Steering Group Update paper
Patient-led inspections of the hospital environment

1. On 6th January 2012, the Prime Minister announced the introduction of a new patient-led inspection regime, covering privacy and dignity, food, cleanliness and facilities management in hospitals. The results of these inspections (which will replace the current Patient Environment Action Team (PEAT) inspections from April 2013) will be reported publicly, to help drive up standards of care. The key feature will be the involvement of patients or their representatives at all stages, including development of the system, the inspection process and validation of inspection results.

2. Earlier meetings of both the NQB and the Steering Group (SG) provided clarification, direction and advice on a range of issues. This note:
    a. provides an update on activity to date
    b. seeks further advice on issues that have been revealed in the course of work to date
    c. seeks approval for proposals where early decisions are needed to assist planning and development.

3. Since full background was included in the initial paper considered at the previous SG meeting, it has not been included in this paper.

Activity to date

<u>Stakeholder Consultation</u>

4. Patient consultation has included:
    a. Consultation with the Department's Strategic Partners' Group, who represent the voluntary sector, to advise on the overall direction of patient engagement work
    b. A workshop with 15 patient-representative groups, to confirm the scope and broad direction
    c. An on-line survey of 2,700 respondents to identify the most important elements in each domain, for use in weighting the final score (see Item 5)
    d. Meetings with specific interest groups including the National Children's Bureau, the Royal National Institute for Blind People, and the National Council for Palliative Care, to identify their particular needs.

5. The overall feeling was that the direction was right, with good consensus about what matters most in each domain, and a firm commitment from almost all groups to participate in piloting and in the final inspections.

6. Meetings have also been held with a number of other organisations including the Care Quality Commission (CQC), the Infection Prevention Society (IPS), and NHS Choices. Further meetings are being organised with the National Institute for Health and Clinical Excellence (NICE).

Development of a revised assessment

7. Drawing on the patient involvement work to date, we have held meetings with the Association of Healthcare Cleaning Professionals, the Healthcare Estates and Facilities Managers' Association and the Hospital Caterers' Association to begin to transform the views of patients into a workable assessment. This process is likely to be complete by the end of July.

Planning of pilot inspections

8. A detailed plan for the pilot phase has been drawn up. We expect to pilot in at least 60 hospitals across the range of sectors. Annex A has details.

Costing and impact assessment

9. We are continuing to work on the equality impact assessment, the economic impact assessment and the likely burden for hospitals and DH.

Specific issues on which the Steering Group's advice or approval is required

10. The following issues require discussion / advice:

Item 1 - Cost neutrality

11. A stipulation for the new process is that it be cost neutral once in place. At present, there are no costs associated with participation in the PEAT process other than staff time. This varies depending on the size of the team and the period over which they conduct the inspection. In practice, we believe that the PEAT process is now considered 'business as usual'.

12. We are committed to devising an inspection that takes no more time to complete, with any increase in detail being offset by a simplified process. That said, we cannot increase involvement of patients without an increased local burden in recruiting and preparing volunteer inspectors. We therefore welcome the SG's view on what 'cost-neutral' means in practical terms, and whether a small increase in administrative time would fall within that broad definition.

13. The SG is asked to provide advice on the interpretation of 'cost neutral'

Item 2 - Inclusion of other sources of data

14. Any inspection that takes place only once a year has limitations. In addition, there are issues that patient's rate as important, but that are difficult to inspect directly (eg the levels of noise at night). Including other sources of information would produce a more rounded report.

15. Suitable sources include the CQC In-patient Survey and the Estates-Related Information Collection (ERIC). However, such information is not available from the private sector; neither is it available from all NHS organisations.

16. Including such sources means that different sectors would be assessed in different ways, although hospitals of a similar type will all be measured in the same way – i.e. all acute hospitals, all mental health hospitals. We feel that the added benefits of a more rounded report for some sectors outweigh the problems of poor comparability between sectors.

17. The SG is asked to advise on whether we should seek to include other relevant sources of information even where this may not be available for all organisations, with the proviso that all organisations of a particular type (e.g. all acute hospitals) will be treated identically

Item 3 - Date of first inspection

18. PEAT inspections are currently undertaken between January and March. The requirement for the revised process to be launched in April 2013 means that this timetable cannot be continued next year.

19. There are mixed feelings on when inspections should take place. Some dislike the current period because January and February are times of peak winter pressures, whilst March is a time when many staff take leave. Others argue that this is precisely why it is the best time – since if an organisation performs well in Jan-March then it is likely that they will do so in easier times. A further criticism of the Jan-March slot is that information from the inspection comes too late to build into capital-planning schedules.

20. There are two issues on which we seek the SG's advice; when should the 2013 inspections take place, and should we seek to bring them back to Jan-March from 2014? (Note that this would mean two inspections within one 12-month period).

