Witness Name:	Peter WALSH
Statement No.:	1
Exhibits:	PW/1
Dated:	18 August 2010

MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

PROVISIONAL WITNESS STATEMENT OF
PETER WALSH

I, Peter WALSH, of Action Against Medical Accidents, 44 High Street, Croydon, will say as follows:

1. I have been the Chief Executive Officer of Actions against Medical Accidents ('AvMA') since January 2003. I make this statement on behalf of AvMA in response to the letter dated 6 July 2010 from the Mid Staffordshire NHS Foundation Trust Public Inquiry ('the Inquiry').

2. I produce a paginated bundle of documents, which I refer to by page number in the statement following, as exhibit **PW/1**.

3. Prior to joining AvMA, from 2001 until 2002, I was the National Director of the Association of Community Health Councils in England and Wales. From 1994 until 2001, I was the Chief Officer of the local Community Health Council for Croydon. Prior to this, I worked in the voluntary sector on community development, patient / public involvement in health and advocacy. All of these positions have given me considerable knowledge and experience of the NHS including:

   (a) the systems of monitoring and regulating healthcare;
   (b) patient involvement in health policy and planning;
   (c) complaints procedures and other methods of addressing clinical disputes; and
   (d) patient safety.

I have an MBA in health service management. I am invited to write and speak regularly on the issues of patient safety, regulation and access to justice in the healthcare context. I am the World Health Organisation's "Patients for Patient Safety Champion," a member of the National Patient Safety Forum, a trustee of the Clinical Disputes Forum and an editorial board member for the journal "Clinical Risk".

A. AvMA'S ROLE AND FUNCTIONS

4. AvMA is an independent UK charity established in 1982 to promote better patient safety and justice for people affected by medical accidents. AvMA defines "medical accidents" broadly to include any occasion when unintended harm is caused as a result of both treatment or a failure to treat patients appropriately or very simply, when "something goes wrong" in healthcare which causes harm. AvMA has no statutory responsibility or authority for the oversight, regulation or management of NHS services. Its responsibilities stem from its unique charitable focus on patient safety and justice.

5. AvMA is a registered charity (number 299123) and a charitable company limited by guarantee (number 2239250). The charity is governed by a council of trustees, of which there are currently 11 members bringing a rich blend of experience and expertise including health professional, medico-legal, patient involvement, patient safety, financial and management expertise. The charity employs 21 staff and has a turnover of approximately £1.2 million.

6. AvMA achieves its objectives in three principal ways:

   (a) Via a specialist *helpline and casework service*

   This provides free, independent advice and information to people who have been affected by medical accidents. A team comprising of trained staff and volunteers provide an initial source of advice for anyone who thinks that they or someone close to them may have been affected by a "medical accident" (AvMA leaflet "Medico-Legal Advice Service" exhibit PW/1, p1 – 2). Callers are advised of their rights with respect to different types of investigation and where appropriate, we will explain the applicable procedure including reporting patient safety concerns, making complaints to the relevant NHS

body or health professional regulator, participating in coroners' inquests, or taking legal action to both challenge decisions made or to obtain compensation.

Where appropriate, callers are either referred to one of our own caseworkers for more in depth advice or to other sources of expert advice and support, such as specialist solicitors or support groups. The helpline received 3,324 calls in 2009-2010 and 667 individuals had a casework file opened and were supported by AvMA caseworkers in making complaints, participating in inquests or engaging in other procedures.

(b) *By raising standards in clinical negligence legal work*

AvMA runs an accreditation system (recognised by the Legal Services Commission) for specialist clinical negligence solicitors known as the AvMA Specialist Clinical Negligence Panel. This is designed to make it easier for potential claimants to access genuinely specialist solicitors in this field. AvMA also provides information, advice and training services to solicitors. For example, AvMA hold a rolling programme of conferences with respect to clinical negligence and it's Annual Clinical Negligence Conference is recognised as the key event of the year for specialists in medico-legal work. Approximately 300 solicitors firms subscribe to AvMA's lawyers resource service which gives them access to AvMA's database of medical experts and regular updates on case law and policy developments.

(c) *By* bringing *about change with the health and legal systems*

As described in more detail below, AvMA works proactively with the relevant authorities, health professions and politicians to promote better patient safety within the health service and fairer systems of investigation and response when people are affected by medical accidents.

7. AvMA's expertise has led to it being widely recognised as the leading patient organisation on patient safety in the UK. AvMA has represented patients' interests on Department of Health patient safety and regulation work as follows:

(a) AvMA is the only patients' organisation represented on the Department of Health's National Patient Safety Forum. This is a high level forum of all key stakeholders brought together to oversee work on patient safety.

(b) AvMA was a member of the reference group for the Chief Medical Officer's Report, "An Organisation with a Memory" (2000) making recommendations to ensure that lessons from the past are used to reduce the risk to patients in the future.

(c) AvMA was a member of the reference group for the Chief Medical Officer's consultation paper, "Making Amends" (2003) which set out proposals for reforming the approach to clinical negligence in the NHS.

(d) AvMA participated in working parties on the implementation of the "Trust Assurance and Safety" White Paper (2007) concerning the regulation of health professionals.

(e) AvMA is currently assisting the Department of Health with the implementation of the White Paper "Equity and Excellence: Liberating the NHS" (2010) (' the "Liberating the NHS" White Paper'), with specific focus on ensuring that hospitals are required to be open with patients about things that go wrong. AvMA is still campaigning for the introduction a "Duty of Candour" as a regulatory requirement of the Care Quality Commission in England (and equivalent bodies elsewhere in the UK).

