Care Quality Commission

Standards

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Standards are not enough!

Standards vs Culture

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- In 1965, 1968, 1976, 2000 and 2010 we created laws or ‘standards’ for racial equality
- And yet culture and practice has not kept up:
  - 29% of BME staff experienced harassment, bullying or abuse from patients, relatives or the public, and 26% from staff
  - 25% of BME staff experienced discrimination at work
  - 1 in 40 NHS chairs and no CEO in London is BME
  - 17 of 40 Trusts have all white Boards

(Sources: Roger Kline, 2014; Mala Rao, 2014, NHS Staff Survey 2013)

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Culture not compliance

Failures tend to happen when:

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- Finance ahead of patient
- Staff are not engaged (clinicians are unaligned with management)
- Culture is inward looking / fearful
- Leadership is weak or in flux
- Isolation – geographic or intellectual
- Adverse views of staff and users/customers/patients /residents

Drivers of improvement

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- Globalisation
- Consumer choice
- Competition

- But weak in health and social care
- Vulnerable people often unheard

Drivers of quality

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- Clinicians
- Providers
- Commissioners
- Consumers
- Regulator

Is the service well led?

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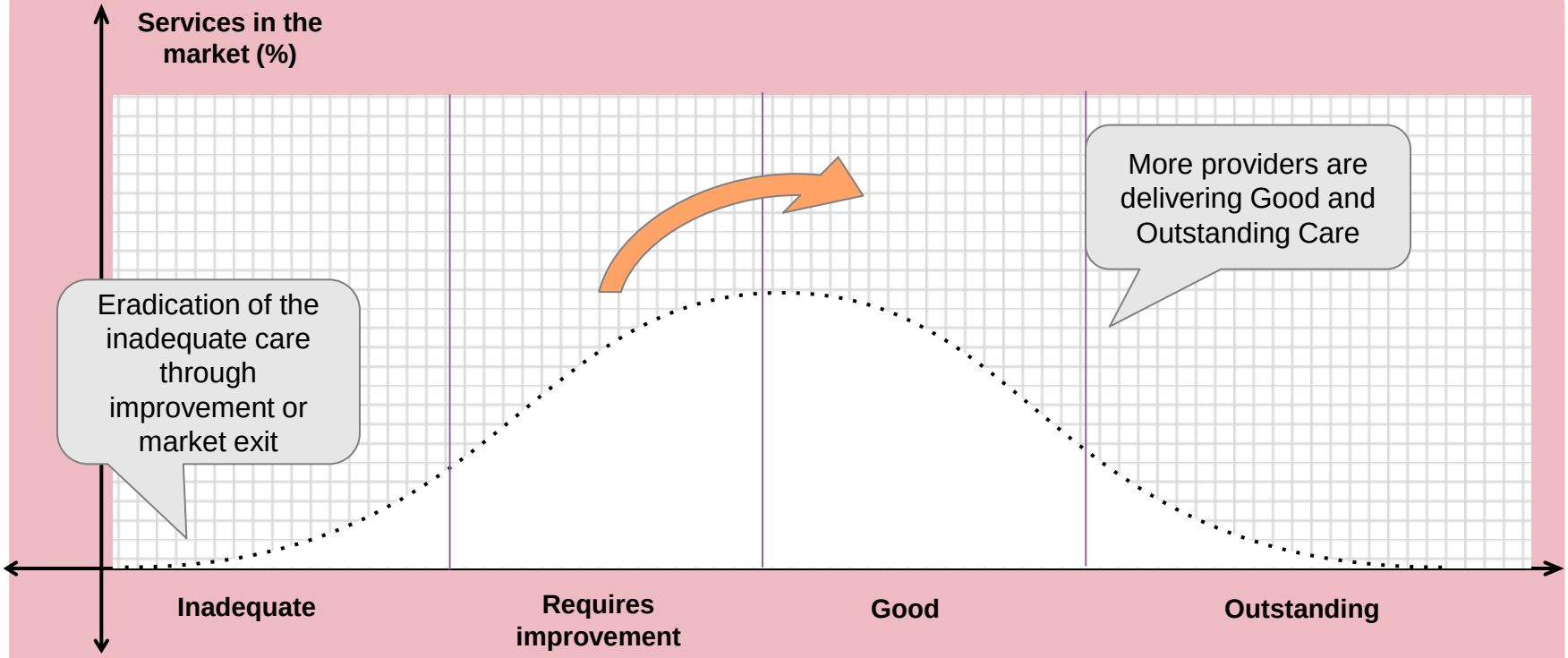
- Is there a clear **vision** and **strategy** to deliver high-quality care and promote good outcomes for people?
- Do the **governance** arrangements ensure that **responsibilities** are clear and that **quality, performance and risks** are identified, understood and managed?
- How does the **leadership** and **culture** reflect the vision and values, encourage openness and transparency and promote good quality care?
- How are **people** who use the service, the **public** and **staff engaged** and **involved**?
- How are services **continuously improved** and **sustainability** ensured?

What we are trying to achieve



Forcing improvement – using *hard levers* of enforcement and registration

Encouraging improvement – using *soft levers* of information, ratings, system overview etc.

Homelessness in CQC's work

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- Homeless groups have fed into our method development
- A CQC workshop in September 2014 highlighted issues:
  - Poor – or denied – access to GPs and dentists is a big problem
  - Long-term homeless people may have complex and multiple needs, and chaotic lives
  - Access to phone and internet is difficult, and literacy is lower
  - Homeless migrants experience issues with translation
- CQC is working with:
  - a network of organisations to reach homeless people to provide information and encourage them and their advocates to speak to CQC
  - Experts by Experience with homelessness experience

Outstanding - it can be done! Charles Berry House, Leicester

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Well-led: 'Strong learning culture…and clear vision…staff felt valued and well-supported'

Integrated: 'Patients accompanied to hospital to reduce DNAs… primary care plus nurse helps with discharge'

Patient-centred: 'Contributes to funeral costs and memorials for homeless patients; created a memory wall'. 'Responsive to differing needs of patient population'

Flexible: 'Offers longer appointments for patients with learning disabilities'

Part of community: 'Nurses work with council outreach to visit homeless patients'

http://www.cqc.org.uk/sites/default/files/new_reports/AAAB9799.pdf

Not just ‘good enough’ standards

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“Always try to be a little kinder than necessary”
J M Barrie

“There is only one way to avoid criticism. Say nothing, do nothing and be nothing”
Aristotle

Culture

Standards are not enough

Leadership and culture drive improvement

Thank you

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