



RESPONSE TO

Consultation by

**WELSH ASSEMBLY GOVERNMENT:
HEALTHCARE STANDARDS FOR WALES**

February 2010

Introduction

Action against Medical Accidents (AvMA) are pleased to offer our recommendation for building on the good work that has already been done on developing healthcare standards for Wales. Whilst a UK-wide charity, AvMA continues to be extremely committed to pursuing its charitable mission of improving patient safety and supporting those people who are affected by medical accidents in Wales. AvMA has over 25 years' experience of supporting people directly affected by avoidable incidents in healthcare every day through our helpline and casework service. We are also proud to work in partnership with stakeholders in Wales such as Welsh Assembly Government, NHS bodies, Community Health Councils and the NPSA. Most recently we have played an important role in helping influence the NHS Redress Measure, 'Putting Things Right' and the 'Speedy Resolution' scheme from the patients' perspective.

Executive Summary

We have limited our suggestions to those where we feel we have the appropriate skills and expertise. We appreciate and support the vast majority of the standards, but make the following important recommendations:

- **We strongly recommend that a new explicit standard introducing a 'Duty of Candour' – a need to fully inform patients or, where appropriate, the next of kin about patient safety incidents which have caused or will result in harm to the patient. (See below, standard 24 for details).**
- We recommend the introduction of a specific standard on supporting whistleblowers.
- We have suggested minor changes to place more emphasis on appropriate engagement with patients and the public over patient safety, and on requirement to implement recommended patient safety changes.

Comments on Individual Standards

1 Governance and accountability framework

We recommend that an additional criteria is added to require healthcare organisations to operate in an open and transparent fashion, including holding board meetings in public. We believe that transparency is key to an effective patient safety culture.

6 Citizen Engagement and Involvement

We recommend the wording is amended to make clear the expectation that patients are involved in patient safety work including reviewing investigation of incidents. We also recommend that a requirement to report annually on how patients have been involved and what changes have been made as a result.

13 Safe and Clinically Effective Care

We recommend including the specific requirements to "Report incidents to the National Patient Safety Agency (NPSA) reporting system" and "ensure that patient safety notices alerts and other communications concerning patient safety are acted upon within the required timescales."

This is the wording that is used in the current standard 16, which we think is more appropriate. There are requirements which are vital for patient safety, and there is a need to be explicit in the standards themselves rather than leave it to guidance.

24 Dealing with Concerns and Managing Incidents

We strongly recommend inserting an additional point under this standard introducing a specific, explicit duty to fully inform patients or, where appropriate, their next of kin about patient safety incidents which have caused or will result in harm to the patient.

We understand that this is entirely in line with existing policy. It would complement the existing 'Being Open' guidance and Welsh Assembly Government initiatives such as the NHS Redress Measure/"Putting Things Right". The positive effect of making this simple addition to the standards can not be under-estimated. This is too important an issue for patients and for patient safety to be left to guidance. Making an explicit standard in this way will send the strongest of messages to healthcare organisations that they have to take steps to ensure openness and honesty with patients. This is accepted as a vital component of an effective patient safety culture, as well as an ethical imperative. All of our experience tells us that this issue is of the highest importance to patients and that the introduction of a Duty of Candour would be very popular. The introduction of this standard would put Wales at the fore of an increasing number of countries with a strong commitment to patient safety who have adopted a 'duty of candour' (or 'open disclosure'). It is only fitting that this be so. AvMA has called its campaign for a Duty of Candour 'Robbie's Law' after Robbie Powell, the young boy at the centre of a well- known Welsh case which has come to symbolise the need for a duty of candour.

25 Workforce Recruitment, Employment and Service Standards

We recommend amending or adding to this standard to make an explicit standard support for whistleblowers. The current wording of 26(d) is fine as far as internal raising of concerns. However, it is important that in situations where it is not possible to raise concerns internally, or these concerns are not acted upon, that staff can take their concerns outside the organisation without fear of unreasonable consequences. Also, that independent support and advice is available to whistleblowers in this situation.

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