8. AvMA was, until March 2010, the National Patient Safety Agency's partner in managing the "Patients for Patient Safety" project designed to implement a Department of Health recommendation to recruit and support patients for patient safety "champions". AvMA were congratulated by the National Patient Safety Agency and others on their successful running of this project but, as of 1 April 2010, the National Patient Safety Authority decided to run this project in-house, due to resource constraints.

9. AvMA's expertise has also been recognised internationally. It is a participating organisation in the World Health Organisation's "World Alliance for Patient Safety." As noted above, in my personal capacity, I have been appointed by the World

Health Organisation as "Patients for Patient Safety Champion" for the European region.

10. AvMA's specialist focus sets it apart from other patients' organisations. Unlike other organisations, AvMA does not deal with issues of general policy or dissatisfaction with health services, for example, complaints with respect to car parking, catering, waiting times and other non-clinical matters. Rather, AvMA focuses exclusively on promoting patient safety and working to ensure that people affected by medical accidents are dealt with fairly. Given AvMA's extensive involvement with those affected by medical accidents through both its helpline and casework, and given its interface on a national level with the specialist clinical negligence legal profession, AvMA has unrivalled knowledge and expertise on patient safety issues. As a national organisation, AvMA is experienced in working with the Department of Health and the NHS, at national, regional and local level.

11. AvMA has an in-depth understanding of past and present systems of patient engagement and complaints support, having worked with Independent Complaints Advocacy Services ('ICAS'); Patient Advice and Liaison Services ('PALS'); Patient Forums; Local Involvement Networks ('LINks') and their predecessors; and Community Health Councils, as well as having advised the Department of Health on reforms. AvMA has for years worked closely with Community Health Councils and alongside ICAS. In addition to my experience with Community Health Councils, AvMA has a number of staff and trustees with in depth knowledge and expertise with respect to these bodies.

12. Due to its specialist experience and knowledge, AvMA is often looked to by other patients' groups and individuals to provide the patient perspective on these issues in national work. AvMA facilitates a wider network of patients' groups and individuals, such as individuals (and their families) who have experienced medical harm and so feel motivated to improve patient safety, and small informal patients' organisations such Patient Concern with an interest in patient safety. This is in order both to keep them informed, and to inform AvMA's own work on these issues. Members are updated on relevant developments and consultations and provided with opportunities to engage with the NHS on patient safety. They also provide a "sounding board" for AvMA to help inform our own policies. This is particularly important given the role AvMA plays in representing the patient

perspective in the National Patient Safety Forum and other national work on patient safety and regulation.

B. AvMA'S INVOLVEMENT IN THE ISSUES CONCERNING THE MID STAFFORDSHIRE NHS FOUNDATION TRUST

13. AvMA did not become aware of the issues within the Mid Staffordshire NHS Trust / Foundation Trust ('the Trust') until the publication of the Healthcare Commission's report "Investigation into Mid Staffordshire NHS Foundation Trust" in March 2009 (the 'Healthcare Commission Report'). Shortly after publication of the Healthcare Commission Report, AvMA established contact with Julie Bailey, the founder of Cure the NHS in Stafford. AvMA would like to pay tribute to Julie Bailey and her fellow volunteers at Cure the NHS in Stafford for the determined, courageous and compassionate role they have played in supporting local people and ensuring the failures at the Trust received the scrutiny they deserve. As we have both said publicly, it was such a shame that we did not know about each others' organisations until this advanced stage.

14. Given AvMA's specialist understanding of the roles of the NHS statutory bodies, the relevant complaints systems and the role of patient engagement and support bodies at the time, it was able to provide support and advice to those affected by the Trust's failures in a number of ways:

(a) *Advice,* information *and support provided to individuals contacting the AvMA helpline*

AvMA received a number of contacts directly from patients and members of their families affected by failures within the Trust. While it is not possible to identify every phone call that was made to our helpline concerning care at the Trust, we know that 45 individuals were subsequently supported by AvMA caseworkers. Services provided included help with pursuing complaints through the NHS procedure, referring health professionals to their professional regulatory body, advice on the prospects of taking legal action / obtaining compensation and where appropriate, referral to specialist solicitors.

(b) Support provided to individuals specifically referred to AvMA by Cure the NHS

Upon publication of the Healthcare Commission Report, AvMA established contact with Cure the NHS in Stafford, a patient support organisation set up by Julie Bailey, the daughter of an elderly patient who died in Stafford Hospital. Subsequently, AvMA reviewed 24 cases referred by Cure the NHS to AvMA. This was in order to give Cure the NHS a clearer idea of the issues arising with respect to these cases and the potential courses of action that should be considered.

(c) Support to families participating in the Independent Case Notes Review

Families who had lost a relative at the Trust were offered an "Independent Case Note Review" by the then Secretary of State for Health, Alan Johnson, after the Healthcare Commission Report was published. As explained below, access to AvMA's services for families taking up the offer of Independent Case Note Reviews was delayed due to the confusion about how this process was to be conducted. However, AvMA eventually supported 13 families through this process, with the costs of our support being met by South Staffordshire Primary Care Trust. This involved AvMA casework staff: travelling to Stafford to meet with families to help prepare for the review meetings; reviewing complaints information and medical records; attending the review meetings with the families; and subsequently reviewing the report from the Independent Case Note Reviews and discussing it with the clients concerned.