21. *The SG is asked to advise on the date (month) of the first inspections, and on the timescale for the programme in future years*

Item 4 – Advance notice of inspection

22. The NQB requested that we consider returning to an 'unannounced' inspection.

23. From 2000-2003, PEAT inspections were undertaken by independent teams of volunteers from the NHS, FM contractors and patients. Trusts were given 48 hours' notice that their inspection was to take place. This imposed a considerable central administrative burden.

24. Maintaining a large enough bank of volunteers became increasingly difficult and in 2004, in line with other data collections, the process moved to one of self-assessment. Since then, whilst guidance advises that notice of the inspections be kept to the minimum number of people, we do know that in many places the date of inspections is known well in advance.

25. It is impossible to have a completely unannounced inspection when hospitals are recruiting their own patient inspectors, who must be given sufficient notice to arrange diaries etc. We therefore propose a system

whereby hospitals are given four weeks' notice of the week in which they should undertake their inspection, with the precise day being left to local determination. Whilst this will not return to the pre-2004 system, it will reduce the period of warning and remove the current position whereby the hospital is in total control of determining the date of inspection(s).

26. The SG is asked to advise on the issue of advance notice – whether they wish this to be built in to the process, and if so whether they agree the above proposal

27. The following items require approval:

Item 5 - Weighting

28. Weighting allows us to identify specific elements where failure to meet the required standards leads to a penalty (eg a hospital with poor cleanliness is marked down even if all other components are excellent). We believe the ability to retain this is important.

29. At present, PEAT weights the environmental assessment by performance in respect of the National Specifications of Cleanliness (NSC). These have been superseded by a Publicly Available Specification that is not compulsory, and does not produce a result that is directly comparable across organisations. We therefore need a new approach to weighting – or to abandon it altogether.

30. We propose a weighting process based on the items that patients have identified as the most important. We also propose extending weighting beyond cleanliness to include food and, if possible, the environmental and privacy and dignity components. Subject to the SG's views, we would produce more detailed proposals on how this would operate in practice.

31. The SG is asked to approve our proposal to continue to weight the assessment and to extend this beyond cleanliness to other sections of the assessment

Item 6 - Annual assessments

32. The NQB asked us to consider how we might increase the frequency of inspections – particularly for larger hospitals.

33. Whilst undertaking more frequent local inspections is good practice, we do not recommend it for the national programme because:
    a. it would undoubtedly raise costs both for the NHS/independent sector and centrally in terms of administrative support
    b. it would undermine the reporting process which requires all results to be published on the same day – subsequent further inspections could not therefore be included in the publication

34. Instead, we propose an annual inspection as a default, with earlier re-inspections where problems are identified.

35. The SG is asked to approve the proposal to continue on an annual basis – subject to satisfactory arrangements being in place for identifying/acting on poor performance

Item 7 - Number of patient inspectors

36. Although many hundreds of patients already take part in PEAT inspections, involvement across the board is inconsistent. We therefore wish to formalise and strengthen their involvement. We propose the following minimum numbers of patient inspectors:
    a. hospitals with up to 149 beds – 2
    b. hospitals with 150 to 249 beds – 3
    c. hospitals with 250 to 499 beds – 4
    d. hospitals with 500 to 799 beds – 5
    e. hospitals with 800 or more beds – 6

37. The SG is asked to approve the minimum numbers of patient representatives to be involved in inspections

Item 8 - Sampling and scope

38. The current requirement is that for hospitals with 10 wards or fewer, the entire hospital should be inspected, and for hospitals with more than 10 wards a 25% sample (with a minimum of 10 wards) is acceptable. We propose to retain this in the revised process.

39. We would also like to specify the type of wards to be inspected. For example, requiring the inclusion of wards providing care for patients with dementia/delusion (where they exist) would provide a powerful way of promoting wider Government policy (e.g. the Dementia strategy). Furthermore, we recommend requiring larger hospitals to ensure that different wards are inspected in subsequent years so that over a 4-year period all wards will be inspected even in the biggest of hospitals.

40. Finally, the NQB also requested that we consider including all hospitals in the scope of the programme – currently any hospital with fewer than 10 beds is excluded. For the NHS, this would add in the region of 180 hospitals to the total requiring inspection – although clearly as these are all very small the time taken to undertake inspections would be minimal. We have no firm figures on numbers in the independent sector.

41. The SG is asked to approve the above recommendations on the scope of the inspection programme both in terms of hospital and sample size

Item 9 - Inclusion of a 'what would improve things' question

42. To help drive up standards, we propose that the process should identify actions for improvement for each domain of the inspection, with an overall "What would you like to see at the next inspection?" question at the end of the assessment. The question would be for patient inspectors only to answer. The answer would form the basis for a follow-up action plan

drawn up by the organisation, which could be monitored through subsequent inspections.

