

## Editorial

**Peter Walsh, Chief Executive**

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While a lot of questions remain unanswered, things are beginning to take shape as regards how the new coalition government will deal with patient safety and the NHS as a whole. One thing that readers of this journal may take some heart from is the reaffirmation by the new Secretary of State for Health, Andrew Lansley, that patient safety remains the top priority. What that means in practice remains to be seen. However, from AvMA's perspective, the signs so far are good. In my last editorial, I mused over whether the new government would honour pledges made by both Conservative and Liberal Democrat parties to hold a full public inquiry into Mid Staffordshire NHS Foundation Trust. A full public inquiry has now been convened under the chairmanship of Robert Francis QC. I noted that the Liberal Democrats had included in its manifesto something that AvMA has been campaigning long and hard for – a statutory 'Duty of Candour' with patients/families when things go wrong in healthcare. That same commitment (to 'require' hospitals to be open when things go wrong) has found its way into the coalition's programme for government. The same can be said for another issue AvMA had called for action on – the requirement for foreign healthcare professionals to undergo robust language and competence tests before practising in the UK, and indeed the commitment to 'strengthen' the role of the Care Quality Commission (CQC) so that it 'becomes an effective quality inspectorate'. (Note the implication that the CQC is not seen as being so at the moment.)

Much has been made of the re-trenchment from the so-called target and 'tick-box' culture. I for one am no fan of targets that divert attention away from safe and effective care to bureaucratic process. However, we would be wrong to dismiss the benefits of targets. Many have played an important role in improving standards of care and patient experience. What any system that uses targets needs is some flexibility and common sense. For example, it was not the 4-hour target to admit patients through Accident & Emergency within four hours that caused the much-publicized failures in emergency treatment at Stafford. It

was the way that clinicians and management failed to use discretion so that patient safety came first. Failure to meet a target should not have adverse consequences if there is a credible reason why it could not be met without compromising patient safety. Other announcements made since the coalition government was formed may generate more debate and even concern in some quarters. Andrew Lansley announced that trusts will be penalized if patients they have treated and discharged are readmitted as an emergency within 30 days. Isn't that a target? While the intentions are laudable, isn't there also a danger of unwanted consequences? Might a trust be reluctant to admit someone as an emergency in these circumstances even if admission is warranted clinically? Should a trust be penalized if the reason for the readmission is not related to the treatment that was provided originally? A bigger question is whether financial penalties are a right and effective way of incentivizing patient safety and quality in a publicly-owned NHS. Whatever the answer is to that, the smart money is on us seeing a lot more of this sort of approach. Do not be surprised to see financial penalties coming soon in the form of non-payment for treatment which is necessary as a result of a so-called 'never event' in the same trust. 'Never events' are incidents that should never occur if basic good practice is followed and include things like wrong site surgery. The National Patient Safety Agency produced a list last year. Incidentally, AvMA are calling for pressure sores acquired in hospital to be added to that list.

The other big changes which we are likely to see in the not-too-distant future are the culling or merging of a quango or two. The CQC is likely to stay. Will it absorb the National Patient Safety Agency? AvMA would have preferred to have the regulation role and the data collection and solution finding roles under one roof. However, is the CQC too unwieldy already to be able to cope with this? How many people fully understand what the 'NHS Institute for Innovation and Improvement' actually does? One thing for certain is that it costs a lot of money. Is there scope for a merger here? Watch this space.