15. Since March 2009, AvMA has been in contact with the following organisations or people concerning issues such as: independent advice and support for people affected by events at the Trust; the Independent Case Note Review process; and learning lessons from what happened at the Trust:

(a) the Department of Health;
(b) the Health Select Committee;
(c) the Members of Parliament for the area;
(d) The Independent Complaints Advocacy Services (POhWER); and
(e) South Staffordshire Primary Care Trust.

16. Since March 2009, AvMA has worked closely alongside Cure the NHS in Staffordshire, in campaigning for a full Public Inquiry into Mid Staffordshire NHS Trust. Cure the NHS and AvMA jointly organised a public meeting in Stafford which was attended by over 100 members of the public with concerns about the Trust, and which was addressed by all three local MPs as well as ourselves. AvMA was represented at two further public meetings held in Stafford.

17. I wrote on behalf of AvMA to the Secretary of State for Health, Alan Johnson MP (letters dated 24 March 2009 and 23 April 2009, exhibit PW/1, p3 – 4) in the weeks following the publication of the Healthcare Commission Report with respect to the need for a Public Inquiry to be convened. We received a response from Health Minister, Ben Bradshaw MP, on 13 May 2009 confirming the view that a Public Inquiry would add little to the Healthcare Commission Report and subsequent reports prepared by Dr Colin-Thome and Professor Alberti (exhibit PW/1, p5 – 6). Following the announcement of Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust ('the Independent Inquiry'), I wrote to the new Secretary of State for Health, Andy Burnham MP on 26 August 2009 suggesting that the inquiry become a Public Inquiry (exhibit PW/1, p7). We received a response from Health Minister, Mike O'Brien QC MP, on 28 September 2009 (exhibit PW/1, p8 – 9) confirming that it was a matter for the Chairman of the Inquiry to determine whether there were compelling reasons for the inquiry to become a Public Inquiry. After Mr Burnham announced a new inquiry would be held in late February 2010, I again wrote to him setting out the areas which AvMA believed should be investigated in a full Public Inquiry under the Inquiries Act 2005 (exhibit PW/1, p10 – 11).

D. AvMA'S VIEWS ON SPECIFIC FAILINGS AND LESSONS TO BE LEARNED

18. AvMA's views on the lessons to be learned from events at the Trust and how the bodies and systems which have a role in helping prevent or intervene in such issues, based on what we know so far, are as follows:

The role of AvMA

19. AvMA's involvement in the period following the publication of the Healthcare Commission Report highlighted that there is a clear need for there to be a greater

awareness of the services AvMA provides and for these to be better promoted to people who may need them. This is particularly the case when there is an incident or situation affecting a large number of people, as was the case in Staffordshire. AvMA is the only independent charity offering specialist services to people who have been affected by "medical accidents" and yet the relevant statutory bodies failed to advise patients or families affected by events at the Trust of AvMA's existence until very late in the day. One way of ensuring that the appropriate support is available in situations like these would be to establish an understanding with the Department of Health, and the NHS, about engaging with AvMA when problems arise with respect to a particular service, hospital trust or area.

Regulation of NHS Trusts and Foundation Trusts

20. It seems clear from the earlier investigations with respect to the Trust that there was a lack of joined-up thinking about who should monitor and regulate NHS trusts, including Foundation Trusts. As addressed within the report following the Independent Inquiry published in March 2010, this is exemplified by the fact that Monitor approved the Trust for Foundation status at the very time that the problems were at their worst.

21. It appears to AvMA, as illustrated by the research completed with respect to the implementation of Patient Safety Alerts detailed below, that there is still a lack of such joined-up thinking between monitoring and regulation functions today. In existing and future arrangements, AvMA believe that it is necessary to clearly define the respective roles of "regulatory" bodies and "commissioning" bodies. In accordance with the Government's current proposals in the "Liberating the NHS" White Paper, it appears that Monitor is to concentrate on financial matters and the Care Quality Commission will be the sole national regulator concerned with quality and safety. Bodies such as Primary Care Trusts, Strategic Health Authorities and the National Patient Safety Agency are to be abolished and a new NHS Commissioning Board will be established which will, amongst other responsibilities, take on the functions currently performed by the National Patient Safety Agency.

22. We perceive both opportunities and threats for the proper promotion and regulation of patient safety in these proposals. A familiar criticism of the National Patient Safety Agency has been that it "lacks teeth". For example, the National Patient Safety Agency issues vitally important Patient Safety Alerts but has no powers to

monitor or regulate their implementation. The NHS Commissioning Board might have "more teeth" to ensure that Patient Safety Alerts are implemented. On the other hand, the main strength of the National Patient Safety Agency has been its pure focus on patient safety, which may be diluted by combining its functions within the NHS Commissioning Board.

23. There is an urgent need to have a consistent approach to deal with data about trusts which comes to the attention of regulators and commissioners, such as high mortality rates, non-compliance with Patient Safety Alerts, individual complaints and legal claims. As has already been accepted by previous investigations and reports into events at the Mid Staffordshire NHS Trust, there were failures to listen closely enough to concerns being raised by patients and their families either informally or through complaints. While the Healthcare Commission's concerns about the high mortality rates at the Mid Staffordshire NHS Foundation Trust eventually led to closer scrutiny and intervention, it appears from the Independent Inquiry Report, that there was no consistent approach to interpreting mortality rate statistics amongst the Trust, Primary Care Trust, Healthcare Commission or the Department of Health. This meant that earlier opportunities to act were missed, not only by the Trust, but by the Strategic Health Authority and Primary Care Trust.

