NQB(12)(01)(03)

NATIONAL QUALITY BOARD

_____

INTRODUCING NEW PATIENT-LED INSPECTIONS OF THE HOSPITAL ENVIRONMENT

A note from the Chief Nursing Officer

Summary

1. On 6 January 2012 the Prime Minister announced that a new patient-led inspection regime will be introduced, covering privacy and dignity, food, and cleanliness in hospitals. The results of these inspections (which will replace the current Patient Environment Action Team (PEAT) inspections from April 2013) will be reported on 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 inspections.

2. Development and implementation of the new process will raise important questions around system alignment which the NQB is well placed to advise on. It is therefore proposed that a Steering Group made up of key health and care organisations is established to advise the Department and that this group should be a sub group of the National Quality Board, chaired by the Chief Nursing Officer (and then the NHS Commissioning Board Chief Nurse).

3. This paper:
    a. provides a summary of latest thinking about how the new patient-led inspections process might work
    b. highlights some of the alignment issues that will need to be considered as this work progresses
    c. discusses next steps

Recommendation

4. The Board is asked to:
   a. note and comment on the role and makeup of the Steering Group
   b. approve setting up the Group as a sub-group of the Board and consider any additional members
   c. provide advice on an initial set of issues to help frame the development of the overall scheme (paras 15-25)

Background

5. The current PEAT process was designed in 2000 and overhauled in 2004. It has been a key contributor to the marked improvement in cleanliness across the NHS (in 2000, almost one-third of hospitals were judged to be "poor" or "unsatisfactory", whilst today only a handful each year fall into these categories). It has also tracked improvements in food quality and in delivering high standards of privacy and dignity. It is entirely separate from inspections carried out by the Care Quality Commission (CQC), but is drawn on by them when creating risk profiles.

6. PEAT was established 12 years ago in a very different NHS. It has served a useful purpose, but the need today is for an inspection regime that is aligned to the new service, and in particular the commitment to reflect patients' expectations. The existing system does not adequately recognise the increasing plurality of healthcare provision, and nor does it reflect the needs of new organisations such as the NHS Commissioning Board (NHSCB). Whilst PEAT has always taken account of patient views (around 80% of inspections include a patient), such involvement has been varied and in some cases minimal. The new system needs to have patient opinions at its heart, and must ensure that their voice is heard. The PEAT scoring system also needs refreshing to allow exceptional performance to be recognised.

A new system of patient-led inspections

7. The Department of Health (DH) will put in place a new system of patient-led inspections by April 2013, to give patients a strong voice in the assessment of privacy and dignity, food and cleanliness in hospitals offering NHS-funded care.

8. DH is guided by a number of key considerations about the new system. It must be broadly cost-neutral once in place and must not represent a significantly greater overall burden than at present. To achieve this, DH plans to retain key features of the PEAT process (for example annual publication of figures by the NHS and Social Care Information Centre (NHSIC), web-based reporting and the avoidance of creating new "inspector" posts). As now, the system will apply to hospitals only. However, the scoring system will be different from PEAT, which will mean it is not possible to compare scores between the two systems.

9. Further, the data that the assessments generate must:
   a. meet the information needs of a wide range of stakeholders involved in maintaining and improving quality, including the NHSCB, CQC and DH
   b. be aligned to (but not duplicate) other inspection and monitoring regimes
   c. most importantly, meet the needs of patients, so that they can understand what standards they might reasonably expect in relation to the hospital environment, and judge their own local hospital in that light.

A steering group to guide the work

10. A Steering Group will be established to guide the development of the new patient-led inspections process, setting a strategic vision for the project, providing advice and guidance to the DH-based teams responsible for its delivery, and helping to resolve risks and issues. The Chief Nursing Officer will chair this group on a transitional basis until the appointment of the NHSCB Chief Nurse, who will then take this forward.

11. When developing the new process DH will need to have regard to important system alignment issues. For example, patient-led inspections will need to complement existing schemes for assuring essential standards of safety and quality, such as that operated by CQC. It is therefore proposed that the Steering Group is positioned as a sub-group of the National Quality Board Where appropriate, the Group could seek advice from the full Board and advise on progress.

12. The DH Patient Environment team will provide secretariat support to the Steering Group, working closely with the main NQB secretariat.

Members

13. Representatives of the following organisations have been invited to form the Steering Group and attend its first meeting on 15 March 2012 (we are awaiting confirmation of individuals nominated by their organisations and their availability on 15 March):

    Care Quality Commission
    NHS Confederation
    Patients' Association
    Age UK
    Mental Health Alliance
    HealthWatch England
    Local HealthWatch/LINks
    Monitor
    NHS Information Centre
    Independent Healthcare Advisory Service
    Healthcare Estates and Facilities Management Association
    Royal College of Nursing
    Business Services Association

14. Current thinking is that the Steering Group will meet quarterly, whilst the DH Delivery Group will meet monthly and its individual workstream groups will meet as required.

The Board is asked to:

- **approve the creation of the Steering Group as a sub-group of the Board**
- **consider the Steering Group's membership and advise whether other members should be invited to join the Steering Group (in particular, whether any Board members would like to join the Group).**

Advice and direction sought on specific issues

15. The key feature of the new inspections is that they will be patient-led. But "patient-led" can mean many things. For the purpose of the new inspections process, it has been taken to mean involvement in designing the system and carrying out inspections alongside other team members. It has also been taken to imply that the pre-eminent voice in any inspection is the patient's. However, it is not envisaged that patients will have to shoulder the burden of planning or organising visits, nor of submitting reports to the NHS Information Centre (they may well be involved in formulating the response). Nor is it taken to mean that patients will be the only members of the inspection team; indeed, it is expected that hospital staff, including nurses, will continue to be heavily involved. Contrary to some reports in the press, it is not expected that this regime will provide patients with the right to "enter and view" premises – such powers will be exercised through Local HealthWatch.

