WESTMINSTER BRIEFING

The HOUSE MAGAZINE

New Hospital Inspections: What to Expect and How to Prepare

16th January 2014

"New Hospital Inspections: What to Expect and How to Prepare"

Chaired By:

Susan Biddle,

Healthy Communities Consultant

"New Hospital Inspections:
What to Expect and How to Prepare"

Morning Policy Session:
Current and Future Policy

"New Hospital Inspections: What to Expect and How to Prepare"

Ann Ford *&* ***Mary Cridge****,*

Heads of Hospital Inspection,
Care Quality Commission

Care Quality Commission

The new CQC approach to hospital inspection

Inspection as a driver for quality improvement

Ann Ford & Mary Cridge
Heads of Hospital Inspections

January 2014

Our purpose and role

Care Quality Commission

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

The new CQC hospital inspection programme

- We recognise that the previous CQC approach was flawed – but it had good elements, in particular in relation to rigorous evidence gathering.
- We will build on the Keogh Reviews process for 14 acute hospitals with high mortality.
- We are aiming to bring together the best of both approaches (and more)
- We aim to be robust, fair, transparent and (hopefully) helpful.

The Chief Inspector of Hospitals' task

Care Quality Commission

- To inspect all acute NHS hospital Trusts/FTs by December 2015.
- To assess whether a Trust is safe, effective, caring, responsive to patients' needs and well-led.
- To provide a rating on each Trust:

  Outstanding
  Good
  Requires improvement
  Inadequate

- To re-inspect when necessary and to undertake focused reviews in response to specific concerns.
- To extend the programme to include mental health, community service and ambulance trusts (and independent sector equivalents).

CQC's approach

Care Quality Commission

- 3 phases:

1. Preparation
2. Site visits
3. Report

Phase 1: Preparation

Care Quality Commission

- Development of a datapack combining
  - Intelligent Monitoring
    (Safety, effectiveness, caring, responsiveness, well-led)
  - Local data from the Trust
  - Data from other sources
    (e.g. CCG, NHS England, HEE, Healthwatch, Royal Colleges, GMC)
- Development of Key Lines of Enquiry (KLOEs)
- Recruitment of inspection team members

Phase 2: Site visits

CareQuality Commission

- Announced and unannounced components
- Announced
  - Interviews: CEO, MD, DoN, COO, Chair + NEDs
  - Focus Groups: Doctors (senior/junior), nurses (registered/student), AHPs, Governors, admin + others
  - Patient and public listening event
  - Direct observation (e.g. wards, A+E, OPD)
- Unannounced visit – will pick up on issues identified at the announced visit.

Inspection Teams

Care Quality Commission

- Chair
- Team Leader
- Doctors (senior and junior)
- Nurses (senior and junior)
- AHPs/Managers
- Experts by experience (patients and carers)
- CQC Inspectors
- Analysts
- Programme management support

Total: Around 30 people

Core services

Care Quality Commission

- The following core services will always be inspected (as they carry the highest risk):
  - A+E
  - Emergency medical services, including frail elderly
  - Emergency surgical services, including theatres
  - Critical care
  - Maternity
  - Paediatrics
  - End of Life Care
  - Outpatients (selected)
- We will also assess other services if there are concerns (e.g. from complaints or from focus groups)
- The inspection team will split into subgroups to review individual areas, but whole team corroboration sessions are vital

Specialist services

Care Quality Commission

- We are aware that many services will not be routinely covered through these inspections e.g.
  - Diagnostics
  - Specialist services (e.g. ophthalmology, dermatology, renal)
- The current model will not be appropriate for assessing specialist Trusts (e.g. Alder Hey, Royal Marsden). Further work is in progress on this.
- Accreditation and peer review programmes will be vitally important. CQC will, in effect, 'accredit' accreditation programmes.

Rationale for ratings

Care Quality Commission

- The public want information about the quality of services presented in a way which is easy to understand
- The approach taken by Ofsted is seen as a model, though we recognise that hospitals are more complex than schools. Patients/public may, for example, be interested in a particular service (e.g. maternity or frail elderly care) rather than a single global rating
- Ratings of services and of Trusts should hopefully be a driver for improvement

Ratings: Proposed approach (1)

- A four point scale will be used for all ratings
  - Outstanding
  - Good
  - Requires Improvement
  - Inadequate
- Ratings will always take account of all sources of information
  - Intelligent monitoring tool
  - Information provided by Trust
  - Other data sources
  - Findings from site visits
    - Direct observations
    - Staff focus groups
    - Patient and public listening events
    - Interviews with key people

Ratings: Proposed approach (2)

CareQuality Commission

- Bottom up approach: Rate each of the 8 core services on each of the five key questions (safe, effective, caring, responsive, well led).
- Then rate the Trust as a whole on the five key questions, including an overall assessment of well led at Trust level.
- Derive a final overall rating.
- Note: Where Trusts provide separate services (e.g. A+E or maternity) on different sites we will attempt to rate these separately

Ratings: Proposed approach (3)

We will rate at:

- at location level for each domain for every acute core service provided;
- at location level for each acute core service;
- at trust level for each of the five domains;
- an overall trust level rating for all relevant core acute services.

