RESPONSE TO

HEALTHCARE COMMISSION
DEVELOPING THE ANNUAL HEALTH CHECK
IN 2007-2008

APRIL 2007

Please comment on whether you think the annual health check will provide an appropriate assessment of the safety of care provided by NHS organisations and how it could be improved.

We welcome the priority being given to patient safety and the Commission's existing work and planned approach do go some way to providing an appropriate assessment of the safety of care. However, we recognise that no assessment of this kind will provide a comprehensive assessment of the actual safety of care being provided. What in effect the annual health check can realistically achieve, is an assessment of how seriously the trusts are taking patient safety and whether they have the essential 'building blocks' in place to continuously improve safety. There is great consensus amongst all key stakeholders that a key element is the development of a 'patient safety culture' within the organisation, and we believe that the assessment should seek to assess whether the organisation is adopting such a culture.

We believe that it is realistic to make such an assessment by asking trusts to report on the extent to which they have followed important guidance issued by the National Patient Safety Agency (NPSA) such as 'Seven Steps to Patient Safety' and 'Being Open'.

We believe that it should be made explicit that implementation of these guidelines will form part of the assessment.

'Being Open' is, we believe, an essential element of any patient safety culture. Trusts should be able to demonstrate that they have adopted a 'Being Open' policy and provided training to staff on 'Being Open'.

As the annual health check relies on self assessment by trusts, we also recommend that some reality – checking is done either on a case by case or randomised basis or as part of a national study. We would recommend an analysis of clinical negligence cases which have been brought against the trust – particularly where there has been an admission or finding of liability (negligence). An analysis of such cases including whether the incident was reported originally; what investigation of the incident took place; whether responses to complaints about the incident (where a complaint was made) were defensive or failed to identify serious error on behalf of the trust; and whether the case was originally defended or not. The ability of trusts to identify where they have been negligent and make a prompt and full admission should be a key indicator of whether a patient safety culture is being adopted. This will also be a requirement under the NHS Redress Act 2006.

The trusts' rating under the Clinical Negligence Scheme for Trusts should also form part of the assessment.