Patient-Led Assessments of the Care Environment (PLACE)

What do we mean by “patient-led”?

Purpose of this paper

1. At their meeting on 15th March 2012, the Steering Group requested further information on what is meant by “patient-led” inspections. They urged the Delivery Group to be ambitious, especially in respect of actual patient involvement in the inspection process. This paper articulates our thinking to date. It is incomplete and will develop as the project unfolds.

Background and introduction

2. The current Patient Environment Action Team (PEAT) inspections were set up in 2000. There was extensive patient engagement in the early years to define what aspects of the built environment should be assessed and how. This has continued since then, especially at the point where assessments of privacy and dignity were included.

3. The Health and Social Care Information Centre (HSCIC), who are responsible for PEAT, advise that patients should be involved in the inspection process, and over 80% of inspections do include at least one patient representative, often drawn from Local Involvement Networks (LINks). However, representation is varied and patchy, and there is concern that in some cases it may be tokenistic.

Proposals for engagement in the new inspections

<u>Design</u>

4. We are consulting extensively with patients around the design of the new system. This includes seeking feedback and ideas about practical involvement with the inspection process. Planned activities include:

    a. A one-day in-depth workshop for representatives from around 15 patient organisations
    b. A electronic survey of 3-5 representatives from each of around 130 organisations (up to 650 respondents)
    c. A two-hour Parliamentary workshop for representatives from around 60 organisations
    d. Regular consultation with DH’s Strategic Partners’ Group (18 organisations representing the Voluntary Sector)
    e. A possible series of Ministerial interviews with a suitable magazine (eg Yours), with request for reader feedback

<u>The inspection process</u>

5. This is where we need to make the biggest improvement from the current system. We cannot finalise our plans until after the design stage is completed and the feedback analysed; however, our current thinking is set out below.

6. The question sets will be devised with a specific focus on what patient's value, and will be worded in a manner that places the patient's experience at the centre of the process.

7. Each inspection will include at least one patient representative. The *minimum* number of patients involved will increase with the size of the hospital, eg (exact numbers to be confirmed):

Fewer than 50 beds	1 patient
50-150 beds	2 patients
151-300 beds	3 patients
301-500 beds	4 patients
501+ beds	5 patients

8. Local HealthWatch will be offered the opportunity, as of right, to attend all patient-led inspections. If they decline or choose to provide fewer than the minimum number of patients, then the trust is responsible for recruiting other patients.

9. All patients will receive training in the inspection process (details to be confirmed, but likely to be delivered locally, using centrally produced materials supplemented with local information). Remuneration should be in line with local policies on patient engagement.

10. The inspection record will contain a number of questions that must be answered by the patient representatives only. These are to be devised, but might include:
    a. Are you (as patient representatives) happy that this inspection report is a fair and accurate description of the service you inspected?
    b. During the course of the inspection, did you see anything that you wish to report to the hospital management that is not covered in the inspection report?
    c. What improvements would you like to see before next year's inspections? (this question may be repeated after each section, and at the end as a "catch-all")
    d. What did you see that is worthy of particular praise?

11. The inspection will include a question about the extent to which local surveys cover privacy and dignity, food, cleanliness and facilities management. Failure to include these topics will be marked down.

12. Hospitals will be provided with a number of case studies showcasing good practice, aimed at helping them ensure that patients give a truly independent view. Such examples might include:
    a. Giving patient inspectors some time together without other members of the inspection team present, to discuss their findings in private
    b. Debriefing patients after the inspection by a recognised patient advocate (e.g. complaints manager, PALS service etc). Debriefing would offer the patient the chance to review their involvement, and to confirm that they were not under undue pressure to record a result they disagreed with

c. Contacting the patient by post or email one week after the inspections, thanking them and asking them to confirm that they were still happy with their assessment

13. Patient inspectors will be asked to formally sign-off the final inspection report (which may be produced after the inspection date).

Validation

14. Again, we cannot finalise the extent of patient involvement in validation until later in the project. In particular, we need to consult with LINks/Local HealthWatch and with local commissioners to agree the extent of their involvement. However, our early thoughts are outlined below.

15. PEAT validation is limited to sending an independent assessor to xx% of inspections. No patients are involved at all at this stage. For the future, we are considering the following possible options for patient-led validation. Other (non-patient led) validation actions will also take place.

16. Patients will be included in the list of independent validators held by the HSCIC, and deployed in up to xx% (to be determined) of inspections. These patients will receive extra training.

17. Local HealthWatch will be asked to confirm that the summary results of the inspection are broadly compatible with their own intelligence about the hospital.

18. The main local commissioner will be asked to confirm, *with their own patient groups*, that the summary results of the inspection are broadly compatible with their own intelligence about the hospital.

19. HSCIC will incorporate the results of national patient surveys (eg the Care Quality Commission's Inpatient Survey) into the final rating where possible (not all hospitals undertake the inpatient survey).

Conclusion

20. Increasing the amount and quality of patient involvement in the inspection process is essential. We plan to consult extensively over the next few months in order to devise a system that clearly gives the defining voice to patient inspectors. We will pilot the approach in October 2012.

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