How Safe Are Nhs Patients In Private Hospitals Learning From The Care Quality Commissionlearning From The Voices In My Head

#NHS patient safety #private hospitals #Care Quality Commission #hospital care quality #healthcare safety

This document explores the critical question of how safe NHS patients are when receiving treatment in private hospitals. It draws essential insights and learnings directly from the findings of the Care Quality Commission, aiming to enhance overall hospital care quality and patient safety standards across these diverse healthcare settings.

Educators may refer to them when designing or updating course structures.

Equity and excellence:

Equity and Excellence : Liberating the NHS: Presented to Parliament by the Secretary of State for Health by Command of Her Majesty

High Quality Care for All

This review incorporates the views and visions of 2,000 clinicians and other health and social care professionals from every NHS region in England, and has been developed in discussion with patients, carers and the general public. The changes proposed are locally-led, patient-centred and clinically driven. Chapter 2 identifies the challenges facing the NHS in the 21st century: ever higher expectations; demand driven by demographics as people live longer; health in an age of information and connectivity; the changing nature of disease; advances in treatment; a changing health workplace. Chapter 3 outlines the proposals to deliver high quality care for patients and the public, with an emphasis on helping people to stay healthy, empowering patients, providing the most effective treatments, and keeping patients as safe as possible in healthcare environments. The importance of quality in all aspects of the NHS is reinforced in chapter 4, and must be understood from the perspective of the patient's safety, experience in care received and the effectiveness of that care. Best practice will be widely promoted, with a central role for the National Institute for Health and Clinical Excellence (NICE) in expanding national standards. This will bring clarity to the high standards expected and quality performance will be measured and published. The review outlines the need to put frontline staff in control of this drive for quality (chapter 5), with greater freedom to use their expertise and skill and decision-making to find innovative ways to improve care for patients. Clinical and managerial leadership skills at the local level need further development, and all levels of staff will receive support through education and training (chapter 6). The

review recommends the introduction of an NHS Constitution (chapter 7). The final chapter sets out the means of implementation.

Learning report: Safer Patients Initative

Reviews of patients' case notes indicate that in the NHS and in other healthcare systems as many as 10 per cent of patients admitted to hospital suffer some form of harm, much of which is avoidable. Tens of thousands of patients suffer unnecessary harm each year and there is a huge cost to the NHS in consequence. This report examines the implementation of safety policy since 2000. That policy has focused on the creation of a unified national mechanism for reporting and analysing incidents, underpinned by a new culture of openness in the NHS. Systems for reporting, and learning from, incidents, were established, centred on the National Reporting and Learning System (NRLS) and the National Patient Safety Agency (NPSA). The Committee finds areas where policy has failed, barriers to change and other reasons for slow progress. It recommends several changes that need to be made in order for there to be further progress in tackling unsafe care. The recommendations are in the areas of: measurement and evaluation; harmed patients and their families or carers; creating a more open, reporting and learning NHS; more patient safety at the front line in the NHS; greater use of technologies to improve care; improvements in the education and training curricula; commissioning by Primary Care Trusts, performance management and regulation; the role of managers and boards; and the role of the Department of Health and Government.

Culture Change in the NHS

This public inquiry report into serious failings in healthcare that took place at the Mid Staffordshire NHS Foundation Trust builds on the first independent report published in February 2010 (ISBN 9780102964394). It further examines the suffering of patients caused by failures by the Trust: there was a failure to listen to its patients and staff or ensure correction of deficiencies. There was also a failure to tackle the insidious negative culture involving poor standards and a disengagement from managerial and leadership responsibilities. These failures are in part a consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable care standards. Further, the checks and balances that operate within the NHS system should have prevented the serious systemic failure that developed at Mid Staffs. The system failed in its primary duty to protect patients and maintain confidence in the healthcare system. This report identifies numerous warning signs that could and should have alerted the system to problems developing at the Trust. It also sets out 290 recommendations grouped around: (i) putting the patient first; (ii) developing a set of fundamental standards, easily understood and accepted by patients; (iii) providing professionally endorsed and evidence-based means of compliance of standards that are understood and adopted by staff; (iv) ensuring openness, transparency and candour throughout system; (v) policing of these standards by the healthcare regulator; (vi) making all those who provide care for patients , properly accountable; (vii) enhancing recruitment, education, training and support of all key contributors to the provision of healthcare; (viii) developing and sharing ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and other stakeholders.