24. Looking at the present and to the future, there still appears to be confusion about how mortality rates should be measured and interpreted. Although the Department of Health has set up a working party to try to agree on a consistent approach to measuring mortality, which is very welcome, there remains the question of how to monitor the data gathered and ensure that issues are identified.

25. AvMA's perception, from the investigations into the Mid Staffordshire NHS Foundation Trust, is that there was a reluctance to interfere with an individual hospital trust, especially a Foundation Trust, unless and until the problems were so severe, and the evidence so overwhelming, that there was no option but to do so. By this time, however, such intervention is too late for many patients affected by unsafe standards and practice. There were opportunities for the Strategic Health Authority and the Healthcare Commission to intervene much earlier with respect to the Trust. We hope that the Inquiry will ask the relevant representatives of these bodies to explain when they first became aware of problems within the Trust and also, to explain the nature and extent of any sensitivity about the timing of when to intervene.

26. Reluctance to intervene and delay in intervening are issues which AvMA believes persist today. This is exemplified by the extreme reluctance of the Care Quality Commission, Strategic Health Authorities, Primary Care Trusts or the Department of Health to intervene in any way over non implementation of Patient Safety Alerts (as shown by our research discussed below). The new Government has made clear its commitment to freeing NHS bodies of unnecessary bureaucracy and targets. We believe that freedoms must be balanced with accountability when it comes to patient safety. We also believe that regulatory bodies must be more proactive in following up indications of unsafe practice in any hospital trust and any inhibitions about their doing so be removed.

27. In February 2010, AvMA published its research into the extent to which Patient Safety Alerts issued by the National Patient Safety Agency were being implemented ("Adding Insult to Injury – NHS Failure to Implement Patient Safety Alerts" (February 2010), exhibit PW/1, p12 – 99). This showed that there was widespread non compliance with the alerts. In one example from our original study, University Hospitals Coventry NHS Trust had 37 out of the 53 alerts outstanding. The same trust has, according to Dr Foster Intelligence, had higher than average standardised mortality rates for a number of years. Our latest report published six months later ("Implementation of Patient Safety Alerts" (August 2010), exhibit PW/1, p111 – 136), highlights that there was still widespread non compliance, with 251 (63%) of trusts non compliant with at least one alert, 29 trusts (7%) being non compliant with ten or more alerts, and some of the overdue alerts being years past their deadline. This was in spite of the public concern that had been generated from our first report, which resulted in the Department of Health writing to all trusts reminding them that they "must" complete the required actions in the alerts by the given deadline and report this to the system.

28. Even more surprisingly, AvMA's enquiries with the Care Quality Commission discovered that they, the national regulator, had taken no action at all with regard to any of the trusts who were non compliant with Patient Safety Alerts – not even those like University Hospitals Coventry NHS Trust which had <u>both</u> multiple alerts outstanding (some of which were several years past the deadline) <u>and</u> about whom there were other worrying indicators, such as high mortality rates. We discovered that the Care Quality Commission had not contacted a single trust even by letter or telephone to follow up these Patient Safety Alerts. Only as a result of AvMA's

intervention did the Care Quality Commission subsequently write to 30 of the 251 trusts which our second study found were non compliant with at least one alert (these being the trusts with the most alerts outstanding). We have been given no indication that the Care Quality Commission intends to take even the minimal steps of writing to trusts with respect to non compliance with Patient Safety Alerts in the future.

29. AvMA believe it is important for the Inquiry to investigate how the various bodies with responsibility for monitoring and regulating the quality and safety of care at the Mid Staffordshire NHS Foundation Trust made use of various indicators available, including compliance with Patient Safety Alerts, complaints and litigation information and mortality rate data. Our first study looked at the situation as it stood at 29 December 2009. It showed that the Trust had 6 patient safety alerts outstanding at that time. Our second study is based on data collected on 7 June 2010 and shows that the Trust was still non compliant with 5 alerts. We find this surprising given the huge focus on patient safety at the Trust since publication of the Healthcare Commission report. We would like to know more about the Trust's compliance with Patient Safety Alerts during the period covered by the inquiry and to understand what use, if any, was made of the data by the present monitoring, commissioning and regulatory bodies.

30. AvMA understand that the Care Quality Commission is currently developing a system of "Quality & Risk Profiles" for each NHS Trust which combines a whole range of indicators such as those described above. We hope that the Inquiry will look at the capability of this system to generate the kind of investigation and intervention which would have prevented a situation like that in Staffordshire developing. Based on what we have seen so far, and particularly in relation to the ambivalent attitude to non compliance with Patient Safety Alerts, we are worried that Quality & Risk Profiles may be too blunt and unresponsive a tool. Rather than waiting for an accumulation of different indicators to spark some action, we believe that a more proactive response is needed. For example, being out of line with a single indicator such as compliance with Patient Safety Alerts or mortality rates, or information from complaints or litigation, should at least prompt questions being asked of the trusts concerned and closer scrutiny of the other indicators.

Patient / public advice, support, complaints and involvement

31. It is particularly worrying that the reported attempts by patients / their families to get their concerns addressed failed, as has been identified by investigations into the Trust so far, reflecting reports made to both Cure the NHS and AvMA by individuals concerned. We believe an important reason for this is the lack of availability of appropriate advice and support for people in pursuing their concerns or complaints. This is an area which AvMA considers is in need of urgent reform. We believe that had individuals been empowered through access to independent specialist advice and support, and had there been a body able and willing to act on the collective concerns which they were hearing from patients/families, then the problems at the Trust may have been identified and acted upon earlier than they were. We think that this is an important area for the Inquiry to consider and to make recommendations on for the future.

