

Witness Name: **Peter WALSH**  
Statement No: **Second**  
Exhibits: **PW/2**  
Dated: **December 2010**

## **THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY**

---

### **SUPPLEMENTARY WITNESS STATEMENT OF PETER WALSH**

---

I, **Peter Walsh** of Action against Medical Accidents, 44 High Street, Croydon will say as follows:-

1. I have already provided a provisional witness statement to the Public Inquiry dated 18 August 2010 on behalf of Action against Medical Accidents ('AvMA') with respect to the issues being considered by the Mid Staffordshire NHS Trust Public Inquiry ('the Inquiry'). I make this further witness statement in response to a number of additional questions that have been asked by the Inquiry's solicitors.

#### **Information received by AvMA concerning the Trust**

2. In paragraph 14(a) of my provisional statement, I state that AvMA received a number of contacts directly from patients and members of their families affected by failures within the Mid Staffordshire NHS Trust ('the Trust'). I have been asked when AvMA received these contacts and specifically, whether they were before or after the Healthcare Commission's report was published. As far as I know, AvMA does not have any record of receiving calls about problems at the Trust until after the publication of the Healthcare Commission's report. However, that is not to say that it did not happen via the helpline.

3. To put some context to this, I explain below how the helpline operates. The helpline receives no external funding and the database of information from our helpline and casework service is therefore not as sophisticated as we would like it to be. We have two lines in operation during the opening times. One is operated from London and the other is based in AvMA's small outpost in Manchester. If AvMA had greater resources it would operate more lines. Currently there are five to six employees working on the helpline. A couple of years ago, we developed a volunteer base to increase the helpline's capacity. We have since recruited appropriate volunteers to provide the first stage of advice on the helpline. The majority of the volunteer base come from a legal background but we also have health professionals such as A&E consultants and midwives. We currently have around fifty volunteers who operate the telephone helpline and this adds to the rich body of medical and legal knowledge available to us. All of our volunteers are carefully selected and receive training on telephone helpline skills, the NHS and private complaints procedures, health professional regulation, clinical negligence and human rights litigation and inquests. Our paid staff provide supervision and deal with calls which are difficult for volunteers to deal with.
  
4. It has not been AvMA's practice to collect methodically the names of particular Trusts from patients or their representatives during telephone calls. The focus of the calls is very much on the individual rather than the organisation. Patients and their families tend to have had an awful experience and it is the role of the helpline advisors to show empathy as part of a specialist organisation and assist them to think about the next stages. People contact the helpline at various different stages. Sometimes the individual will have very firm reasons to believe that something has gone badly wrong and they may even have complained, or contemplated or commenced litigation. In other instances, we are contacted at a very early stage when there is simply a suspicion that something was not right.
  
5. Although we try to be alert to any emerging problems, we would not necessarily notice if there was an over representation of a particular Trust as this relies upon the discretion and judgement of the people operating the helpline. We would like to develop the database so that we can monitor particular trends of areas of concern arising from the calls we receive on the helpline. Ideally, we would like to

develop a database with fields compatible with the NHS's relevant databases so that we could share data on the nature of the complaints and issues affecting particular Trusts, clinicians or departments. Whilst AvMA has the IT infrastructure to maintain such a system, we are dependent on receiving further funding to develop this particular project. One of the issues to consider in this Inquiry is whether that type of system, if one wound the clock back, might have allowed AvMA to be in a position to alert the relevant authorities about the failures of the Trust.

6. I have been asked about the nature of the calls AvMA received concerning the problems at the Trust. The vast majority of the calls concerned treatment and care concerns which have been well documented in the Healthcare Commission's Report and subsequently in the Independent Inquiry. These included poor quality nursing care, issues with staff attitude, difficulty getting hold of staff, infection, toiletry issues and poor hygiene.
7. I believe that the vast majority of the complaints were still at Trust level and not many patients or families had progressed to the second stage of the complaints process by contacting the Healthcare Commission. My impression was that the complaints we were receiving were on issues of treatment and care rather than on the actual complaints procedure. I have now learnt through both contact with particular clients supported by AvMA and evidence given to date at the Inquiry that patients were frustrated with delay in the complaints procedure and a feeling that the Trust and Patient Advisory Liaison Service ('PALS') were not taking the complaints appropriately.