43. We feel that this goes a long way to answering the NQB's exhortations to be ambitious in our interpretation of "patient-led". Clearly, some recommendations (eg "provide free car parking") might be rejected, but none-the-less we feel it is important that the hospital management considers them seriously.

44. The SG is asked to approve the inclusion of a 'what would make things better' section within the assessment (final wording to be confirmed).

Item 10 - Local surveys of cleanliness, environment, food, and privacy and dignity

45. The Operating Framework 2012/13 states "NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on … local and national surveys." We believe it is good practice that cleanliness, environmental factors, food and privacy and dignity should be included in such surveys. We therefore propose to include a question on whether organisations undertake such surveys, and for organisations to be rewarded for this with extra marks.

46. The SG is asked to approve the inclusion of a question relating to the undertaking of local surveys, and for this to be recognised in the final assessment

Next Steps

47. Subject to SG approval, we will enact the items above.

48. The next key area for consideration will be how the new scores are used in practice, including escalation and sanction. Currently, PEAT scores are published locally and nationally, but there is considerable variation in terms of how they are acted on. They are used by SHA performance management staff, commissioners and CQC, but the weight given to them is varied and there has been no consistent approach to escalation, or how poor performance is managed. For instance, a hospital falling from "excellent" to "good" may pass unnoticed. Conversely, a hospital with excellent ratings in all other areas may be picked up by CQC if they are deemed to be only satisfactory in PEAT terms.

49. We will work with CQC and with emerging teams at NHS Commissioning Board (NHSCB) to ensure that a consistent (and achievable) approach to escalation and sanction is built into the guidance. We will report on this at the next SG meeting.

Conclusion

50. Progress to date has been satisfactory and the project remains on track. We need the Steering Group's opinion and advice on a number of issues to support our next steps.

51. A key item for consideration at the next SG meeting is escalation and sanction for hospitals that perform poorly in patient-led inspections. This will be discussed with NHSCB.

Annex A - Patient-led Inspections pilot phase plan

The new patient-led inspections will be piloted during October 2012. The pilot phase will enable us to test the following:

1) the inspections process in terms of what worked well/not so well – from both patient inspectors and NHS staff
2) gather sample data to give a picture on whether the new scoring mechanism is working, whether the scoring mechanism is allowing us to detect excellence, and what the data would show in terms of a national picture. This will also give us baseline data to allow us to model aggregating the results of the inspection with other data relating to the environment/patient views.
3) whether patient recruitment mechanisms are realistic in practice
4) that the new inspections work for all types of setting, and size of unit / hospital.

Papers / documentation required:

1) Brief for Trusts – this will set out what exactly will be expected of them during the pilots, including areas to be inspected, information on the new scoring mechanism, how to recruit and train patient inspectors.
2) Patient recruitment guidance – this will set out how to recruit patient inspectors, what skills and experience to look for, and how many inspectors should attend each inspection.
3) Training guidance – this will be for NHS staff and eventually local Healthwatch to use when training patient inspectors.
4) New patient-led inspections assessment form (excel spreadsheet version to be produced for the pilot phase only with scoring mechanism already built in).
5) Pilot questionnaire – this will be for pilot Trusts to complete following the inspection. The questionnaire will ask specific questions about the inspection process, with a free text box to allow for further comment.

Pilot site selection:

Pilot site selection will be based on the type of facility and bed numbers, to ensure that we test the inspections in as many different type of setting as we can. We are intending to pilot in around 60 sites.

Type of facility:

1) Acute
2) Specialist
3) Mental health/Learning Disabilities
4) Community
5) Children's

Bed numbers and minimum number of patient inspectors:

1 to 149 beds – 2 patient inspectors
150 to 249 - 3
250 to 499 - 4
500 to 799 - 5
800+ - 6

Timetable for pilot phase:

DATE ACTION	**ACTION**

COMPLETE BY	
14/06/12	Write to current Patient Environment Action Team (PEAT) contacts to seek pilot volunteers
29/06/12	Deadline for pilot expressions of interest
06/07/12	Complete analysis of pilot expressions of interest to ensure cover all category types (see below)
13/07/12	Write to those Trusts not chosen as a pilot
13/07/12	Write to Trusts that have been chosen as a pilot. Letter to include dates for undertaking inspections – between 1st and 12th October. With results in by 19th October
17/08/12	Send out training materials and recruitment guidance to pilot Trusts
14/09/12	Send out new assessment form, questionnaire and excel spreadsheet version of assessment form to pilot Trusts
01/10/12	Start of the pilot phase
19/10/12	Pilot inspections complete and results returned
16/11/12	Review and analyse pilot results and feedback