32. In the past, Community Health Councils provided a local "one stop shop" for patients and the public. People could go to the Community Health Councils for a range of reasons, including:

(a) Advice about patient's rights within the NHS;

(b) Help with making complaints to the relevant bodies within the NHS;

(c) Raising issues of concern for the Community Health Councils to follow up with its monitoring role;

33. In addition, Community Health Councils were responsible for monitoring the NHS and raising issues identified with the trusts concerned or the relevant authorities. Community Health Councils were independent from the NHS, which enabled these bodies to effectively raise both individual and systemic concerns and press for appropriate changes to be made. Further, given their combined functions, the information received from patients contacting the Community Health Councils with respect to individual concerns would inform their monitoring role. While the Community Health Councils were locally accessible, as part of a national body, it meant that information obtained was shared in order to provide an overview of issues arising and identification of particular patterns of concern.

34. Community Health Councils were abolished in 2004 as a result of controversial plans announced in the Government of the time's "NHS Plan" (2001). The actual reasons for the abolition have been the subject of fierce debate ever since. Some

suspect that this was a deliberate means of weakening the patient voice in order to dilute potential opposition to reforms – that Community Health Councils had become a watchdog with too much bite. Little detailed rationale was ever provided other than the Government stating that it believed the reforms would strengthen rather than weaken the patient voice. Whatever the reasons, Community Health Councils have been replaced by a confusing and fragmented range of bodies (PALS, ICAS and LINks) performing their former functions. These are discussed below.

Patient Advice and Liaison Services

35. PALS were and are essentially "customer care" services provided by staff employed by the relevant trust itself. However, while they are part of the trust and not truly independent, they are portrayed by the Department of Health as part of the system of patient and public involvement. We have received feedback from the families of patients at the Trust who we have worked with, and from Cure the NHS, to suggest that there was some confusion at the Trust about the role of PALS as opposed to the complaints staff of the Trust itself.

36. AvMA believe that the Inquiry should seek information to assess the extent to which this service ensured that patients concerns were appropriately dealt with; whether key information was used to inform monitoring and regulatory bodies internally and externally; and whether potential complainants and claimants were advised of the availability of independent advice and support from bodies such as ICAS and AvMA.

37. There is a need for a clearer understanding about the role of PALS and consistency in PALS' provision across the country. In AvMA's experience, PALS can be a very useful and effective service both in resolving patients concerns before they get too serious, and in providing feedback to the trust about patient experience. However, PALS are resourced and organised differently across the country. In some cases, they are extremely poorly resourced and in some, as has been suggested in the case of the Trust, there is confusion between the PALS and the complaints function. AvMA has found that some of our clients are given the impression that it is almost a requirement to seek to resolve problems with PALS before having a complaint formally investigated, which may put off some patients from proceeding further.

38. While AvMA receives a number of referrals from PALS, it appears to us that there is also a lot of inconsistency about the information that is provided about independent sources of advice for patients with concerns and complaints. We note for example that there is still no information about ICAS or AvMA available on the Trust's website. We believe that information about ICAS and information about more specialist national services, such as those provided by AvMA, needs to be more proactively made available to patients by PALS, complaints and claims staff in individual trusts, and also through national information sources such as the Department of Health and NHS Choices websites.

Independent Complaints Advocacy Services

39. ICAS is a service established to replace the complaints support function previously provided by Community Health Councils. The Department of Health awarded contracts to three charities for provision of ICAS in different parts of the country.

40. In Staffordshire, ICAS are provided by an organisation called POhWER. AvMA has been unable to find any public information provided by POhWER about complaints it dealt with concerning the Trust or any actions it took to follow up concerns within different bodies. Further, telephone calls AvMA made in March 2009 to the regional office requesting a discussion about the issues within the Trust have not been returned. AvMA believe that, as with PALS, the Inquiry should obtain information to assess the extent to which this service ensured that patients concerns were appropriately dealt with and whether key information was used to inform monitoring and regulatory bodies internally and externally.

41. We are concerned that the contractual relationship between the Department of Health and ICAS may potentially hinder, or be perceived to hinder, its ability to be proactive in raising concerns, due to concerns that ICAS providers may have about the effect this will have on future contracts. In the case of POhWER, according to its Annual Accounts for the year 2008 / 2009 (exhibit PW/1, p137 – 159), over 70% of the charity's income under service level agreements for that financial year was from the contract with the Department of Health for ICAS. We have no evidence that POhWER in Staffordshire were in fact inhibited in the way they offered services to the people affected by events at the Trust or in speaking out about what they learnt from their casework. However, we believe that complaints support

and advice services must both be completely independent and also, be seen to be independent.

42. We would like the Inquiry to look in detail at how ICAS operated during the period in question as well as how complaints support might be more effectively provided in the future. AvMA also believe that the complaints support functions need to be integrated within the bodies responsible for representing patients and the public interests in health, social care and monitoring services (as was the case with Community Health Councils).

43. It became even more apparent to us as a result of the work AvMA has done advising and supporting people in connection with their concerns about the Trust, that in addition to generic help and advice with NHS complaints, there needs to be more specialist advice services available to members of the public with complex and serious concerns about healthcare. For example, cases we have dealt with have included the need to explain medical and medico-legal terminology; support people through inquests; advise people about making referrals to health professional regulators; and advising them on options for taking legal action of one kind or another and putting them in touch with suitable specialists where appropriate. These are issues which are outside the remit of ICAS, which aims to help people navigate the NHS Complaints Procedure, and requires quite specialist expertise.