#### **AvMA's role and responsibilities**

8. It is also really important to stress that AvMA, whilst widely recognised as providing good quality specialist advice services, is not part of the official regulatory system or the official sources of advice and support, for which funding is provided through state channels. AvMA has offered to complement these services on a number of occasions but has never been given funding to do so.

9. Due to the lack of resources, the priority for AvMA has remained the individuals needing our help. AvMA is a people centred charity; we consider our main role is to support the patient and family. If we were aware of a particular issue we would flag it up to the authorities.
  
10. I explain in paragraph 13 of my provisional statement that shortly after publication of the Healthcare Commission's report, I made contact with Julie Bailey. I have been asked why I think Julie Bailey and her colleagues had not been aware of AvMA's services prior to me contacting her. Until people have the need for AvMA, we tend to find that people have not heard of us. AvMA is not a household name like better known charities such as Age Concern or Shelter. We publish information on the internet and have brochures and leaflets which some PALS, Independent Complaints Advocacy Services ('ICAS') and other advisory services give to people who would benefit from our services. We also receive referrals from NHS trusts and ICAS staff. Although we were disappointed that Julie Bailey did not know about us earlier, we were more disappointed to learn that that nobody said to Julie Bailey, Cure the NHS or patients' families that AvMA's services were available to them. From the evidence provided by relatives so far, it is clear that the Trust was not telling patients about statutory funded services such as ICAS let alone where they could go for specialist independent advice. It was not until very late in the day that they were being told about the services of AvMA and only after our efforts to ensure that patients and families needing support were provided with our details.
  
11. I have been asked whether the services AvMA provides could be provided in-house rather than by an independent charity. In my view, patients, particularly those with serious problems, need specialist independent help and advice. Our great strength is that we are completely independent, and specialise in dealing with the more serious complaints concerning actual harm, patient safety and regulatory issues. There will always be a need for Trusts to have an internal team whose job it is to iron out problems, but any service dealing with difficult and contested issues needs to be independent and to be seen to be independent. This is partly due to trust or perceived trust as it will not be there if provided by the NHS itself. If the services that AvMA provided were part of the hospital, it would be part

of the system that the individual was complaining about. If the service was provided in-house, there would always be torn loyalty of employees working in it. In particular, people who have had a bad experience are incredibly nervous about who to speak to and, in these circumstances, it is very important to the clients that they speak to someone truly independent. Staff in NHS trusts who tell people about AvMA do so because they understand this, and want the patient or their family to benefit from a credible source of independent, specialist advice.

### **AvMA's interaction with the Department of Health**

12. I have been asked about AvMA's interaction with the Department of Health. I personally meet members of the Department of Health on a regular basis through my membership of the National Patient Safety Forum. AvMA's policy work also brought it in contact with the Department of Health. With the benefit of hindsight, it is a regret to me and the organisation that perhaps when the Department of Health became aware of the failures at the Trust, no one in the Department of Health or indeed the Healthcare Commission thought fit to contact us. Both the Department of Health and the Healthcare Commission knew the report was coming out for some time and they could have pulled together experts, including AvMA, to consider how the patients could be supported. As I explain in my provisional statement, there should be a more thought through process for future incidents. When a large scale incident affecting a lot of people occurs, there should be a protocol to deal with the issue rather than relying upon another individual like Julie Bailey in a different part of the country. This is something that we have brought up to ensure that, as and when another incident does occur, patients and families get the right independent advice and support. AvMA may be in an ideal position to help with that.
13. It has always been our mission as a charity to work in partnership with the NHS to improve the service. Although I believe that there has been some hesitancy in engaging with us in the past, there is now an awareness that we are a very positive organisation and a "critical friend". Whilst we do not hold back and we are entirely independent, senior people within the Department of Health, the NHS and other key stakeholders also know that we will work in partnership with them.

Through this interaction, we have gained a lot of respect from these organisations and the way in which we can contribute is recognised. However, whilst most people in senior positions see us as a partner, there will always be an underlying nervousness about our role. There is still a culture in some Trusts and with some clinicians that patients who complain and litigate are perceived badly and are stigmatised as a result. As a body that helps these patients, I believe that we are perceived by certain people in the same way.