	A&E	Maternity	Acute Medical	Acute Surgical	Critical Care	Paediatrics	End of Life Care	Out-patients
Safe								
Caring		Good						
Effective								
Responsive								
Well-led								
Overall								

Trust level				
Safe	Caring	Effective	Responsive	Well-led
	Good			

Overall trust level rating
Good

During Wave 2 we will be testing how we report at location (hospital level) and whether we will be rating at this level.

Safety

Care Quality Commission

Data/Surveillance

- Never events
- Serious incidents
- Infections
- Safety thermometer
- Staff survey (selected items)

Direct observation

- Safe environment
- Safe equipment
- Safe medicines
- Safe staffing*
- Safe processes
- Safe handovers
- Safe information/records

Effectiveness

Care Quality Commission

Data/Surveillance

- HSMR
- SHMI
- Mortality alerts
- National clinical audits

Direct observation

- Management of the deteriorating patient
- Care bundles
- Pathways of care

Caring

Care Quality Commission

Data/Surveillance

- Inpatient survey
- Cancer patient survey
- Friends and Family Test

Direct observation

- Staff/patient interactions
- Comfort rounds
- Patient stories
- Response to buzzers

Responsive

Care Quality Commission

Data/Surveillance

- Waiting time standards
- Cancelled operations
- Ambulance stays
- Analyses of complaints

Direct observation

- Patient reports
- Translation facilities
- ‘Comfort factors’

  (e.g. TVs, seating areas, rooms for parents)

Well-led

Care Quality Commission

Data/Surveillance

- Staff survey (7 items)
- Staffing levels
- Sickness rates
- Flu vaccination rates
- Board minutes
- Quality governance minutes
- Mortality reviews
- Handling/learning from complaints
- Risk register

Direct observation

- Interviews (CEO, MD, DoN etc.)
- Focus groups
- Board/ward interactions
- Staff reports (e.g. of bullying)

Summary

Care Quality Commission

1. The new approach to inspecting hospitals represents a radical change.
2. Quality will genuinely be at the heart of everything we do.
3. Please help us to shape the programme and join the inspection teams.

"New Hospital Inspections: What to Expect and How to Prepare"

Dr Patrick Cadigan,

Registrar,
Royal College of Physicians

The New Hospital Inspections

Dr Patrick Cadigan

FRCP FRCPE FRCPI

Heart of England Foundation Trust

Royal College of Physicians

Setting higher standards

An Inspector Calls

The New Hospital Inspections

- Prejudices
- Regulation post-Francis
- The new inspection experiences

Regulation post-Francis

Principles from the report

- Patients must be at the centre of the NHS
- The quality of healthcare must include all aspects of care, clinical and non clinical
- Patient safety must be at the centre of quality
- Openness and transparency are crucial
- The Bristol inquiry 2001

Robert Francis

"There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective"

Inspectors

"It is of real concern to me that as inspectors we have had no real training how we could potentially spot when this was happening "

(evidence to Francis inquiry)

Robert Francis

Recommendation 50

The CQC should retain an emphasis on inspection as a central method of monitoring non-compliance.

Robert Francis

Recommendation 51

The Care Quality Commission should develop a specialist cadre of inspectors by thorough training in the principles of hospital care. Inspections of NHS hospital care providers should be led by such inspectors who should have the support of a team, including service user representatives, clinicians and any other specialism necessary because of particular concerns.

Chief Inspector of Hospitals

Challenges for CQC and providers

- Resources
- Speed of implementation
- Defining standards of care
- High stakes of ratings
- Governance of judgements
- "Well Led" as a quality and safety domain
- Early warnings
- Failure to detect problems
- Politics
- Evolution and stability of system

Recommendation 53

Any change to the Care Quality Commission's role should be by evolution – any temptation to abolish this organisation and create a new one must be avoided.

Preparing for CQC

- Staff communications
- Emphasise positive
- Present problems and planned solutions at initial meeting
- Practical preparations
- Opportunity to review governance systems and processes

Question	Response	Evidence	How could staff respond?
For recent increase in HSMR and the spike in Geriatric Medicine SHMI in example, how quickly was the Board informed?	HED data show the Trust had a raised HSMR for June 12/May 13 of 113 (time periods of text and graphs do not match so cannot give a figure also SHMI from PWC) and monthly analysis shows a spike in mortality rates in February and March 2013. The Trust monitors mortality using Dr Foster data. The mortality spike in Feb/Match 2013 and raised HSMR April12/March 13 of 107.5 were responded to when the data became available at the end of June 13 and August 13 respectively /March 2013 of 107.5 and the spike noticed in January and February 2013 when the data became available. The Trust board was made aware of these trends at Board meeting on 2nd July three days after the Feb/March data was available from Dr Foster and possible raised HSMR for the year in the August meeting. The monthly Mortality and Morbidity performance group commenced a review into the diagnoses/procedures (using Dr Foster data) which alerted during Feb/March period using a combination of review of case notes, coding and data analysis including •Pneumonia •Acute myocardial infarction •Secondary malignancies •Diagnostic imaging of the heart The work to date has not identified systemic shortcomings in care in the largest two diagnoses groups and the procedure of diagnostic imaging of the heart although we have identified some opportunities for improvement. A provisional report on mortality for the above alerts will go to October G&R and Executive Management Board and a more detailed report covering the other alerts from HED data will be prepared by the end of October.	Draft of Clinical outcomes dashboard and introductory letter Terms of Reference of M&M group Report to Committee re: increased HSMR	