16. A variety of mechanisms are planned to select patients for involvement in the inspections process, both centrally and locally. For instance, DH may use national focus groups or seminars to help develop the system, with individual hospitals recruiting patients locally to take part in inspections. The details will be confirmed following stakeholder engagement, but it is anticipated that Local HealthWatch will always be offered the opportunity to engage in

inspections. Where they decline to do so, organisations will be able to use other approaches to deliver genuine patient engagement.

The Board is asked to comment on the interpretation of "patient-led".

17. When first introduced, PEAT inspections were carried out by independent assessors and were unannounced[1]. Since 2004, they have been self-assessments, and take place within a pre-announced three-month period. This has been essential to keep costs down, and a reversion to fully independent, unannounced inspections would be prohibitively expensive. In particular, it would be difficult to assure full patient representation in an unannounced system. Nonetheless, it might be possible to explore the feasibility of shortening the notice time, with the agreement of the Steering Group.

The Board is asked to endorse the continued use of self-assessment, and express a preference about the notice period.

18. The Prime Minister has confirmed that the new system should cover at least the same broad areas as the current regime. These are the environment (including cleanliness), food (but not nutritional care), and privacy and dignity.

19. PEAT currently includes a small number of questions that are essentially clinical (eg questions about nutritional screening), but the overwhelming focus is on facilities management and the environment. In the past, there has been pressure to increase the number of clinical questions, especially where the facilities management and care aspects of the environment overlap. This is particularly the case with the links between food quality and nutritional care.

[1] Note – "unannounced" means that less than 48 hours' notice is given of the visit. This is so that relevant staff can be available to meet the assessors.

20. This has meant PEAT can generate information that would otherwise be unavailable and this has been especially helpful to CQC in allowing them to generate Quality Risk Profiles. However, it has also distorted the original purpose of PEAT (to assess the non-clinical hospital environment). There is an opportunity now to decide the scope of the new patient-led inspections process. It could continue to cover clinical content, although any significant increase in clinical content beyond what PEAT currently covers would run counter to our commitment to cost-neutrality. Alternatively, it could be restricted to non-clinical topics only, but this may threaten alignment with CQC's needs.

The Board is asked to comment on the value of continuing to include a small number of clinical questions, taking into account the wishes of patients, the information needs of stakeholders and the requirement to remain cost-neutral.

21. PEAT assessments use a five-point scale – unacceptable, poor, satisfactory, good and excellent. In order to demonstrate the new focus on patient views (and thus distinguish these inspections from PEAT) a new scoring system will be developed. Early feedback from the NHS indicates a preference for a three-point scale – "clear pass", "fail", and "needs attention". This has the advantage of simplicity, and allows trusts to identify quickly where they need to target their improvement efforts, but it has the disadvantage of not allowing the truly excellent trusts to demonstrate their achievements. An alternative is to develop a dashboard approach. Whatever approach is taken, it must meet the needs of patients. The Steering Group will engage closely with stakeholders to test the model before making a final decision.

The Board is asked to comment on their preferred scoring system to inform more detailed deliberations by the Steering Group and following further stakeholder engagement.

22. The PEAT process is voluntary, but has extremely high compliance (all NHS hospitals of 10 beds or more participated last year, including all foundation trusts) and an increasing number of independent sector hospitals also take part (over 100 last year). Other data collections (eg breaches of mixed-sex accommodation guidelines) require every hospital providing NHS-funded care to report, and this review would offer an opportunity to follow that same principle. Mandating the data collection would not increase the cost to the NHS (as coverage is already universal), but independent providers wishing to take up NHS work might need to introduce inspection in order to comply with contracts.

23. Mandating patient-led inspections could only be carried out via the contracting process, and would therefore need to be included in the NHSCB's instructions to commissioners. An alternative would be to maintain the current voluntary approach.

24. PEAT inspections currently apply only to hospitals with 10 beds or more. This is essentially a pragmatic decision, which captures over 90% of NHS hospitals, and which reflects other estates-related data collections. The intention is to maintain this approach.

> **The Board is asked to advise on whether the new process should be mandatory for all hospitals providing NHS-funded care, and to comment on the mechanism by which that mandate might be set in the future.**
>
> **The Board is also asked to confirm that it agrees that the current approach of excluding hospitals with fewer than 10 beds should be maintained.**

25. PEAT inspections take place in January to March, during peak winter activity when the environment is hardest to manage. The new system is intended to take over from April 2013, which would mean that the present round of PEAT inspections will be the last. However, it is possible that the Steering Group

will request that the winter inspections are maintained, which would mean there may need to be one further PEAT round in early 2013.

The Board is asked to note the remote possibility that a further PEAT round may be required in 2013, if the Steering Group determines that winter inspections are essential.

Next Steps

26. Subject to the Board's advice, a first meeting of the Steering Group will be held in March. Early stakeholder engagement should be completed by summer, allowing time to develop the technical specification and pilot the proposed model by autumn 2012.

27. Because the current PEAT inspections fall within the ambit of official statistics, any change must be subject to public consultation. This is expected to take place at around the same time as the pilots, allowing for refinements to take into account consultation responses before launch in April 2013. This consultation relates entirely to the new collection's status within official statistics guidelines – the more fundamental issue of whether the collection meets the needs of patients and the service will be addressed much earlier by extensive stakeholder engagement.

The Board is asked to approve the plan and agree to provide on-going advice.