### **AvMA's interaction with the Independent Complaints Advocacy Service**

14. I have commented on ICAS in paragraphs 39 to 44 of my provisional statement. I have been asked what interaction AvMA had with ICAS providers. I should explain some of the background to the formation of ICAS. In my previous role as National Director of the Association of Community Health Councils in England and Wales, I campaigned against the abolition of Community Health Councils ('CHCs'). Originally, there was no plan to replace the complaints function of CHCs as the assumption was that PALS would be so good that it was not needed. ICAS was not going to exist. As a result of our campaign, provisions were added to allow an independent complaints advocacy service. This is something that AvMA values very highly, but believe could be delivered in a better way, as was originally intended.
15. Under the original plans, the Commission for Patient and Public Involvement ('CHPPI') were to be the conduit for the funding for both ICAS and the Patient Forums. It was very consciously planned in this way to keep ICAS independent and focussed. It was also originally planned that ICAS would be an integral part of a "one stop shop" which would be the Patient Forums. As part of this, in each region, the Patient Forum would provide or commission the ICAS services. In other words it would not be dissimilar to how CHCs had operated. Unfortunately, the plan was never implemented in the way that ministers said it would.
16. I recall the decision made by CHPPI that ICAS would not be provided by patient forums but instead, the service would be commissioned from charities. Whilst the abolition of the CHCs was going through and before the final arrangements for

ICAS had been made, there was a transition period. It was agreed that during this transition period there would be a number of pilots for ICAS. AvMA was commissioned to provide a specialist back up service on a national basis during this pilot to provide support and guidance to advisors and clients.

17. CHPPI awarded four contracts to four different charities: POHWER; National Association of Citizens Advice Bureaux; South East Advocacy Projects; and Careers Federation. As soon as AvMA knew who the providers were, it contacted them to see if they wanted to continue to work with AvMA. AvMA put in place contracts with each of the providers of ICAS. As resources for ICAS became tighter and tighter, first one and then another decided not to renew the contracts with AvMA. AvMA went from having formal arrangements to the position now where there some ICAS staff pass on our details on an ad hoc basis but there is no formal arrangement and no funding for the work we pick up from ICAS. If we get enquiries for assistance on how to formulate a complaint or if it is not a clinical/medical issue we point the patient in the direction of ICAS. Similarly, although inconsistently, many ICAS staff tell patients or relatives about AvMA but others do not. We do not know exactly why, but it is fair to say that relationships between AvMA and ICAS at the corporate level are not as good as they should be. Although AvMA has tried to develop a relationship with ICAS providers, we have received little or no response to our efforts to make contact and establish links with the service.
  
18. There are now only three providers of ICAS services as the Citizens Advice Bureaux lost its contract. My concern is that the reason behind this is may be that the Citizen's Advice Bureaux started to use information from the complaints they received to inform their policy work and publications. The Citizens Advice Bureaux could afford to do this as they were a large organisation and the income from the Department of Health contract for ICAS, although significant, would have been a small percentage of its overall revenue. The Citizens Advice is a very principled organisation and consistently use information gleaned from work with its clients to inform its policy making.

19. The other three providers started out as locally focused small charities. Now all three have huge contracts with the Department of Health covering large areas of the country. As I have said in paragraph 41 of my provisional statement, it is a cause for concern that the contractual relationship between the ICAS providers and the Department of Health may potentially hinder, or be perceived to hinder, their ability to be proactive in raising concerns. I should note that I have not seen evidence that the independence of ICAS is in fact compromised by the nature of the contractual arrangements. These arrangements do not necessarily mean that the organisation is not committed to doing the very best it can for its patients, but there is danger, not least in terms of perception, that they are so reliant on the funding that they might not be as robust and independent as organisations which was not reliant upon funding. It was for these reasons that ICAS was originally meant to be funded through CHPPI – not directly from the Department of Health.
  
20. AvMA have not, to the best of my knowledge heard from POhWER, the ICAS provider in Staffordshire about any of the issues with the Trust prior to the Inquiry. I have been to two public meetings at Stafford which ICAS were invited to but I have received no communication from them. I have personally tried to contact their regional office to see what they knew and whether we could collaborate in providing support to the patients. I have not received calls back. I believe that there was a perception in Stafford that ICAS was somewhat remote and not robust in supporting people. People were more reliant on Julie Bailey rather than ICAS.
  
21. With respect to ICAS, my concerns are: first, whether or not patients were not being informed of the availability of ICAS's potentially valuable services; second, whether or not POhWER was being proactive enough in making the services available; and third, why it appears that nothing was done with the information which was presumably available to them through their contact with complainants to communicate concerns more widely. I accept that ICAS may not have been in a position to raise the issues earlier in Stafford as they may have been in the same boat as us, but I do not understand why at a policy level, they have not subsequently been publicly engaged in raising concerns.



