ASAPNHS
Action for a Safe and Accountable People's NHS

PATIENT SAFETY IN SCOTLAND'
PUBLIC INQUIRY
UPDATE 3 SUMMARY

'The Breakdown of Government'

22 March 2016

There are major problems on patient safety in Scotland. The safety of the public is not ensured. The Scottish government has refused to acknowledge the internationally-recognised problem of avoidable deaths in healthcare. It has rejected the UK-wide legislation that should ensure patient safety. There is not the legally required effective independent regulator making sure that precautions are in place and protect them to the legal standard and that they are effective. The government has rejected the rule of law with its wide and severe consequences for Scotland. The government refuses to accept its devolved responsibilities for delivering healthcare and justice, and there is not the accountability. These are fundamental aspects of a breakdown of government.

'Scottish healthcare with its absence of regulation repeats the main error behind the Piper Alpha disaster, and with worse consequences for the people of Scotland'.

The Scottish First Minister on 16 March 2016 again refused to comply with, or uphold, the UK-wide law on patient safety. This repeated failure of Scottish ministers will permit a very large number of avoidable deaths in Scottish healthcare and related social care.

1. Introduction

Everyone in Scotland is likely to know someone who has been very seriously affected by avoidable harm in healthcare. Such harm is a world-wide problem and a major cause of avoidable deaths. In the UK this is harm which can be reasonably prevented by compliance with the legislation that already applies to healthcare. The law has not been implemented in Scotland. There is major non-compliance and there is not the legally required effective regulation to prevent the harm to patients. The consequences are likely to be about 2,000 reasonably preventable premature deaths a year in Scottish healthcare and the related social care (from Department of Health estimates). There will be other serious harm, and wasted expenditure.

The hazards and risks in healthcare are very high. The legislation requires effective and proportionate risk management systems to be in place to control these risks. In the UK this legislation also applies to other high hazard sectors. It has been highly successful in 'solving 'safety in those sectors. So for example, without complacency, for the last few years we have had the safest railways in Europe.

This is the third update to the case for the public inquiry 'Patient Safety in Scotland'. It was submitted to the Secretary of State for Scotland on 30 January 2015. The requirement that healthcare is safe and effective is the devolved responsibility of the Scottish government. The requirement that it is safe is covered by reserved legislation. The case was also submitted to the Scottish Affairs Committee on 01 February 2015. The case is backed by substantial evidence and it builds all the time. The case developed with new issues continually becoming apparent. The two updates of 18 May and 25 August 2015 added more on frontline failures but also introduced the breaking of the constitution and the justice system. The third update continues to add to consequences of the failings in the approach to healthcare. It shows rather surprisingly how the investigation by ASAP-NHS has revealed that it is symptomatic of the underlying breakdown of the current Scottish government.

2. Summary

1. **Rule of Law** The Scottish government has refused to commit to the Rule of Law. This is a fundamental requirement of democracy, and of being in the EU.

2. **Rejection of Government** It has refused to accept its responsibility for devolved matters of healthcare and of the justice system.

3. **Public Safety** There are fundamental failings in the approach to ensuring public safety, these go beyond patient safety. The Glasgow bin lorry disaster is an example. In Scotland we also have a poor record on worker safety.

4. **Justice System** There is a failure to understand or apply the law on public safety, and particularly patient safety. With the Lord Advocate as both the lead public prosecutor and as a minister of the government the situation places the Scottish government beyond the rule of law. He has already refused to investigate the statutory responsibilities of ministers or his government over avoidable deaths in the NHS. He fails to uphold the law on patient safety and

general public safety to the great detriment of Scotland. The bin lorry incident and failure to prosecute was a failure to apply or understand the UK legislation. There is the fundamental failure of the current Scottish justice system to protect its people.

5. **Failure of Perception** Actions depend on perceptions. The Scottish government refuses to recognise the scale of avoidable deaths and other harm in healthcare. It fails to see that the law applies and that it should act as a main driver to deliver acceptable standards. It fails to see and accept its legal and constitutional responsibilities for devolved matters of healthcare and justice.

6. **OECD Report** The OECD found major problems in the government's approach to healthcare. It recognised the highly anomalous lack of independent regulation (relative to the rest of UK and OECD members). The government links policy and its implementation (with the HSCD and NHS Scotland) but it then rejects its responsibility and accountability. There is an absence of assessment and benchmarking of NHS Scotland. The performance data systems are poor, and particularly on a major killer – hospital acquired infections. The system of peer review of hospital deaths was abolished in 2009. Critical incidents are not reported nationally and there is consequently not an effective learning system. It found that there is no independent challenge on healthcare.