Feedback – what went well

- Felt different from previous inspections.
- Very thorough and professional
- Staff appreciated that they were being inspected by peers
- Staff enjoyed the interactions during the week
- Report picked up key areas of challenge (although we highlighted these at the outset)
- Support for difficult decisions

Feedback-what went less well

- Impression of “twin track” team.
- Lack of challenge or cross check to anecdote
- Final report more superficial and anecdotal and less “expert” than expected
- No in depth follow up or analysis of data variance eg FFT

Data Variance- FFT

Are services caring?

Most people we spoke to described their care as good and said that staff were caring, despite being busy. This was corroborated at the focus groups and listening events, in talking to patients on the wards and through the comment cards we placed around the hospitals.

FFT - CQC findings Jan 2014

"The trust was below the national average in the Friends and Family Tests introduced in both A&E and inpatients.This means that patients the numbers of patients who were likely to recommend the trust to a family member or friend was low. **This was in contrast to the positive feedback from patients during the inspection** who felt that, overall, care was responsive and provided in a sensitive and dignified manner, despite caring staff being busy"

We also think that while it is right that the CQC focus on surveillance and inspection, there needs to be an onus on the providers to be continuously assuring themselves that they provide good quality care. Assurance should be a vital part of board activity, not something that is done for the purposes of placating the regulator. CQC should be non-prescriptive on the form that assurance takes, but focus on questions of whether the frontline care meets the standard and whether the board would be able to tell if it did not

Nuffield Trust 2013

Final word

It is important to recognise that any system of regulation has its limitations. Like the police who are better at crime detection than crime prevention, regulators are likely to be more effective at retrospective inquiries to establish what has gone wrong than they will be at preventing deficiencies occurring in the first place. Regulators are always going to be more distant from the provision of services than the ward sister or the provider's Chief Executive.

"New Hospital Inspections: What to Expect and How to Prepare"

***Dr Linda Patterson**,*

Consultant Physician,

Former Clinical Vice President, Royal College of Physicians

Measuring Quality

The Physicians perspective

Dr Linda Patterson OBE FRCP

Jan 16th 2014

Royal College of Physicians

Setting higher standards

Quality

- Safety
- Clinical effectiveness
- Patient experience

The Mid Staffordshire NHS Foundation Trust Inquiry

Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009

Volume I

Chaired by Robert Francis QC

The Mid Staffordshire NHS Foundation Trust
Public Inquiry

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Volume 1: Analysis of evidence and lessons learned (part 1)

Royal College of Physicians

Setting higher standards

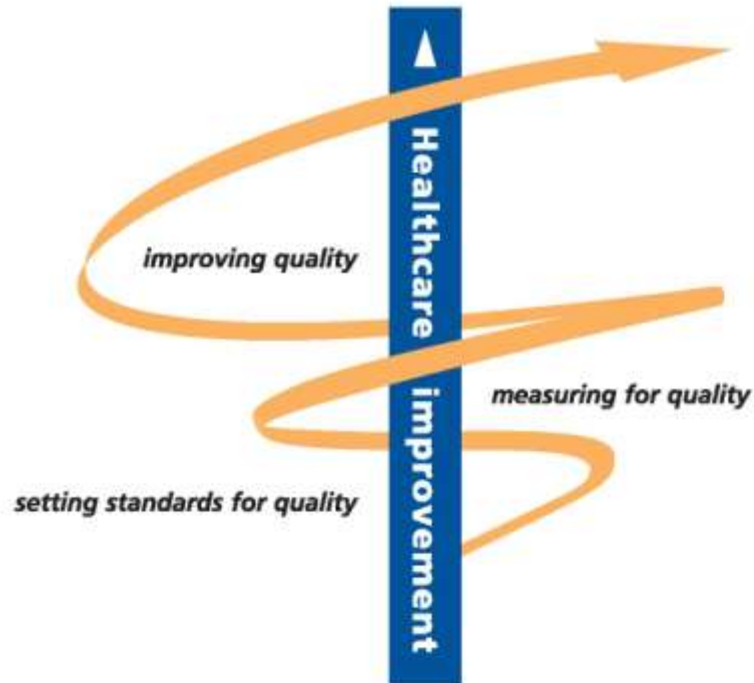
Patient experience

- Listen to what patients tell us -eg moving wards “like a parcel”
- Act –Future Hospital report -we will not move you unless clinically essential
- Consequences –we will have to change the way we work.