22. I refer back to the system of patient and public involvement under CHCs (and the way in which Ministers promised it would work after the abolition of CHCs) in which the staff providing ICAS would be part of the local "one stop shop" and be able to pass emerging concerns seamlessly through to members of the CHC / PPIF or LINK in their monitoring capacity. If this had been the case in Stafford, it is possible that the PPIF or LINK would have been better informed, and in all probability that it would have been more proactive and vocal in raising concerns and getting some form of earlier intervention.
  
23. I would also like to know whether there is anything in the formal arrangements between the Department of Health and ICAS providers which gag the ICAS providers or some form of protocol that ICAS providers have to sign up to which prevents them from publicising issues or speak with other agencies about them.
  
24. It may help the Inquiry to understand how services like ICAS and AvMA differ and can complement each other. ICAS is a generic service designed to help any complainant "navigate" the NHS complaints procedure. A complainant can receive advice and support from ICAS no matter what the subject of their complaint. For example, it may concern cancelled appointments, long waiting times, staff attitude, car parking, as well as concern about the quality of treatment. ICAS is not able to help with legal challenges or with disciplinary "fitness to practise" procedures concerning health professionals, or inquests. AvMA is only concerned with clinical complaints where there is actual or perceived harm, patient safety, medico-legal or regulatory issues. We provide more specialist medico-legal advice which includes not only making best use of the NHS complaints procedure, but also support with inquests; advice on prospects of taking legal action and referral to specialist solicitors where appropriate; help with referring cases to health professional regulators and dealing with other regulatory and patient safety bodies. ICAS receives considerable State funding. AvMA receives none.

**AvMA's interaction with the Stafford Primary Care Trust, Strategic Health Authority and other bodies**

25. AvMA has had no specific dealings with either the Strategic Health Authority or Primary Care Trust (apart from the arrangements for the Independent Case Note Review). When the PCT was given responsibility for the Independent Case Note Review, we were pleased to see a marked improvement in communication. AvMA had occasional liaison with the Healthcare Commission at policy level and does now more regularly with the Care Quality Commission ('CQC').
26. We do have conversations with MPs around the country. MPs who are knowledgeable or who have staff that are knowledgeable about health issues often refer issues to us. I am pretty sure that the only contact AvMA has had with MPs in Staffordshire is since the publication of the Healthcare Commission's report. This has been in the context of lobbying them for a full public inquiry, making them aware of our services and engaging with them in public meetings held by, for example, in conjunction with Cure the NHS.

#### **Monitoring of key indicators of poor care and treatment**

27. I have been asked about the role of the various regulators and commissioners in monitoring and regulating the Trust. AvMA's opinion is that the various bodies should be more proactive in regulating and monitoring. The most obvious indicator was the mortality rates which should have been taken much more seriously by the Trust, the Primary Care Trust and the Strategic Health Authority. I have heard from other sources that these bodies allowed themselves to be placated of the significance of the mortality rates with statements such as "there were problems with the figures". To be clear, AvMA would not claim using one indicator on its own is proof that there is a systemic problem. There might be quite understandable reasons why mortality rates are out of kilter with the norm. The issue is that questions should be asked at the point that a single indicator gives rise to concern rather than simply assuming any discrepancy to be explainable.
28. I would supplement this by saying that there were other indicators specific to the Trust, including a strong theme of patients and families not being listened to. How did, for example, the complaints and claims not lead to earlier intervention? I draw an analogy with patient safety alerts, which serve as another indicator. I have

explained the significance of these in greater detail in my provisional statement. There were a number of patient safety alerts that Stafford did not implement and although they are not the worst offenders, one wonders what action the Primary Care Trust, Healthcare Commission and Strategic Health Authority were taking in monitoring compliance with these alerts.