44. These particular issues were formally acknowledged by the Department of Health's "Tackling Concerns Locally" working group set up to plan implementation of the White Paper of Health Professional Regulation "Trust Assurance and Safety - the Regulation of Health Professionals in the 21st Century" (2007). This White Paper sought to take forward the lessons from various inquiries into health related scandals, including the Harold Shipman inquiry. The specific recommendation to fund a specialist, independent service to advise and support people who may wish to report concerns about a health professional to the appropriate regulator has not been taken forward as yet. Further, in the report published by the working group set up to deal with "Tackling Concerns Locally" (2009), it was recommended that dedicated specialist support should be commissioned for vulnerable patients or those with complex needs. There remains no such service funded for cases with the most serious consequences for patient safety, while millions of pounds are spent annually on generic NHS complaints advocacy in the form of ICAS.

Local Involvement Networks

45. LINks are the patient and public involvement bodies which replaced Patient Forums. In turn, Patient Forums had replaced the patient involvement and monitoring functions of Community Health Councils. Patient Forums and subsequently, the LINk, covering the Trust were clearly not able to provide a strong and independent voice for patients concerned about the Trust. Had they effectively fulfilled this role, there may not have been the need for Cure the NHS in Stafford to have been created at considerable cost and inconvenience to the dedicated and skilled individuals who did so. It is not reasonable to expect every local community to be able to rise to a need in the impressive way that Julie Bailey and her colleagues did.

46. Apart from the chaos created by the abolition of Community Health Councils and then Patient Forums, AvMA believe there are inherent weaknesses in the organisation of LINks:

(a) Their separation from the complaints function described above;

(b) The lack of their own paid staff. Instead, Local Authorities appoint "host organisations" to provide certain support services to LINks. This is not the same as having a dedicated and specialist staff team who are part of the same movement as the voluntary members. Staff are unlikely to be as motivated and work as part of a team with the voluntary members as they would be if they were part of the same movement, and there is a danger of conflicts of interest (between the interest of the LINk, the host organisation and the Local Authority, whose social care services the LINk monitors);

(c) There is no national association funded to provide national support and co-ordination for LINks and to pursue issues with national implications based on intelligence from local LINks.

47. Had Community Health Councils been in place at the time in Staffordshire, AvMA believe it would have been likely that more people would have approached the Community Health Council for help with their complaints. In turn this would mean that:

(a) More use would have been made by the Community Health Council of information that came to its attention through complaints, which would have led to the concerns being brought to the attention of the Trust and other relevant regulatory bodies; and

(b) The Community Health Council would have publicly raised concerns and applied pressure for the relevant bodies to intervene with the Trust.

48. AvMA believe that the Government's proposals for "HealthWatch" outlined in the current "Liberating the NHS" White Paper and related publications, have the potential to address these weaknesses, although it is difficult to assess how this will work without further detail. AvMA's immediate concerns with the proposals, as we currently understand them, is the actual and perceived independence of the national HealthWatch if it is housed with the Care Quality Commission; and of the local HealthWatch being commissioned by local authorities whose social care services they need to monitor. As discussed above, we feel that HealthWatch would be stronger, more independent and effective if it had its own staff / secretariat paid for from a set budget.

The role of the Department of Health / Secretary of State in responding to the public

49. We understand from our work with Cure the NHS, and our attendance at public meetings, that several people wrote directly to the Secretary of State for Health, as others did through their MPs, in an effort to raise the alarm about how bad things had become at the Trust. We appreciate that there were, and are, other mechanisms in place for members of the public to raise concerns and that ministers cannot be expected to personally deal with individuals' direct correspondence in detail. However, we suggest that it may be relevant for the Inquiry to investigate how correspondence sent in this way was dealt with. We feel that there may be lessons to be learned about how the Department of Health can be more proactive in responding to members of the public raising their concerns directly to it.

Openness, Honesty and Transparency

50. The lessons learned from what happened within the Trust are relevant not only to the Trust itself but to the policy and regulatory environment in which it worked, and in which all hospital trusts continue to work.

51. As the Independent Inquiry discovered, there were real problems with staff feeling unable to "whistle blow" at Stafford. It is widely acknowledged that a culture of staff feeling unable to report mistakes is not unique to Staffordshire but widespread (possibly endemic) in the NHS. More needs to be done to enable and encourage staff to report problems in a positive culture of openness and candour without fear of personal and professional reprisal.

52. A related issue is the degree to which hospital trusts are not required to be open and honest with patients, their families, or even other inquiries (such as a coronial inquest) about things that "go wrong" in healthcare. This has the dual consequences for leaving the patients and families without appropriate resolution or redress of their concerns and preventing relevant information being acted upon by monitoring and regulatory bodies. A particularly serious example is the case referred to within the Independent Inquiry Report concerning the misdiagnosis of a 20 year old man following a bicycle accident, leading to his avoidable death. This is a case in which AvMA is currently providing casework support to the family concerned. It appears that an employee of the Trust suppressed a critical internal medical report about the standard of care provided by the Trust from not only the family, but also the coroner. The family only became aware of internal report and how it had been suppressed as a result of the Independent Inquiry. We suspect that more than one member of staff would have known and been compliant with this cover up.