How to measure patient experience ?

- Revalidation
- Real time on wards
- Friends and Family
- National surveys
- Patient opinion, Iwantgreatcare etc
- Care Connect

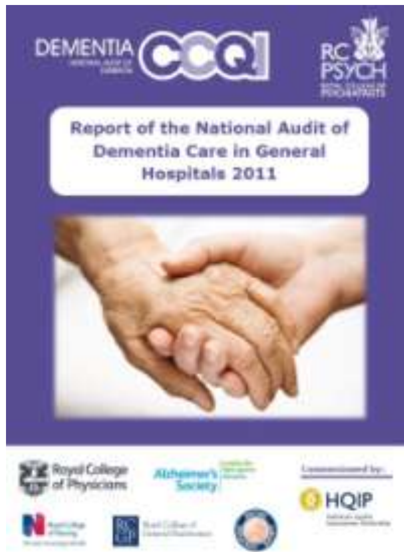
Defining Care, Measuring Care and Improving Care for Patients

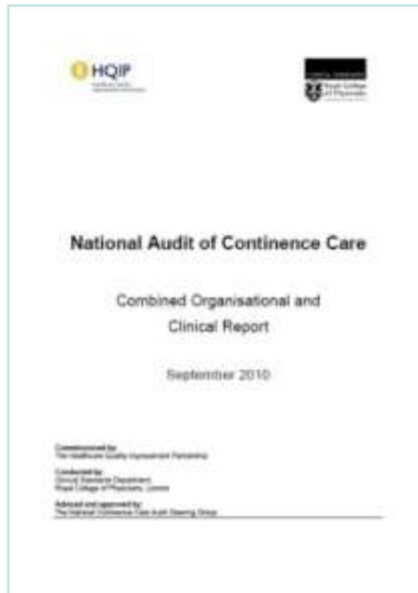


Clinical Audit

- Measurement for improvement
- Clinically led
- Multi professional
- Improvement tools

RCP audits





National Clinical Audit -we lead

with partners, developed qi tools

- **Fall/fracture** –care bundle developed National hip fracture data base.
- **COPD** –PREM developed
- **Inflammatory Bowel disease** -peer review
- **End of life care** –with Marie Curie
- **Asthma** –deaths, with Asthma UK and BTS
- **Stroke** –real time data, CCG level

National Clinical Audit –in partnership

Dementia

Lung cancer

Care of acute medical patients

Advise on Heart attack, Blood transfusion, intermediate care

Bid to evaluate the National Early warning score

Background to RCP Stroke Programme (RCP-SP) and CCGs

Why do it?

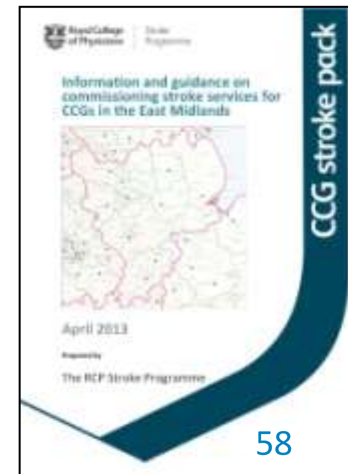
Paucity of high quality information for CCGs and clinicians about what to commission for stroke

We knew what they needed:

1. **Evidence** – what works
2. Clear and appropriately defined **targets/measures/indicators**
3. **Results** giving the optimal performance for the hospitals they commission benchmarked nationally and with surrounding competitors
4. If the service has problems, is there **help** available

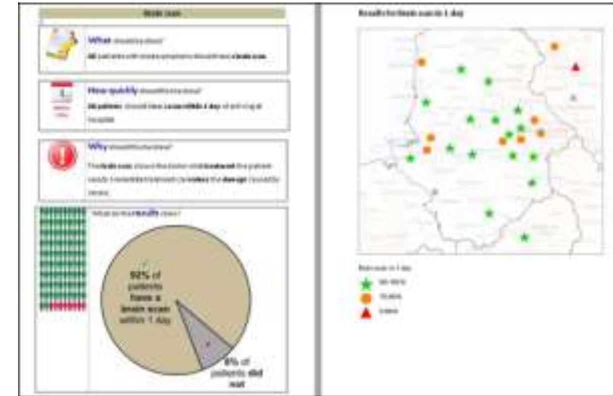
We put this into a **portfolio** and on **RCP website**

www.rcplondon.ac.uk/stroke/ccg



Presentation – website and hard copy pack

- Audit results presented in accessible formats
- Colour coded national and regional maps with CCG boundaries
- Stroke indicators clearly highlighted
- CD provided



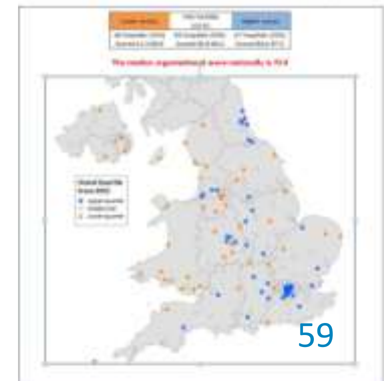
Dissemination

Initial mailout

- Hard copy packs sent to stroke lead in 211 CCGS
- Electronic portfolio sent to all known contacts