Patient safety

This report comes in the middle of the biggest overhaul to the NHS in over 60 years due changes brought about by the Health and Social Care Act 2012. As the changes in the NHS take place, the Ombudsman's Office caseload suggests that embedding good complaint handling will be essential to avoid the risk of patient complaints going unheard. Last year the Ombudsman received 50% more complaints from people who felt that the NHS had not acknowledged mistakes in care. 16, 333 complaints were resolved. This report, as well as providing statistics and case studies, outlines the learning from the casework in 2011-12. It also suggests how the NHS can improve it's complain handling and sets out ways in which the Ombudsman's own work is change to enable to us to share more information more widely.

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

The Department of Health estimates that one in ten patients admitted to NHS hospitals will be unintentionally harmed (a rate similar to other developed countries), due to incidents such as an injury from a fall, medication errors, equipment related incidents, record documentation errors and hospital

acquired infections. About half of such incidents could have been avoided, if lessons from previous incidents had been learned. This NAO report examines the progress being made in the NHS to improve the patient safety culture, to encourage incident reporting and to learn lessons for the future. The report finds that most trusts have developed a predominantly open and fair reporting culture at the local level, driven largely by the Department of Health's clinical governance initiative and more effective risk management systems. However, a 'blame culture' still exists in some trusts, and there have been delays in establishing an effective national reporting system. There is scope for improving strategies for sharing good practice and for monitoring that lessons are learned.

Listening and Learning

The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England. Its purpose is to "make sure health and social care services provide people with safe, effective, compassionate, high quality care, and to encourage them to improve". The Commission is a non-departmental public body, sponsored by the Department of Health (the Department). The Committee of Public Accounts last took evidence from the Department and the Commission in 2012. In its report the Committee expressed serious concerns about the Commission's governance, leadership and culture, and its failure to intervene quickly or strongly enough in failing providers of health or social care services. The Commission has since been working with the Department to implement significant changes, under a three-year transformation programme between 2013-14 and 2015-16.

A Safer Place for Patients

The Government's initial response, Patients First and Foremost (Cm. 8576, ISBN 9780101857628), set out a radical plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. This document now provides a detailed response to the 290 recommendations the Inquiry made across every level of the system. It also responds to six independent reviews commissioned to consider some of the key issues identified by the Inquiry. This document sets out how the whole health and care system will prioritise and build on this, including major new action in vital areas including: transparent monthly reporting of ward-by-ward staffing levels and other safety measures; a statutory and professional duties of candour; legislate at the earliest available opportunity on Wilful Neglect; a new fit and proper person's test which will act as a barring scheme; all arm's length bodies and the Department of Health have signed a protocol in order to minimise bureaucratic burdens on Trusts; a new Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users; and the Care Bill will introduce a new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation. It looks at preventing problems; detecting problems quickly; taking action promptly; ensuring robust accountability and ensuring staff are trained and motivated

HC 501 - Care Quality Commission

Primary Care Trusts (PCTs) are responsible at the local NHS level for the statutory "duty of care\

Department of Health: Hard Truths: The Journey to Putting Patients First - Cm. 8751

There are currently two separate statutory processes for handling complaints about health and social care services. NHS organisations are accountable to the Department of Health and social care services are accountable through their local authority, whilst adult social care rests with the Department. There are differences in the numbers of stages and timescales involved, and in the arrangements for advocacy support and independent investigation. The Health Service Ombudsman is responsible for the ultimate review and decision on NHS complaints and the Local Government Ombudsman for social care complaints. The NAO is this report (HCP 853, session 2007-08), has undertaken an evaluation of existing performance, capability, capacity and costs of complaints handling in both health and adult social care. The NAO has set out a number of findings and recommendations, including: that where people are dissatisfied, there is a low number who make formal complaints; that navigating the complaints systems is not straightforward, partcularly for health service users; only a small proportion of NHS complainants are aware, or receive national advocacy support; that the culture and attitudes of the organisations are often a barrier to responsive complaint handling; neither the health or social care

organisations know the cost of complaints handling; that pursuing a complaint requires considerable time, determination and resilience.