29. My view is that one indicator should spark serious questions but for there to be more than one and nothing to happen raises considerable concern. Looking back I wonder whether what was happening in Stafford was that people were ignoring systemic indicators that would have alerted them to the problem. What it belies is a culture of regulators being laid back and complacent about monitoring. I question whether people were actively looking at complaints and whether the Primary Care Trust and Strategic Health Authority were showing any interest in the indicators they were receiving.
30. I refer in my provisional statement to there being a culture where there is reluctance to regulate and otherwise "interfere" within hospital trusts, and especially Foundation Trusts and query whether this explained why bodies did not intervene earlier at Stafford. The current way of thinking, which in principle I can agree with, shifts the balance of power to the front line service providers. However, the increased freedom and flexibility needs to be balanced by appropriate accountability and monitoring.
31. Part of the culture, particularly pertinent in relation to Foundation Trusts is an element that people want to "believe their own propaganda." Patient safety alerts, on the face of it, are a fantastic initiative but it is complacent to assume that all Trusts subscribe to the same level of patient safety and will implement the alerts or otherwise have good reason not to do so. In part, some of this is down to resources and capacity for the regulatory and commissioning bodies. A system of light touch regulation prevails and whilst it is impossible to quality assure everything in every Trust, there needs to be a common sense approach with respect to key issues relating to patient safety. Regulatory bodies should look at and react to key indicators such as mortality rates, patient safety alerts and high infection levels.

32. In relation to the Healthcare Commission, I thought the report on Stafford was frank and well presented report. My biggest concern was why did the Healthcare Commission not intervene earlier. At what stage did they know from monitoring data and second stage complaints about the failures at the Trust and could the Healthcare Commission have intervened at this stage?
33. I refer in my provisional statement to a lack of joined up thinking about who should monitor and regulate NHS Trusts. There is, for example, no agreement or protocol as to who should monitor patient safety alerts. I have had meetings with the Department of Health, CQC, the Strategic Health Authorities and the Primary Care Trusts and no one has a clear idea as to whose role it is to monitor patient safety. CQC has said there is a role for them but there has not even been a meeting between the NPSA, the Primary Care Trust, the Strategic Health Authority and the Department of Health as to what their respective roles are on this. It cannot be the case that it all falls solely on the regulator; there must be a role for the Strategic Health Authority and the Primary Care Trust as commissioning bodies.
34. In relation to Monitor, it is still very unclear what their role in patient safety should have been or currently is. We have found Monitor to be the least responsive of bodies that we have been in contact with. We have not had a meeting with them in relation to Stafford despite our requests. When we wrote to them on one occasion they sent us a copy of their annual report and said that we could find everything that we needed to know about Monitor in there. Just recently we have had an offer to meet with them, albeit I do not know whether this is a response to the Public Inquiry.

#### **Openness and Honesty / Duty of Candour**

35. In my provisional statement, I have outlined AvMA's strong view that a statutory "Duty of Candour" should be introduced. In essence, we believe that there should be a clear duty, backed up with suitable sanctions, to be open and honest with patients and their families when things do go wrong. This issue is strongly related to the issues highlighted above, in that if patients and families are equipped with

the relevant information, they can contribute to the process of ensuring that measures are put in place to prevent accidents being repeated.

36. As I have indicated in my provisional statement, AvMA supported a number of people affected by poor treatment within the Trust. This included a number of those who have provided evidence to the Inquiry: Janet Robinson, Ron Street, Christine Dalziel, Debra Haseldine and Jeff Guest.
37. In particular, both Janet Robinson and Ron Street have given very important evidence to the Inquiry with respect to the delayed disclosure of the key reports arising from investigations. In Mrs Robinson's case, after the death of her son in April 2006, she referred to not receiving key report concerning the care of her son until the Independent Inquiry took place in early 2009. With respect to Ron Street, he confirmed that the Serious Untoward Incident (SUI) investigation report concerning the death of his friend Gillian Astbury in April 2007 was not disclosed to her family until May 2008.
38. Since completing my provisional statement, I have received important information from a journalist we have been working with who has made several requests to the Trust with respect to disclosure of SUI reports. I am seriously concerned with respect to the Trust policy on this issue and to discover that there appear to be other families who had this information concealed from them. I will be submitting written evidence from these investigations separately to the Inquiry.
39. In addition to openness and honesty with patients or their families when things go wrong being vitally important for the patient and families themselves and the only right way to act morally and ethically, we believe it is a vital part of a "patient safety culture." The same culture which allows an NHS trust to think that it is acceptable to withhold information from a patient and families we believe is responsible for Trusts failing to realise that they are failing. A Duty of Candour helps underpin other work to change the culture in healthcare which allowed the situation in Stafford to develop as it did.