2nd wave mailout

- Commissioning support units
- Strategic clinical networks and senates
- Local area teams
- Public Health England



Accreditation

Accreditation

Joint Advisory Group on gastrointestinal **endoscopy (JAG)** accreditation scheme

Safe Effective Quality **Occupational Health** Service (SEQOHS) accreditation scheme

Improving Quality in **Physiological diagnostic Services** (IQIPS) accreditation scheme

Improving Quality in **Allergy Services** (IQAS) (under development – currently a registration scheme)

Quality Mark for **older peoples** wards (RCPsych)

Working on general methodology

Links with CQC

National quality mark for wards

Healthy staff

Health and Work development unit

NHS staff health improvement –
audit,(NICE guidelines) then visited 40 trusts

Consultant Responsibility

- One person in charge –need to change organisation of care –Future Hospital Commission
- Restate clinical leadership at bedside, holistic care of patients-hydration, pressure areas, dignity, kindness etc
- Needs teamwork, with nurses and others.

Ward leadership

Ward rounds in medicine Principles for practice

Setting Higher Standards – Professionalism

The Royal College of Physicians must

"uphold standards –both for their own honour and for public benefit"

1518 Henry VIII

"New Hospital Inspections: What to Expect and How to Prepare"

Afternoon Session: Policy into Practice

WESTMINSTER
BRIEFING

The HOUSE MAGAZINE

"New Hospital Inspections:
What to Expect and How to Prepare"

Carol Dight

Executive Director of Nursing and Governance,
Musgrove Park Hospital Taunton & Somerset NHS Foundation Trust

The New Hospital Inspections

What to Expect and How to Prepare

16th January 2014

Carol Dight Director of Nursing & Governance

Taunton and Somerset NHS FT

- One site acute Trust
- 700 beds
- 4000 staff
- £240m turnover
- Serve a population of between 350,000 to 500,000

- 1st wave of the first 18 Trusts selected
- Inspected on 23-24,27-29 September and 3rd October
- Quality summit 19th November
- Report published 21st November along with the data pack
- Improvement plan agreed with CCG by 19th December

Preparation phase

- Data and information review
- Communications
- Site preparation
- Development of presentation
- Logistics
- Responding to requests
- The inspection
- Out of hours visits
- Report and recommendations

Inspection Phase

- Focussing on improvement methodology
- Mix of inspectors, clinical experts and lay users with a much larger team – logistically challenging at times
- The patient at the centre of the inspection
- Improving triangulation for key lines of enquiry
- Varying staff experiences
- Response on initial draft report
- Quality Summit – work in progress

Observation and learning

- Responsibility for success
- Lay inspectors
- Regulation through Improvement
- Timing versus quality of outcome
- Data Pack

Thank You . . .

Any Questions . . . . .

"New Hospital Inspections: What to Expect and How to Prepare"

Malcolm Alexander,

Vice Chair of AvMA,
Member of Healthwatch Programme Board

HOSPITAL INSPECTIONS

POLICY INTO PRACTICE

NEW EXPERIENCES FOR PATIENTS AND FAMILIES?

Malcolm Alexander

JANUARY 16th 2014

MY PREVIOUS EXPERIENCE

- **MONITORING VISITS TO HOSPITALS THROUGH CHC's, PATIENTS' FORUMS AND LOCAL INVOLVEMENT NETWORKS**
- **PATIENTS FORUM FOR THE LONDON AMBULANCE SERVICE**
- **ACTION AGAINST MEDICAL ACCIDENTS (AvMA)**
- **DEVELOPMENT OF HEALTHWATCH**
- **HEALTHWATCH AND PUBLIC INVOLVEMENT ASSOCIATION (HAPIA)**

CREATING AN ENVIRONMENT WHERE PEOPLE WILL SPEAK FREELY

PATIENT-FOCUSSED INSPECTIONS

- **CQC,HEALTHWATCH, VOLUNTARY SECTOR – ALLIANCES**
- **CONTINUOUS VISITING PROGRAMMES**
- **INTERVENING IN RESPONSE TO REPORTS OF DECLINING SERVICES**
- **WATCHING AND INTERACTING**
- **QUALITATIVE APPROACHES TO LISTENING AND HEARING**
- **THE WELL INFORMED VISITOR**
- **FEEDING BACK TO SERVICE USERS**
- **EMPOWERED SERVICE USERS/FAMILIES/CARERS**
- **THE DUTY TO RESPOND**
- **ACTION RESEARCH APPROACHES – SAFETY AND QUALITY THROUGH ACTION**