Improving quality and safety

Enabling power: Health and Social Care Act 2008, ss. 8 (1), 20 (1) to (5A), 35, 86 (2) (4), 87 (1) (2), 161 (3) (4). Issued: 11.07.2014. Made: .- Laid: -. Coming into force: In accord. with reg. 1. Effect: S.I. 2012/921 partially revoked & 2010/781; 2011/2711; 2012/1513 revoked. Territorial extent & classification: E. For approval by resolution of each House of Parliament

Continuous improvement of patient safety

PASC is inquiring into how incidents of clinical failure in the NHS are investigated - and how subsequent complaints are handled. The Committee is considering ways that untoward clinical incidents could be investigated immediately at a local level, so that facts and evidence are established early, without the need to find blame, and regardless of whether a complaint has been raised. It is hoped that this work will reduce the need for complaints to go to the Parliamentary and Health Services Ombudsman (PHSO), whose main role relates to administrative and service failures in the NHS in England.

The Role of Acute Care Managers in Quality of Care and Patient Safety

NHS patients have the right to receive elective pre-planned consultant-led care within 18 weeks of being referred for treatment. In 2012-13, there were 19.1 million referrals to hospitals in England, with hospital-related costs of around £16 billion. The standards are that 90% of patients admitted to hospital, and 95% of other patients, should have started treatment within 18 weeks of being referred. In April 2013, NHS England introduced zero tolerance of any patient waiting more than 52 weeks. The Department of Health cannot be sure that the waiting time data NHS England publishes, based on information from NHS trust, is accurate. Trusts are struggling with a hotchpotch of IT and paper based systems that are not easily pulled together, which makes it difficult for them to track and collate the patient information needed to manage and record patients' waiting time. The National Audit Office (NAO) found that waiting times for nearly a third of cases it reviewed at seven trusts were not supported by documented evidence, and that a further 26% were simply wrong. Multiple organisations have a quality assurance role. However the external audit provided in the past by the Audit Commission has yet to be replaced and the Department acknowledged the need to do so, with regular spot checks being undertaken to ensure accuracy. But responsibilities have not been clearly defined.

Feeding Back? Learning from Complaints Handling in Health and Social Care

Organising care around patients is not for the fainthearted. Naomi Chambers and Jeremy Taylors have curated twenty-five accounts from people who agreed to tell the story of what happened when they or their loved ones came into contact with the NHS. The authors defy you not to laugh or cry, or hold your breath in disbelief, at some point when reading this book. In these true and compelling accounts, we learn the experiences – good and bad – of people grappling with birth and death, caring for loved ones, living with mental illness, coping with long-term conditions, and struggling in older age. This book is a call to action aimed at healthcare professionals, managers and politicians: a manifesto for more patient-centred care. These stories show the NHS at its very best – and also when it falls significantly short. Patients or carers currently battling with the system will derive some hope and encouragement, and clues about what to expect, what to ask for, and from whom.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Print and web pdfs are available at https://www.gov.uk/government/publications Web ISBN=9781474144988

HC 886 - Investigating Clinical Incidents in the NHS

Aimed at clinical and non-clinical staff working in the NHS and allied health professionals, this guide offers a step-by-step guide to each stage of the information process from developing an information policy to writing and disseminating print and electronic materials.

Approaches to Better Value in the NHS

Presents a research-based perspective on patient safety, drawing together the most recent ideas on how to understand patient safety issues, along with how research findings are used to shape policy and practice.

