for patient safety and justice

Mr John O'Hara QC
Chairman
The Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast BT1 4GB

25 October 2013

Dear Mr O'Hara

The Inquiry into Hyponatraemia-related Deaths

I have pleasure in providing the following submissions to the Inquiry, and would be happy to assist further if you would like me to.

Background

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. Over the 30 years of its existence, AvMA has supported over 100,000 who have been affected by lapses in patient safety ('medical accidents'). The charity provides emotional support and practical advice through a team of specialist medico-legal advisers. This has provided us with an in-depth understanding of the way that the NHS deals with the aftermath of a medical accident and the way that affects the people concerned.

This submission will concentrate on how such incidents are handled in the NHS and how this could be improved. It will also touch on how patient safety and regulation could be improved so as to help prevent such incidents in the future.

AvMA's experience of how the complaints system operates in Northern Ireland in particular is not vast. We deal with around 12-20 cases a year from Northern Ireland. However, we believe that the issues we come across from across the UK are just as relevant to the NHS in Northern Ireland. We deal with approximately 3,000 cases a year from across the UK.

I have set out our main comments in this letter, but you may also wish to refer to the attachments:

- Our submission to the Clwyd/Hart review of complaints.
- Our briefing on the need for a Duty of Candour (Robbie's Law).
- Our witness statements to the Mid Staffordshire NHS Foundation Trust Public Inquiry.

The need for openness and honesty when things go wrong – a "Duty of Candour"

For years, based on the experience and priorities of the people we help, one of our biggest priorities has been to seek the introduction of a legal/statutory Duty of Candour. It remains the case across the UK that there is no statutory rule banning the cover-up of incidents which have caused harm in healthcare

There are, of course, statements of principle and guidance about this. We believe that a culture of cover-up and denial still pervades in certain parts of the NHS. This results not only in the gross injustice of patients/their families being denied the truth, but in the NHS failing to recognise error and how to prevent it in the future.

In England, following the recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry, the Government is planning to introduce a statutory Duty of Candour on all healthcare providers. For further information about the need for a Duty of Candour please see the attached briefing and our submission to the Mid Staffordshire public inquiry. We believe the introduction of a statutory Duty of Candour in Northern Ireland would be the single most important improvement to ensure that incidents that cause harm are dealt with appropriately.

A Duty of Candour could be made one of the "Quality Standards for Health and social Care" in Northern Ireland. The current standard "to have systems in place that promote on-going communication ……. where things go wrong" is far too general.

NHS Complaints Procedure

The NHS Complaints procedure operates in a very similar way in Northern Ireland to England, Scotland and Wales. We would draw the Inquiry's attention to the (attached) submission AvMA made to the review of NHS Complaints in England by Ann Clwyd MP and Professor Tricia Hart. This was commissioned by the Secretary of State for Health (England) to inform his response to the Mid Staffordshire Public Inquiry. We would also commend the findings of the Mid Staffordshire Public Inquiry itself regarding NHS complaints. The Clwyd/Hart review of complaints in England is due to publish its report on 28th October and may also be of interest to this inquiry.

In summary, we believe the NHS Complaints procedure in Northern Ireland could be greatly improved by:

- Removing any restriction/delay in investigating complaints on the basis of legal action which is being taken or intended.

- Independent involvement in monitoring and auditing Health Boards' handling of complaints.

- National standards, guidelines and regulation of how the NHS handles complaints in Northern Ireland.

- Complaints staff to be suitably senior in rank and receive training and accreditation for their role.

- Boards to receive and consider fuller reports of complaints, to include lessons learnt and action emanating from them – not just statistics.

- The complaints advice and support service provided by the Patient & Client Council could be improved by making provision for clients to be put in touch with more specialist sources of advice on clinical or medico-legal aspects of complaints.

Promoting and regulating Patient Safety

The failure to regulate healthcare providers adequately was a key theme in the Mid Staffordshire NHS Foundation Trust Public Inquiry. Whilst responsibility and leadership for patient safety must reside primarily with the provider, regulation can help set and uphold standards and provide a safety net by recognising problems and intervening early. We do not have enough familiarity with the system of regulation and promoting patient safety in Northern Ireland to comment specifically on it. However, we would suggest that some of the themes from the Mid Staffordshire Inquiry itself and our own submissions to it (attached) will be relevant.

Yours sincerely

Peter Walsh

Peter Walsh
Chief Executive

encs