CQC,HEALTHWATCH, VOLUNTARY SECTOR – ALLIANCES

- CQC CARRIES OUT OCCASIONAL HIGH LEVEL INSPECTIONS
- QUALITY OF PREVIOUS REGIME OF INSPECTIONS SOMETIMES POOR
- LOCAL HEALTHWATCH HAS STATUTORY VISITING POWERS WITH ACCESS TO MOST PARTS OF HOSPITALS + FUNDING
- LOCAL VOLUNTARY OFTEN TAKES PART IN VISITING WARDS
- LHW SHOULD COLLABORATE WITH CQC, VOLUNTARY SECTORS AND 'EXPERTS BY EXPERIENCE', TO DEVELOP INSPECTION PROGRAMMES, AND FEEDBACK TO PATIENTS, HOSPITAL AND LOCAL COMMISSIONERS

CONTINUOUS VISITING PROGRAMMES

- TO HAVE REAL IMPACT LOCAL VISITING PROGRAMMES NEED TO BE CONTINUOUS
- LHW IS FREE TO RECRUIT, TRAIN AND CRB CHECK VOLUNTEERS TO CARRY OUT CONTINUOUS VISITING PROGRAMMES
- DOING THE JOB WELL REQUIRES A LOT OF EXPERIENCE – OCCASIONAL VISITING IS UNLIKELY TO CREATE EFFECTIVE, EXPERIENCED LHW
- WORKING CONTINUOUSLY WITH CQC INSPECTORS AND SHARING INFORMATION IS ESSESSENTIAL FOR EFFECTIVE INSPECTIONS
- LHW SHOULD CARRY OUT INSPECTIONS ROUTINELY NOT JUST BECAUSE OF ADVERSE EVENTS

INTERVENING IN RESPONSE TO REPORTS OF DECLINING SERVICES

- CQC WOULD ONLY INTERVENE AND INSPECT RAPIDLY AS A RESULT OF A VERY SERIOUS ADVERSE EVENT
- LOCAL HEALTHWATCH SHOULD BE ABLE TO VISIT TODAY OR TOMORROW AND REPORT BACK TO PATIENTS, CQC, PROVIDERS AND COMMISSIONER
- CASUALTY WATCH TO MONITOR EVENTS IN A&E IS ANOTHER APPROACH WHICH CAN BE VERY POWERFUL
- DEVELOPING RAPID RESPONSES TO PATIENTS AND FAMILIES CONCERNS CAN SUBSTANTIALLY INCREASE CONFIDENCE IN SERVICES

INTERVENING WHERE THERE ARE DECLINING SERVICES

Casualty Watch Results All Regions - Longest 60 **Trolley Only** ***29 April 2002***

