

Having asked for comments on the process of assessments, it is important for the public to be kept informed. We think therefore that the information should be publicly available.

- **Do you have a view on how we incorporate assessment of leadership and organisational capacity in the annual rating? Should it be part of a single overall rating or a separate rating on the organisation's prospects?**

The overall performance of the service (core purpose of the organisation) in itself should be an indicator of its leadership and organisational capacity.

Independent Healthcare

Do you agree with our proposals for independent healthcare to reduce the burden of regulation through proportionate inspection that is effective in targeting risk?

Yes

Appendix:

Assessing the robustness of Inequalities Agenda and attention to some specific needs of the Muslim community

It should be appreciated that BME communities are not a homogeneous group, their needs are different, solution to their problems need separate approaches, methods of reaching them may be different. These need to be taken into consideration when assessing healthcare provision to the groups

There should be specific and measurable targets for meeting the inequalities agenda.

A provider that wishes to remove health inequalities should have first established the burden of disease and disease pattern in its BME and faith communities.

Perceptions and needs of the local (minority) community should be ascertained.

How are the most vulnerable and least vocal being reached? Is there a programme of screening such individuals for health? Are there voluntary organisations that cater for the requirements of these 'disadvantaged' communities? How do they engage with the local voluntary organisations, local mosques etc?

How do providers establish their community's need and how they engage the vulnerable community should form a measure of their commitment to removing inequalities. Only then would their proposed agenda for change be credible.

Having identified the needs of the community, how do providers plan to go about addressing the issues?

What is being done to improve awareness? Is the right approach being taken to educate the relevant group: using the language, medium and appropriate individuals?

Do PCTs and local service providers have appropriate resources (or allocated appropriate resources) to meet the inequalities agenda, commensurate to their burden of the population? Is this also going to be assessed?

How is the healthcare organisation's 'inequalities of resources' going to be addressed? How is fairness assessed?

How are different groups engaged or consulted? Health Promotion and Health awareness and healthcare provision should be cultural and faith-specific – if they are to benefit.

For many minority ethnic groups faith plays an important role in their lives. What use do healthcare providers make of the local mosques and community centres to access the hard to reach sections of the community?

What health promotion and health awareness programmes have been set up? What screening services are provided?

Provision of multi-faith spiritual care has also become an aspect of good care;

some trusts either have very good arrangements and/or will respond to such new emerging standards – but many would not include this in their list of priorities. How does the Healthcare Commission propose to cover this kind of 'inequalities'.

Food: Dietary requirements for certain groups are exacting,

eg from faith perspective. Attention to this is not included in Core standard 15 of Fourth Domain.

Patient dignity:

same sex wards are not appropriate form of delivering culture-sensitive, faith-sensitive healthcare services.

Need to define different patient groups and ensure that all types / groups are focused on. How do we ensure that these are met?

Over representation of ethnic minority patients in the mental health system

is a matter that gives cause for great concern to the community. How can the Healthcare Commission address this issue?