Glass half full or half empty? Patient safety, Candour and ‘Safe Space’

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WHAT IS AvMA?

- The independent UK charity for patient safety and justice
- Provides advice and support to individuals affected by a medical accident
- Works in partnership with NHS, private healthcare, health professionals, Gov’t departments and lawyers
- Helped secure the Mid Staffs inquiry & recommendations – especially Duty of Candour
Sir Liam Donaldson

“To err is human, to cover up is unforgivable, and to fail to learn is inexcusable”
SOBERING FACTS

- UNTIL November 2014 A HEALTHCARE ORGANISATION WAS NOT IN BREACH OF ANY STATUTORY RULE IF IT ‘COVERED UP’ A MEDICAL ACCIDENT

- THE SYSTEM *FROWNED UPON* BUT TOLERATED COVER UPS
Duty of Candour ("Robbie’s Law")

SUPPORT

ROBBIE'S LAW

AVMA for patient safety and justice
The statutory Duty of Candour

- Brought in following recommendation of Sir Robert Francis / Mid Staffordshire Inquiry
- A “Fundamental Standard” in the Care Quality commission (CQC) regulations
- Applies to the organisation
- Full regulatory powers can apply if breached
20. (1) A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must—

- notify the relevant person that the incident has occurred in accordance with paragraph (3), and............
“notifiable safety incident” means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

- the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition, or
- severe harm, moderate harm or prolonged psychological harm to the service user;
“OK we harmed them, but does it meet the threshold for having to tell them?”
What needs to happen:

- Notification of patient / family (in person) including apology (within 10 days)
- Offer of reasonable support (and involvement in investigation if appropriate)
- Written notification including apology and explanation of what will happen
- Keep updated and offer further explanations and apologies if appropriate
But also…

- Training & Support for staff!
Beyond compliance

- Awareness
- Training
- Support
- Monitoring
What about Wessex?

- How much training has taken place?
- How well is Duty of Candour being implemented?
- How would you know? Is there robust monitoring / audit?
CQC Guidance

- CQC Guidance does not differentiate:

See our guidance for patients/families

Other developments

- CQC / fundamental standards
- Freedom to Speak Up
- League tables (!)
- Patient Safety campaign
- Healthcare Safety Investigation Branch (HSIB)
HSIB: openness with patients v “safe space”

- Expert Advisory Group said: all relevant information about a patient’s treatment ‘must’ be shared with the patient/family and that they would be ‘free to use it as they wish’

- HSIB Directions say: Chief Investigator ‘may, when requested’ disclose such information to the patient ‘but such disclosure may only be made… to such extent that the Chief Investigator judges… to be consistent with the safe space principle’
What do professionals need protection from?

- Patients / families knowing the truth?
- Employers
- Regulators

Does a ‘safe space’ for professionals trump openness and honesty with patients?
The biggest ever breakthrough in patients’ rights & patient safety?

SUPPORT

ROBBIE'S LAW
Thank you!

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