RESPONSE TO THE HEALTHCARE COMMISSION CONSULTATION
'ASSESSMENT FOR IMPROVEMENT'

Introduction

Action against Medical Accidents (AvMA) is the only patients' charity which specifically promotes patient safety and justice when things go wrong in healthcare. It has been doing this for twenty-three years. AvMA's contact with approximately 5,000 people affected by medical accidents each year and close relationships with other patient groups gives us a unique insight into the experience and priorities of patients affected by medical accidents and the issues pertaining to patient safety and fair and effective investigation of medical accidents. AvMA also works closely with other agencies such as the NHS, Department of Health, National Patient Safety Agency (NPSA), and private healthcare providers. We are pleased to be able to contribute to the development to the Healthcare Commission's new approach to assessment, and look forward to working closely with the Healthcare Commission in the future.

We have restricted our response to the issues in which we have sufficient knowledge and experience. Firstly, on the overall process and secondly on the assessment of the individual core standards.

Overview

We understand the rationale for developing a different approach from that which was adopted by CHI, but have fears that the new approach relies too much on self assessment by healthcare organisations themselves. NHS managers and boards are more than capable of interpreting and presenting the information and prompts suggested in ways that show their organisation in a better light than is the case in reality. Whilst it is envisaged that the organisations' assessment will need to be corroborated by local bodies such as Overview and Scrutiny Committees and Patient Forums, these bodies are in their infancy, under resourced, and in the case of Patient Forums, do not even have any staff of their own. They are unlikely therefore to be able to be in a position to guarantee an appropriate degree of scrutiny of the self-assessments of the NHS organisations.

We recommend that here are more robust 'reality checks' on the organisations' self assessments than are currently proposed. There should be more emphasis on what happens in practice rather than whether there are 'systems in place'. The document mentions unannounced 'spot checks' and we would like to see much more detail about the nature and frequency of these. One option would be to conduct a small number of in-depth reviews each year. This would mean that the organisations would face such reviews very infrequently, thus succeeding in relieving much of the burden of inspections whilst giving some assurance about the rigour of the system.

The Healthcare Commission will need to overcome pressure from NHS organisations who will seek to undermine the credibility of bodies such as Patient Forums and Overview & Scrutiny committees who are critical or questioning of their self-assessment. The refusal of either of these bodies to approve an organisation's
assessment should spark an independent assessment by the Healthcare Commission. The Healthcare Commission should use whatever influence it has to enable Patient Forums to have their own staff to support them (based in PCT patient forums) and benefit from the added intelligence which providing the Independent Complaints Advocacy Service (ICAS) would bring.

We are concerned that Foundation Trusts should be subject to exactly the same standards, monitoring, inspection and public reporting as other NHS trusts.

We would like to see independent providers of healthcare subject to the same sorts of standards and monitoring as the NHS as soon as possible. This would be assisted by the Healthcare Commission taking on responsibility for the independent stage of a new complaints procedure for independent healthcare, which is consistent with the NHS complaints procedure.

Assessment of Core Standards

Core Standard C1: Patient Safety

AvMA welcomes the fact that Patient Safety is the first core standard and agrees with most of the approach suggested by the Healthcare Commission in *Assessment for Improvement – Understanding the Standards.* However, we have several comments about the elements of the standard, suggested prompts and potential sources of information which should be used to make the assessment.

In particular, we would like to see implementation of the "Being Open" guidelines which have been developed by the NPSA being monitored as part of the assessment for this standard. It is widely acknowledged that the development of an 'open and fair' culture or 'safety culture' is a vital factor in increasing the reporting of incidents and resultant learning from them. We believe that an essential factor in developing such a culture which is less concerned with individual blame is building confidence amongst patients and the public that there is more openness and honesty in reporting medical accidents to patients and families, as well as to the NPSA. The "Being Open" guidelines (and the training that will hopefully accompany them) can be a powerful tool to help develop such a culture, but only if they 'have teeth'. Compliance with the guidelines should therefore be carefully analysed as part of the Healthcare Commission assessment. We think that trusts should be required to provide evidence that they are implementing the guidelines and promoting them to staff. In particular, we think that trusts should be able to produce evidence of patient/family
involvement in adverse event / root cause analysis investigations. Further information which should be sought in order to make this assessment include:
- analysis of any complaints which have been brought to the Healthcare Commission to ascertain whether there is evidence of the guidance being implemented or no
- analysis of clinical negligence claims against the trust which have been defended but eventually settled to ascertain whether the guidance had been followed
- seeking feedback from advice agencies such as AvMA and providers of Independent Complaints Advocacy Services (ICAS)

We feel that the Developmental Standard 'D1' should in fact be an element of the core standard.

We believe that achievement of the top clinical negligence scheme for trusts (CNST) standard by all trusts should be a developmental standard.

In our opinion, trusts' rating in the CNST scheme should be regularly and publicly reported upon.

Core Standard 4: Healthcare Acquired Infections

We suggest that complaints data and where appropriate data from clinical negligence claims is sought to inform the assessment of how well infection prevention and control is actually practised, and where there have been lapses.

Core Standard 7: Clinical Governance

We suggest that the Healthcare Commission assesses whether patients and families are involved in investigations of medical accidents / adverse events (see also core standard 1) and that patients and the public are involved in the clinical governance work of the trust (see also core standard 17).

Core Standard 11: Staff

We suggest that every healthcare organisation should be assessed as to whether they check that all healthcare staff are appropriately indemnified. This is particularly important in PCTs, where it should apply to any independent practitioner on the PCT's list**,** to help avoid the possibility that patients may not be able to be compensated for clinical negligence.

Core Standard 14: Complaints

We believe that the Healthcare Commission assessment should go further than simply establishing that 'systems are in place'. **We recommend that an assessment is made as to whether the trust operates an effective complaints system.** Sources of information for this assessment should include evidence from ICAS and other agencies such as AvMA; surveys of complainants; and analysis of complaints brought to the attention of the Healthcare Commission.

We think that some of the suggested prompts need reconsideration. **Rather than asking whether the healthcare organisation 'provides advocacy', it should be established whether the organisation has a Patient Advice & Liaison Service (PALS) which is sufficiently resourced to resolve problems informally and advise people of formal complaints procedures where appropriate.**

The Healthcare Commission should seek evidence that the organisation's information on complaints contains information on independent organisations to contact for advice, including ICAS, without having to go through PALS.

Regarding core standard 14 (b): Discrimination, **we recommend that an important source of information would be numbers of patients removed from patient lists following complaints.**

Core Standard 17: Views of Patients and Carers

Organisations should be asked to demonstrate how they involve patients and carers in adverse event investigations and patients and the public more generally in the clinical governance / patient safety work they conduct.