CHC	Hospital	Health District	Age	Sex	Postcode	Time of arrival	Provisional Diagnosis/ Reason for Attending Casualty	Plan for patient	Time of decision to admit	Total wait so far CHC	Total wait so far DoH	Trolley/ Bed/Chair
WEST SURREY & NE HAMPSHIRE	FRIMLEY PARK	West Surrey Health Authority	34	M	GU14	28/4/02 17:19	COLLAPSE	AWAITING INVESTIGATIONS FOR EPILEPSY	01:30	**23:11**	**15:00**	T
REDBRIDGE	KING GEORGE, REDBRIDGE	Redbridge and Waltham Forest Health Authority	81	M	IG5	28/4/02 18:38	UNWELL	AWAITING WARD BED		**21:52**	**0:00**	T
NEWHAM	NEWHAM GENERAL	East London and The City Health Authority	29	F	E15	28/4/02 22:02	PULMONARY EMBOLISM	TO BE ADMITTED		**18:28**	**0:00**	T
SOUTH WEST SURREY	ROYAL SURREY COUNTY	West Surrey Health Authority	101	M		28/4/02 23:24	FALL	AWAITING BED	01:40	**17:06**	**14:50**	T
NEWHAM	NEWHAM GENERAL	East London and The City Health Authority	72	F	E6	28/4/02 23:45	CONGESTIVE CARDIAC FAILURE	TO BE ADMITTED		**16:45**	**0:00**	T
EAST SURREY	EAST SURREY HOSPITAL	East Surrey Health Authority	34	M		01:50	RENAL COLIC	AWAITING RESULTS		**14:40**	**0:00**	T
HARINGEY	NORTH MIDDLESEX	Barnet, Enfield and Haringey Health Authority	20	M	N9	02:35	ASTHMA	WAITING FOR PORTER TO GO TO WARD	06:30	**13:55**	**9:00**	T
HARINGEY	NORTH MIDDLESEX	Barnet, Enfield and Haringey Health Authority	36	M	N18	02:36	MENINGITIS	WAITING FOR BED	15:00	**13:54**	**1:30**	T
KIDDERMINSTER & DISTRICT	WORCESTER ROYAL INFIRMARY	Worcestershire Health Authority	22	M		03:23	FIT	WAITING FOR BED	05:40	**13:07**	**10:50**	T
KINGSTON	KINGSTON HOSPITAL	Kingston and Richmond Health Authority	34	M	SW15	03:29	CHEST PAIN	TO ADMIT		**13:01**	**0:00**	T
NEWHAM	NEWHAM GENERAL	East London and The City Health Authority	47	F	E6	03:48	UNSTABLE ANGINA	TO BE ADMITTED		**12:42**	**0:00**	T
BEXLEY	QUEEN MARYS SIDCUP	Bromley Health Authority	72	F		03:50	PER RECTAL BLEED	BOOKED BED		**12:40**	**0:00**	T
HARROW	NORTHWICK PARK	Brent and Harrow Health Authority	85	M		04:47	DIFFICULTY IN BREATHING		14:30	**11:43**	**2:00**	T
HARROW	NORTHWICK PARK	Brent and Harrow Health Authority	85	M		04:47	DIFFICULTY IN BREATHING		14:30	**11:43**	**2:00**	T
HILLINGDON	HILLINGDON HOSPITAL	Hillingdon Health Authority	62	M		04:58	EXARCEBATION OF CHRONIC OBSTRUVTIVE PULMONARY DISORDER	WAITING FOR BED	12:35	**11:32**	**3:55**	T
HILLINGDON	HILLINGDON HOSPITAL	Hillingdon Health Authority	62	M		04:58	CHRONIC OBSTRUCTIVE PULMONARY DISORDER	WAITING TO COME IN	12:35	**11:32**	**3:55**	T
KIDDERMINSTER & DISTRICT	WORCESTER ROYAL INFIRMARY	Worcestershire Health Authority	68	M		06:14	LEFT VENTRICULAR FAILURE	WAITING FOR BED	07:25	**10:16**	**9:05**	T
HARINGEY	NORTH MIDDLESEX	Barnet, Enfield and Haringey Health Authority	87	F	N18	06:32	CONGESTIVE CARDIAC FAILURE	WAITING FOR WARD TO PREPARE	11:30	**9:58**	**5:00**	T
SOUTH EAST KENT	WILLIAM HARVEY, ASHFORD, KENT	East Kent Health Authority	27	F	CT14	06:54	ABDOMINAL PAIN	REFERRED		**9:36**	**0:00**	T
KINGSTON	KINGSTON HOSPITAL	Kingston and Richmond Health Authority	34	M	KT3	06:58	ABDOMINAL PAIN	TO ADMIT		**9:32**	**0:00**	T
WANDSWORTH	ST GEORGES, TOOTING	Merton, Sutton and Wandsworth Health Authority	5	M		07:10	DIFFICULTY IN BREATHING	TO BE ADMITTED	16:00	**9:20**	**0:30**	T
MERTON & SUTTON	ST HELIER	Merton, Sutton and Wandsworth Health Authority	71	M	CR4	07:17	CEREBRAL BLEED	4 HOUR WAIT FOR MEDICS		**9:13**	**0:00**	T

ChC = CHC COLLECTING DATA **© Southwark Community Health Council** **DOH waits are calculated from time of decision to admit** **0:00 = not recorded by the DOH** 7

WATCHING AND INTERACTING

- YOU CAN ONLY FIND OUT WHAT IS REALLY GOING ON IF YOU'RE THERE REGULARLY
- WATCH, OBSERVE, LISTEN – DEVELOP RELATIONSHIPS PATIENTS
- 2 WARDS ON SAME FLOOR - VERY DIFFERENT STANDARDS OF CARE
- CULTURAL ISSUES CRITICAL IN RELATION TO HIERACHIES AND POOR LEADERSHIP BY SENIOR STAFF
- WATCH FOR SENSITIVITY TO PATIENTS AND FAMILIES
- LISTEN OUT FOR PATIENTS IN DISTRESS
- ? PATIENT LED INSPECTIONS?

Up to 1,200 needless deaths, patients abused, staff bullied.

- **Up to 1,200 patients died unnecessarily**
- **Patients were ‘routinely neglected’ in some wards and A&E**
- **Focus on meeting the demand of Monitor to become and FT**
- **Government obsession with abolishing public involvement bodies**

Panorama at Winterbourne View: The human rights angle …

‘I watched Panorama’ expose of institutional abuse of adults with learning disabilities at Winterbourne View Hospital with mounting horror.

What legal mechanisms were available to prevent abuses like this, or bring justice to victims?

There can be no doubt that the acts of the carers towards the patients were inhuman and degrading … a violation of Article 3 rights.

It is highly questionable whether the establishment fulfilled their rights to privacy and dignity under Article 8 – the right to a private and family life.’