53. AvMA (and our panel of specialist solicitors) regularly come across other examples of patients, or their families, not having been dealt with openly and honestly when things have gone wrong. The Department of Health itself recognises that there is a "culture of denial" in the NHS ("Safety First: A Report for Patients, Clinicians and Healthcare Managers," Department of Health 2006). In the executive summary to the "Liberating the NHS" White Paper, the Government says it will "require" hospitals to be open and honest with patients when things go wrong. However,

there is no detail within the body of the paper explaining how this proposal will be put into effect.

54. Although the Department of Health appears to encourage whistle blowing and honesty with patients and families when things go wrong, for example through including such a commitment in the NHS Constitution, AvMA do not believe that this goes far enough to:

(a) deter and / or prevent unacceptable pressure being brought to bear on potential whistle blowers, so as to stop them from reporting problems; nor

(b) to positively require providers of healthcare to be fully open and honest with families when things have gone wrong.

55. AvMA believe that new and clear statutory requirements need to be implemented so as not to deter whistle blowers and to place a positive duty on medical healthcare providers be fully open and honest with patients/families when things do go wrong (a "Duty of Candour"). AvMA believe that such a Duty of Candour, backed up by suitable sanctions, would significantly help create the right environment for vastly improved patient safety, as set out in AvMA's briefing note "The Need for a Statutory Duty of Candour in Healthcare" (exhibit PW/1, p160 – 168).

56. It should be noted that the "Liberating the NHS" White Paper contains what at first sight appears to be a commitment to introduce a statutory "Duty of Candour", saying it will "require" hospitals to be open and honest with patients when things go wrong. However, AvMA has since received a letter from Health Minister, Simon Burns MP, on 21 July 2010 (exhibit PW/1, p169) indicating that a statutory duty is only one option being considered. AvMA is represented on a Department of Health working party looking at this issue.

57. A further significant factor to take from events at the Trust was the lack of transparency at the Trust Board level. As detailed in the Independent Inquiry Report, complaints, incidents and patient safety were not reported and discussed at board meetings and the board did not meet in public. It remains the case that Foundation Trust boards can choose not to meet in public. AvMA believe that this

aspect of transparency is essential in promoting better accountability and governance.

58. We would like the Inquiry to look at the issues of openness, honesty and transparency not only at the Trust during the relevant period, and how the other relevant bodies dealt with these issues at the time, but how improvements could be introduced in this policy area in order to reduce the likelihood of the events at the Trust being repeated.

Response to large scale incidents such as those at the Trust

59. AvMA believe there are important lessons to be learnt from how the healthcare system, including the Department of Health, responded to the problems which emerged at the Trust during and since the period covered by the Independent Inquiry. We set out our main concerns below.

Circumstances in which a Public Inquiry should be held

60. AvMA consider that much valuable time (and money) has been lost as a result of the previous Secretary of State's refusal to hold a full public inquiry immediately following the publication of the Healthcare Commission Report. This has been very damaging to overall public confidence in the system and maintained a veil of controversy and uncertainty over the Trust itself during a time when its focus should be on improving the standards of service and identifying lessons for the benefit of the wider system. AvMA campaigned for a comprehensive public inquiry soon after publication of the Healthcare Commission Report and continued to do so (see p3 - 11 of exhibit PW/1 referred to above). We have consistently made the point that if a public inquiry under the Inquiries Act 2005 was not justified in this case, it would be hard to imagine a situation in healthcare in which one would be justified. We believe it is important that guidance be issued on the nature and extent of investigations that should take place into large scale healthcare failures, such as those that occurred within the Trust. This should include some guidance as to when a public inquiry under the Inquiries Act 2005 would be justified.

Liaison with patients and their families

61. We believe that the Department of Health (and any other suitable bodies) should also have a plan in place for how to communicate with patients and families who

may have been affected by large scale failings such as those at the Trust, and make provision for specialist advice and support to be available. For example, while we were impressed to hear the then Secretary of State, Mr Johnson, on national television immediately after the Healthcare Commission Report was published offer "Independent Case Note Reviews" to families of anyone who had died at the Trust, we were surprised to discover that there had been no pre-planning about how this process would actually work.

62. After the Independent Case Notes Review process was announced, AvMA offered advice and assistance to the Department of Health and the Trust in the design of this process. Initially, I wrote by email to the Department of Health on 23 March 2009 offering AvMA's help and advice and seeking a discussion with the appropriate person (exhibit PW/1, p170). In my letter to the Secretary of State on 24 March 2009, I sought details of the process and indicated that I expected AvMA's helpline to receive a large number of calls. After no response was received, I sent a further letter on 24 April 2009 requesting a meeting with Mr Johnson (exhibit PW/1, p3 – 4). Although our offers to be involved in planning the review were not accepted, AvMA subsequently became involved when an independent consultant, Professor Laker, was appointed to conduct the review and the Primary Care Trust took responsibility for this process. Further to information provided by Helen Moss concerning the review process on 30 April 2009 and 13 May 2009 (exhibit PW/1, p171 - 178, I wrote on 20 May 2009 confirming that AvMA hoped to assist families involved in the review process (exhibit PW/1, p179 – 180). Further to confirmation of receipt of my letter from Dr Moss on 19 June 2009 (exhibit PW/1, p181), I wrote again on 29 June 2009 following up the issues raised in my earlier letter (exhibit PW/1, p182) and Dr Moss confirmed on 21 July 2009 that AvMA information was being sent to families involved in the review (exhibit PW/1, p183 – 184).