NHS Waiting Times for Elective Care in England - HC 1002

This learning report describes the work undertaken by two NHS trusts as part of the Health Foundation's Flow Cost Quality programme. It illustrates the problems created by poor flow that the programme was set up to address, and provides practical examples of how focusing on flow can improve quality, use available capacity effectively and save money. The report summarises key lessons from the programme and highlights important challenges for designing services and approaching change by focusing on flow. Flow Cost Quality ran in two NHS hospital trusts: South Warwickshire NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust. South Warwickshire looked at the emergency flow for all adult patients, while Sheffield focused on one clinical subspecialty - geriatric medicine. The case studies that accompany the report provide more details of the work done by each of the trusts.

Organising care around patients

The purpose of this report is to identify the potential benefits and constraints of accommodating suitable patients in a patient hotel as an alternative to a hospital ward and to assist managers and clinicians in deciding whether to invest in such facilities. The key conclusions of the report is that where a patient hotel can be justified and has the support of clinicians, it provides a quality alternative to ward care and benefits both patients and the hospital. If satisfactory levels of utilisation are achieved, it will also save up to 45 per cent of the hotel costs incurred on conventional wards. The report draws on the operational experience of the patient hotel at University Hospital, Lund in Sweden. There are no operational patient hotels in the UK so the report looks at the circumstances in which plans for patient hotels are going ahead in the UK and provides some examples of local progress. Alternatives to patient hotels are also examined, including wards or hostels, which have been adapted by some NHS hospitals to cater for certain groups of low dependency patients

Care Quality Commission Annual Report and Accounts 2016/17

Nurse leads define nurse-led care as the combination of extending nurse roles and a culture that promotes equality between different professions and the empowerment of patients. Nurse-led PMS pilots have begun to put into practice a new model of care that is consistent with the Government's objectives for the NHS. This report describes the experiences of the nine nurse leads as they have developed their projects, and analyzes the programme's success in various patient communities and its possible future effects on primary care in the NHS.

Producing Patient Information

Extending patient choice is central to the government's reform of the NHS. Patients will be offered a choice of hospitals for planned operations from December 2005 & will soon be offered choice in other areas of health care. This paper presents the key findings from ten focus groups held to explore public views about these choices.

Patient Safety

Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission which published a highly critical report in March 2009, followed by two reviews commissioned by the Department of Health. These investigations gave rise to widespread public concern and a loss of confidence in the Trust, its services and management. This Inquiry was set up primarily to give those most affected by poor care an opportunity to tell their stories and to ensure that the lessons learned were fully taken into account in the rebuilding of confidence in the Trust. The evidence received about the patient experience covered many areas of basic nursing and medical care, communication and discharge management. The culture of the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff due to: attitudes of patients and staff; bullying; target-driven priorities; disengagement from management; low staff morale; isolation from the wider NHS community; lack of openness; acceptance of poor standards of conduct; reliance on external assessments; denial. The report also looks at the management of significant issues - ward reconfiguration, finance, staff cuts

- governance, staff review, the Board, mortality statistics and external organisations. Major themes identified by the Inquiry are: focus on process not outcomes; failure to listen to complaints; insufficient attention to maintenance of professional standards; lack of support for staff; failure to meet the challenge of care for the elderly; lack of transparency; disregard of the significance of mortality statistics.

Improving Patient Flow

This report looks at communication with patients, relatives and carers in the acute hospital setting. It considers not only the giving of information, both general and clinical, but also the ways in which information is obtained from patients, either unsolicited (in the form of complaints) or solicited (by techniques such as surveys). In all these areas, patients are experiencing difficulties both with the content of information and with the way that it is given or requested. A common complaint is that there is not enough information. Equally, information often exists, but the quality is poor - it is not clearly written, for example, or it is not what the patients wants. Even when the information is adequate, the way in which it is communicated can diminish its usefulness. Minor changes can lead to improvements in the design and production of information leaflets, and signposting. It is more difficult, but still possible without significant expenditure, to change the way clinical staff work together, and developing guidelines on what to tell patients at each stage in their care, plus rules about recording what they have been told, will improve communication with health professionals.

