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healthwatch

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8th December 2014

Dear Ruth,

Thank you for your response of 14th August regarding our concerns with St Andrews Hospital in Northamptonshire.

I am pleased that local Healthwatch are part of the oversight and assurance process for St Andrews. As concerns have been raised into quality of care by the provider, it will be vital that the assurance and oversight process in place is robust enough to identify any shortcomings in the provision of care at St Andrew's and to act when necessary to ensure the safety of patients of St Andrews. We should all have the interests of patients and the provision of quality care at the forefront of our actions.

In your response you indicated that the results of your review into St Andrews would be completed three months from commencement of the review so we assume in November. Can you therefore please send myself and colleague Rosie Newbigging of Healthwatch Northamptonshire the summary report of the review as soon as it is in circulation. As the release of the CQC report into its recent inspection of St Andrews has been delayed, it is even more vital that the results of the NHS England review are promptly released.

I am pleased to hear that the summary report of the review will be made public. However, we still feel that the full report (or an adapted full report that removes patient identifiable information if necessary) is shared with Healthwatch England

and Healthwatch Northamptonshire. As a statutory partner, I do not understand why Healthwatch should not be able to view the full report.

We still remain concerned that the Terms of Reference for the review changed so substantially away from a review into the deaths at St Andrews. Whilst the review focuses on current care it is vital that lessons from the deaths, and other serious incidents, have led to the necessary improvements in care needed at St Andrews.

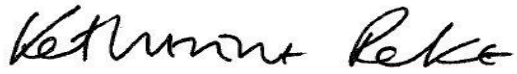
We wrote to you on 15th August asking you to join a proposed roundtable meeting. The purpose of the roundtable is to reflect on and understand better the various roles and responsibilities of local partners to enable effective collaborative working. I am disappointed that you do not feel it necessary to attend the roundtable meeting. We are continuing to organise this meeting with CQC colleagues – both national and regional and Healthwatch Northamptonshire and hope that you will reconsider and attend.

With regards to the wider policy issue of the investigation of deaths in mental health settings, we are surprised that there is not parity with the investigation procedure in mental health settings versus other custodial environments. We have raised this concern with Norman Lamb and our Committee remain concerned at the disparity. We are still awaiting the release of the updated version of the Serious Incident Framework. At the very least we hope that the updated framework will provide clarity on the process of investigation and lead to greater consistency in investigations, although we remain concerned on how the framework will be implemented.

I look forward to receiving your response and the results of the NHS England review into St Andrews.

With best wishes

Katherine



Dr Katherine Rake
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