## Complaints and Patient Advisory & Liaison Services (PALS)

40. I have been asked about my views on PALS and its effectiveness at Stafford Hospital. I have received anecdotal reports that when somebody wanted to complain, they had been told to PALS would first need to attempt to solve the problem. Some people have even said that PALS were not helping with the process and were advising patients they were not able to complain formally there and then. People have also told us it is hard to understand the complaints process and that they perceived barriers were put in place. For example, patients were being told that they had to use PALS before making a formal complaint. My impression from members of the public is that there is rather a lot of confusion as to the difference in roles between PALS and the complaints staff. This is a problem which we have experienced in other parts of the country also, which is exacerbated in some Trusts where staff carry out both roles.
41. According to the feedback we have had, the response of PALS and to complaints tended to be fairly defensive in Stafford. In some areas, despite being employed by a Trust, PALS representatives do champion the patient and believe what the patient says. However, the defensiveness alluded to is not uncommon around the country. It is not helped by the fact that there is no central policy or guidance by the Department of Health and a refusal by the Department of Health to provide a national body to provide this consistency amongst PALS services.
42. In our view PALS needs to be seen as distinct from the complaints procedure. PALS should seek to resolve problems wherever they can and explain people's rights to complain formally without making this any more difficult for people. People should not feel that they have to go through PALS before they can complain. Moreover, it is vitally important that PALS and complaints staff readily advise people of where they can get independent advice. At the very minimum, any potential complainant should be made aware of the services of ICAS and how to contact them. With respect to more serious and complex clinical complaints, people should be informed of sources of specialist independent advice services such as those provided by AvMA. It is clear that at Stafford, there was a marked reluctance to put people in touch with providers of independent advice.

Consideration should also be given at the national level as to how these services can be made more accessible to those that need them either in individual one-off cases, or in larger scale responses to problems in a given trust or area.

43. We believe the experience of complainants at Stafford also underlines another of our concerns about the NHS complaints procedure. This is now a two stage process. If dissatisfied with the Trust's own response, the only option left is to appeal to the Ombudsman. AvMA's experience is that when the Ombudsman does investigate, she is very robust. However, we query whether due to capacity issues there is too much emphasis on referring cases back for further "local resolution" rather than investigating. Only a small proportion of cases are taken on for investigation. Access to an independent review of a complaint is now much harder to obtain with a consequent danger that serious problems will be missed and complainants will simply be worn down.

## **Litigation**

44. Litigation is something which in our experience is something which patients and families usually turn to very reluctantly. Either because they need and deserve compensation and this is currently the only way of getting it or, as is very often the case, because they have not been dealt with openly and honestly or have experienced unreasonable defensiveness. Often claims are initially defended but upon the evidence being robustly reviewed by specialist lawyers with the benefit of independent medical expert reports, it is realised that there has in fact been negligence. The importance of this process in allowing lessons to be learnt for patient safety should not be underestimated. We note that a large number of claims regarding substandard care at the Trust have been settled. We will want to explore to what extent the lessons from claims were being used by the Trust to inform patient safety. The potential of having to settle claims also provides a strong financial incentive to the NHS to improve safety and is largely responsible for recent improvements in risk management and clinical governance. We are profoundly worried by current proposals to remove legal aid funding for clinical negligence claims and further restrict funding under Conditional Fee Agreements available for clinical negligence claims. This will make pursuing a claim impossible

for many would be claimants. Quite apart from access to justice issues, we believe that this will result in less learning and improvement as a result of clinical incidents.

### **“Whistle-blowing”**

45. I have been asked how whistle-blowers should be encouraged to come forward and be protected from reprisals. I see the issue with openness with patients to be closely connected with allowing staff to be open. There is no formula to deal with this. However, I do not think that the current legislation is sufficient. It provides some recourse for people whose employment is affected but that is too late. We need provisions to encourage earlier disclosure. AvMA and others are campaigning for both a statutory duty for CQC regulators to support staff in raising concerns as well as to promote openness and a statutory “Duty of Candour” with patients/families when things go wrong. I see these two things as being closely aligned. This would not in itself solve the problem; there would also need to be a cultural change. However, CQC regulation might just work if the CQC can take it into consideration when assessing and monitoring Trusts and implement sanctions if a culture of openness and transparency is not apparent.
46. I understand that in the current Department of Health consultation on whistle blowing, it is suggested that a statement will be added to the NHS constitution. AvMA considers this to be somewhat of a blunt instrument as only NHS bodies are required have to have regard to the NHS Constitution. AvMA recently made a Freedom of Information Act request to the Department of Health asking for details of any intervention that had been made with any trust over failing to have due regard to the NHS Constitution. The response confirms that officials responsible for that area of departmental business were aware of no instance of this ever happening. I produce this response as exhibit **PW/2**. The other advantage of having something in the CQC regulations is that it will apply equally to the private sector whereas the NHS constitution would not.
47. A related issue is “gagging clauses” in agreements for whistle blowers leaving their employment. I understand that Trusts are not supposed to use gagging orders but



that it does happen from time to time – and this is an issue which the Inquiry should consider in more detail.