Patient Hotels

The Ombudsman investigated three cases in which local statutory supervision of midwives failed, all of which occurred at Morecambe Bay NHS Foundation Trust. The cases clearly illuminate a potential muddling of the supervisory and regulatory role of supervisors of midwives. The current arrangements do not always allow information about poor care to be escalated effectively into hospital clinical governance or the regulatory system. This means the current system operates in a way that risks failure to learn from mistakes, which cannot be in the interests of the safety of mothers and babies and must change. Working with the Nursing and Midwifery Council (NMC), the Professional Standards Authority for Health and Social Care, NHS England and the Department of Health, the Ombusdman has identified two key principles that will form the basis of proposals to change the system of midwifery regulation: that midwifery supervision and regulation should be separated; that the NMC should be in direct control of regulatory activity. The Department of Health should convey these recommendations to its counterparts in Northern Ireland, Scotland and Wales and develop proposals to put these principles into effect.

Can I Help You?

This edition my be sold Worldwide; If You Need Urgent Care Would You Know What Your Choices Are? NHS Family Choice will empower you to make those choices; NHS Family Choice lists all NHS hospitals as well as many private and overseas hospitals, clinics and medical facilities. NHS Family Choice will change the way patients choose their treatment and the treatment of their loved ones within the healthcare system. NHS Family Choice is an absolute necessity for the family that wants to be fully informed and needs to get the best out of the healthcare service. This 848 page volume allows you to search for a hospital or consultant by disease area or medical condition. It is bursting with information on hospitals, departmental specialities, specialist consultants, star ratings, patient surveys and professional health advice. New Guide Set To Boost Patient Power; After lengthy government talks and media hype surrounding NHS patient choice, a new landmark reform is set to reduce hospital waiting times by giving patients the power to choose where they receive treatment. top medical titles, whose essential new guide, NHS Family Choice, will greatly assist patients in this hospital selection process. By September 2004, the Department of Health's plan will mean all patients waiting over six months for elective surgery can be offered a choice of moving to another hospital or provider. And, by December 2005, all patients who may require elective surgery can be offered a choice of four or five hospitals or providers on referral by a GP. But while this ruling appears to provide the answer to enabling patient choice, the fact remains that most people don't have access to enough NHS information to allow them to make an informed choice. Launched in October 2004, nhs Family Choice will provide patients with all the information they need to make the crucial choice of where to receive their treatment. Olivia Gordon, editor of NHS Family Choice, explains: The government's plans include the introduction of 'patient care advisors' who will give patients information about their alternative choices for treatment, while GPs will be able to provide some advice on different hospitals. information, which is where nhs

Family Choice comes in. Set out in an easy-to-use format, the guide tells the patient everything they need to know about healthcare treatment within the NHS, including: which disease specialities are treated at which hospitals; the names of all the specialist consultants; complete star ratings; and, the waiting times at each institution. Also included are the results of patient surveys that address the topical issues of hospital hygiene and satisfaction with treatment.

Nurse-led Primary Care

This learning report describes the work undertaken by two NHS trusts as part of the Health Foundation's Flow Cost Quality programme. It illustrates the problems created by poor flow that the programme was set up to address, and provides practical examples of how focusing on flow can improve quality, use available capacity effectively and save money. The report summarises key lessons from the programme and highlights important challenges for designing services and approaching change by focusing on flow. Flow Cost Quality ran in two NHS hospital trusts: South Warwickshire NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust. South Warwickshire looked at the emergency flow for all adult patients, while Sheffield focused on one clinical subspecialty - geriatric medicine. The case studies that accompany the report provide more details of the work done by each of the trusts.

Public Views on Choices in Health and Health Care

The report finds examples of good practice regarding: the strong commitment to staff development and lifelong learning; and the staff support services available, including training to protect staff against violent and aggressive behaviour. Areas of concern are: the lack of privacy for patients in the intensive care and coronary care units; the lack of awareness of pain management techniques amongst clinicians generally; and the need to improve the service in the accident and emergency unit.

Learning Not Blaming

The collective principle asserts that... no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means. — Aneurin Bevan.

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

What Seems to be the Matter