QUALITATIVE APPROACHES TO LISTENING AND HEARING

- LOCAL HEALTHWATCH NEEDS TO FIND WAYS OF BUILDING TRUSTING RELATIONSHIP WITH PATIENTS, FAMILIES AND CARERS
- CHATTING TO PATIENTS MAY REVEAL FAR MORE THAN SURVEYS
- IN A MENTAL HEALTH WARD SITTING AROUND THE TV FOR AN HOUR, WILL PROVIDE A KEY TO UNDERSTANDING WHAT IS HAPPENING FROM THE PATIENTS VIEWPOINT
- BUT IF YOU SIT AND LISTEN YOU MUST ALSO FEEDBACK
- WITH GOOD LIAISON THIS APPROACH PROVIDES INVALUABLE INFORMATION FOR CQC INSPECTORS

THE WELL INFORMED VISITOR

- THE APPROACH OF CQC – ENSURING THAT INSPECTORS HAVE INFORMATION ABOUT INCIDENCE OF ULCERS, FALLS, MEDICATION ERRORS, SIs and COMPLAINTS IS CRITICAL

- COHERENT DATA ON ACCIDENTS, INCIDENTS AND COMPLAINTS CAN BE HARD TO OBTAIN FOR LHW AND SOME TRUSTS ARE SECRETIVE ABOUT THE SERIOUS INCIDENT REPORTS

- SOME CHIEF EXECUTIVES OF TRUSTS IGNORE EMAILS FROM THE PUBLIC ON PATIENT SAFETY ISSUES

- LHW AND CQC NEED TO SHARE DATA-SETS AND INTELLIGENCE

- EACH HAS A VERY DIFFERENT BUT COMPLEMENTARY ROLE

FEEDING BACK TO SERVICE USERS

- VISITING, WRITING REPORTS AND PUBLISHING THEM SERVES THE SYSTEM BUT NOT NECESSARILY THE PATIENT
- MOST PATIENTS DON'T LOOK AT THE CQC WEBSITE AND IF THEY DID IT MAY NOT TELL THEM MUCH
- LONDON AMBULANCE SERVICE IS ALL GREEN TICKS, BUT THE INSPECTOR IGNORED DETAILED INFORMATION PROVIDED BY PATIENTS' FORUM, WHICH CONTRADICTS THE CQC REPORT
- PATIENTS AND THEIR FAMILIES ARE ENTITILED TO RECEIVE FEEDBACK AFTER INSPECTIONS AND EVIDENCE THAT CQC RECOMMENDATIONS ARE BEING IMPLEMENTED AND TRANSFORING THE QUALITY OF CARE

EMPOWERED SERVICE-USERS, FAMILIES & CARERS

- EMPOWERED PATIENTS DON'T OBSERVE GROUPS OF SMARTLY DRESSED CQC PEOPLE WALKING THROUGH WARDS AND WONDER WHO THEY ARE
- EMPOWERED PATIENTS HAVE BEEN BRIEFED ABOUT THE CQC VISIT, KNOW WHO THE MEMBERS OF THE TEAM ARE (PHOTOS) AND FEEL COMFORTABLE ABOUT TALKING TO THEM
- EMPOWERED PATIENTS DO NOT FEAR REPERCUSSIONS IF THEY TALK TO CQC TEAM MEMBERS
- EMPOWERED PATIENTS KNOW WHO TO CONTACT IN THE CQC TEAM AFTER THE VISIT IF THEY HAVE MORE INFORMATION AND THEY EXPECT FEEDBACK ON PROBLEMS AND SOLUTIONS

THE DUTY TO RESPOND

- QUESTIONS FROM PATIENTS AND LHW TO CHIEF EXECUTIVES OF HOSPITALS ABOUT SAFETY ISSUES MUST BE ANSWERED!
- PATIENTS WHO HAVE SUFFERED HARM OF ANY KIND MUST BE TOLD BY THE HOSPITAL, AND CQC TEAMS ARE PROVIDED WITH EVIDENCE THAT PATIENTS HAVE BEEN TOLD
- PATIENTS ARE ALWAYS ACTIVELY INVOLVED IN THE DEVELOPMENT THEIR CARE PLANS
- IF PATIENTS OFFER ADVICE TO THE HOSPITAL ABOUT HOW SERVICES CAN BE IMPROVED THEY ARE LISTENED TO AND THEY RECEIVE FEEDBACK ABOUT THEIR IDEAS
- THE CQC TEAM, THROUGH DISCUSSIONS WITH PATIENTS AND FAMILIES, IS SURE THAT THE HOSPITAL RESPONDS EFFECTIVELY TO ISSUES RAISED BY PATIENTS

ACTION RESEARCH APPROACHES – SAFETY AND QUALITY THROUGH ACTION

- PATIENTS AND FAMILIES ARE OFFERED THE OPPORTUNITY OF WORKING WITH STAFF TO IDENTIFY ANY ISSUES THAT MIGHT HARM PATIENTS OR UNDERMINE PATIENT CARE - AND JOINTLY FIND SOLUTIONS
- PATIENTS ARE REGULARLY INVITED TO JOIN IN SERVICE IMPROVEMENT ACTIVITIES AND CAN WITNESS REAL CHANGE
- A BROAD RANGE PATIENTS AND FAMILIES CAN CONTRIBUTE THEIR IDEAS
- EVIDENCE OBTAINED FROM THIS JOINT APPROACH BETWEEN PATIENTS AND STAFF IS PROVIDED TO THE CQC AND LHW AS EVIDENCE THAT THE NHS CONSTITUTION IS TAKEN SERIOUSLY BY THE HOSPITAL

You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.

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