63. AvMA was particularly disappointed to find that its offers of our advice and assistance in planning this process and in supporting families through the process were not taken up either by the Department of Health or the Trust. AvMA even found it difficult to get the Trust to tell people about our existence and only became directly involved when the review process was transferred to the Primary Care Trust. Consequently, a large number of families who went through, or potentially could have gone through, the Independent Case Note Review process never heard

about the availability of independent specialist help. AvMA is an independent body ideally placed to help in these circumstances yet its strengths were not utilised.

Coroners' inquests

64. AvMA has assisted or is in the process of assisting three families of patients whose deaths have been or are due to be the subject of an inquest relating to care at the Trust. The potential for coroners' inquests to get to the bottom of healthcare related deaths and to identify shortcomings which can be addressed by the system is a particular priority for AvMA. We have recently launched our own project designed to ensure that specialist representation is made available to all families in healthcare related inquests (AvMA leaflet "Inquests into deaths following medical treatment" PW/1, p185 – 192), and we have lobbied long and hard for changes to the coronial system. We have been surprised at the low numbers of inquests held in relation to deaths at the Trust. Some members of the public have voiced concerns to us that an ex-employee of the Trust was employed as deputy coroner in the area.

65. In light of these concerns, we consider it would be appropriate for the Inquiry to consider the operation of the coroner's service in relation to deaths at the Trust, and at how inquests might by highlighting problems that occurred at the Trust, ensure that lessons are learned and that these events do not happen again.

Clinical negligence litigation

66. AvMA has long been concerned that not enough use is made of information from clinical negligence claims to inform work on patient safety and regulation. We understand from solicitors within AvMA's network that a number of serious claims were made during the period in question relating to alleged clinical negligence at the Trust. We are in the process of collecting further information on this from our member solicitors.

67. We hope the Inquiry will want to investigate if and how this information was captured by the NHS Litigation Authority ('NHSLA') and reported to the relevant supervisory and regulatory bodies. Consideration should also be given to the role that the NHSLA plays in relation to risk management through its Clinical Negligence Scheme for Trusts ('CNST') and how this interacts or should interact with other NHS work on patient safety.

68. With respect to the involvement of the NHSLA in monitoring issues in healthcare, we have recently become aware of an initiative from the NHSLA requiring Defendant panel member solicitors to provide anonymised risk assessments for all cases reported to the NHSLA from February 2010, to be forwarded to the relevant NHS trust to inform its own risk management processes (Letter from Steve Walker, Chief Executive of the NHSLA dated 2 February 2010, exhibit PW/1, p193 – 195). This is an open acknowledgment by the NHSLA that their claims management and risk management functions should play an important role in addressing patient safety issues, which has not happened to date. This development is welcomed by AvMA.

Accountability of both clinical and non-clinical staff

69. One of the ways in which it is hoped that both healthcare and management staff are incentivised to prioritise patient safety is through the holding to account of those who have seriously failed in this regard through either disciplinary and / or regulatory measures. Accountability should not be confused with "blame culture" which relates to the scapegoating of staff following more systematic failures. The current terminology for an organisational culture conducive to good patient safety is an "open and fair culture" in which we believe it is only right and proper that those staff or managers that have failed their obligations be held to account, both to prevent them doing so again and as an example to others. There is a strong feeling amongst members of the public with whom we have spoken, both at Stafford and beyond, that this does not appear to have happened here.

70. While we appreciate that the Inquiry is not there to apportion blame to individuals, we do think there are important lessons to be learned from: how key people have or have not been held to account for their role in allowing events at the Trust to have taken place; the systems that exist for doing this; and what can be done to improve the systems.

71. With respect to health professionals within the Trust, AvMA made a Freedom of Information Act request to the Trust on 17 June 2009 asking how many doctors had been referred by the Trust to the General Medical Council ('GMC') in the period 1 January 2002 to 17 June 2009. The same information was sought with regard to nurses and the Nursing and Midwifery Council ('NMC') (exhibit PW/1,

p196). The Trust responded by letter dated 3 August 2009 (exhibit PW/1, p197). We found it surprising, given the reports of such widespread and seriously sub standard care within the Trust, that so few referrals had been made since 1 April 2005: only two doctors had been referred to the GMC and only one nurse had been referred to the NMC.

72. Also surprising is the Trust's admission that "our records prior to April 2005 do not contain enough detail to confirm the number of referrals made". We find it staggering that an NHS trust did not maintain accurate records of which of its employees it has referred to a health professional regulator. However, it seems that the Trust was not alone. AvMA made the same request under the Freedom of Information Act to Maidstone and Tunbridge Wells NHS Trust. In its response dated 13 July 2010 (exhibit PW/1, p198 – 199), it confirms that "the information is not held by this Trust prior to the last financial year." Furthermore, this trust confirmed that they had referred to the GMC and NMC, which were unable to help answer the question for them.

73. The fact that so few referrals to regulators have been made and that such poor systems exist for recording referrals made to regulators, raises serious questions about the way the Trust and other trusts deal with: regulatory matters; their relationship with the health professional regulators; and about whether the health professional regulators themselves need to be more proactive in getting involved in trusts where there are serious widespread problems reported. We would like the inquiry to consider these issues further.

74. However, our concerns do not just relate to the regulation of health professionals. It is a cause of concern that non-clinical staff within senior management roles at the Trust (as well as the bodies responsible for monitoring and regulating the Trust) are neither bound by any professional code nor subject to any duties or responsibilities overseen by a compulsory regulatory body. This is something that we consider to be a flaw in the current system and it is also an area that we would like the Inquiry to consider.

75. I believe that the facts stated in this witness statement are true.

Name..... PETER WALSH

Signed .....

Dated 18/08/10