48. We see a culture of openness as part and parcel of patient safety. We see a secretive attitude / culture and high a level of patient safety to be entirely inconsistent. If members of staff are prepared to cover up important information then one has to assume that the ethics, culture and approach to patient safety is poor. For an organisation to be committed to patient safety, you have to have an open, transparent attitude towards patients as well.

### **The Stafford Coroner's Court**

49. I have been asked about my dealings with the Coroner in Stafford. I question why there have not been more inquests arising from the issues within the Trust. I also question what the Coroner is doing with the information that he has gleaned. I believe that the Coroner should maintain an overview of issues causing death in his district and of course, is empowered to provide recommendations to prevent deaths occurring in future. In Stafford, after Stuart Knowles was appointed Deputy Coroner, we became concerned that the Coroner was too close to the Trust.

### **Regulation of non-clinical staff**

50. I have been asked whether non-clinical staff in management roles should be subject to professional codes and a regulatory body in the same way as clinical staff are. I understand that a working party has been set up to consider the regulation of NHS managers. I do think this is worth considering but I am not passionate about setting up another layer of bureaucracy. I think the bigger issue is how accountable NHS managers and non-clinical staff should be. One way to approach this is a professional regulatory body.
51. Doctors and nurses are already subject to a statutory duty of candour due to their professional code and regulatory bodies. Having a similar regime for non-clinical staff would simply point the finger at individuals rather than at the corporate body. In any event, from our experience of health regulatory bodies, it is difficult to have

action taken against clinical staff. In my view, the professional bodies are not appropriate for managing systemic failures in an institution. However more crucial in my view is that an organisation corporately is totally accountable. I think this is achievable. If you use the example of openness to patients, Stafford was not breaking any statutory rules in covering up issues. However, if there were sanctions available through, for example, the CQC then this in turn may lead to greater accountability

52. I confirm that I am willing to attend the hearing and give oral evidence for this Inquiry if required to do so.

Statement of Truth

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

Signed .....

**Peter Walsh**

Dated.....

Witness Name: **Peter WALSH**  
Statement No: **Second**  
Exhibits: **PW/2**  
Dated: **December 2010**

**MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY**

---

**EXHIBIT PW/2**

---

This is the exhibit "**PW/2**" referred to in the witness statement of Peter WALSH dated December 2010.

Signed .....

**Peter Walsh**

Dated.....

Our ref: DE00000565615

6 December 2010

Dear Mr Walsh

Thank you for your email of 16 November asking, under the Freedom of Information Act (FOIA), for information held by the Department of Health on any instance of action being taken with regard to an NHS body not "having due regard" to the NHS Constitution, from the point of creation of the NHS Constitution up to the point of receiving this request. You also asked us to include the name of the NHS body concerned; the nature and date of the action or intervention; and the relevant part of the NHS Constitution to which the NHS body was considered not to be paying due regard.

While the officials responsible for this area of Departmental business are aware of no instance, recorded or otherwise, falling within the terms of your request, we have estimated that the searches needed to establish beyond doubt that this is the case would be such as to entail costs exceeding the £600 or 3.5 person/day limit specified for central government bodies under s12 of the FOIA. We do not therefore propose to extend searches beyond the areas in which relevant information might reasonably be expected to be located.

I hope that this is helpful. If you are dissatisfied with the handling of your request, you have the right to ask for an internal review. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to:

Head of the Freedom of Information Team  
Department of Health  
Room 317  
Richmond House  
79 Whitehall  
London  
SW1A 2NS

Email: [freedomofinformation@doh.gov.uk](mailto:freedomofinformation@doh.gov.uk)

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure provided by the Department. The ICO can be contacted at:

The Information Commissioner's Office  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire  
SK9 5AF

Yours sincerely,

Colin McDonald

FOI Casework Manager