7. **Who Regulates Patient Safety in Scotland?** No-one**.** There is no independent regulator ensuring patients in Scotland are safe. This fundamental error is a repeat of one of the main factors in the Piper Alpha disaster (see Cullen Public Inquiry Report). In terms of avoidable deaths, the consequences of the current error are much greater.

8. **Audit Scotland** This failed in its statutory duty to report on effectiveness and efficiency of NHS Scotland. At the Public Accounts Committee it did not say what we got for the £11.3 billion spend on healthcare. There is a failure of accountability. It did though note the reduction in government spend on NHS services of 0.7% in real terms between 2008/09 and 2014/15.

9. **Independent Scrutiny** This is also missing. There are not the checks and balances that should be required on patient safety and healthcare quality in Scotland.

10. **Civil Service in Scotland** The Civil Service and its senior officers have failed to address the governmental failings and refused to comply with the Civil Service Code to uphold the UK-wide law on patient safety.

11. **Breakdown of Government** With the failing to ensure public safety, the refusal to govern on essential responsibilities, the demise of the rule of law, and the loss of the separation of powers, there is a major breakdown of government. The government ceases to function as a part of a modern democracy.

12. **Whistle-blowing** This plays a vital role in the healthcare sector but the government and NHS Scotland systems are particularly poor. There is institutionalised mistreatment and bullying of healthcare staff of all grades. There

is very poor protection. The proposed arrangements in Scotland do not address the UK-wide concerns found by Sir Robert Francis.

13. **Reasonable Persistence** When government ministers and civil servants are unable to answer questions such as 'When are you going to implement the UK law on patient safety that would prevent many deaths?' they invoke the Scottish government policy of 'Unreasonable persistence'. This is in a situation where persistence is essential and entirely reasonable. Ministers and civil servants abuse process by issuing inappropriate 'banning orders'. This is another democratic failure.

14. **Scottish Affairs Committee** The previous committee planned to act on the case for a public inquiry into patient safety in Scotland. The current committee published the inquiry case but has failed to schedule and investigate this major cause of avoidable deaths in Scotland.

15. **United States Approach to Healthcare in Scotland** The government buys-in a US system that fails to meet the legal essential safety requirements. Consequently it fails to deliver patient safety in Scotland.

16. **Standards** Scotland only has guidance, it completely neglects the legal requirements. Standards are inadequate, out of date, or missing.

17. **Ayrshire and Arran NHS Board Prosecutions** There were two prosecutions over preventable deaths as rare examples of HSE in Scotland being compelled to act. They show the failures of the US approach. There were 'Forty Suspicious' deaths at the Board and still there has been no independent investigation of them. The case brought out major failings of the Lord Advocate, the COPFS, Police Scotland and the justice system.

18. **Ayrshire and Arran NHS Board Maternity Unit and Morecambe Bay** The Ayrshire and Arran NHS unit has been placed on red alert. Its own reports showed serious failings in care, these are similar problems to those found in the Morecambe Bay inquiry. The government lacks the organisation and intent to implement the UK-wide recommendations.

19. **Healthcare Acquired Infections (HAI)** This is a major cause of hospital deaths but the Scottish government disregards the law that should control them. Two recent public inquiries failed (Vale of Leven Hospital and Penrose).

20. **Lothian NHS Critical Incident Report 'Cover-Ups'** Like Ayrshire and Arran before, Lothian's failed to comply with FOI and obstructed the system. It illustrates the systematic cover-up of critical incidents. Incidents in Scottish healthcare are hidden, there are none of the independent checks to uncover specific incidents or even the bigger scandals.

21. **Mental Welfare Commission Scotland Report 'Investigation into Death of Ms MN'** This report was an example demonstrating the absence of all the essential safety requirements in Scottish mental health and related social care.

22. **Scottish First Minister** Successive Scottish First Ministers and other ministers were asked to commit to the implementation of the binding UK-wide legislation that would prevent the very large number of avoidable deaths in Scottish health and social care. There are repeated refusals to commit to upholding the law. They have been inactive and have refused to reverse their policy of obstructing healthcare regulation.

23. **Conclusion** Immediate actions are needed to systematically prevent the very large number of avoidable deaths in Scottish healthcare and to bring it into line with UK-wide legal requirements. The public inquiry is required to investigate and address the failings of the many organisations involved in patient safety in Scotland. It is also required to provide the legally compliant approach to its future. The continuance of the Scottish government's non-compliance with the rule of law is not an option.

3. Conclusion

This document is the third update supporting the initial case for the public inquiry 'Patient Safety in Scotland' (31 January 2015). Immediate actions are needed to prevent the very large number of avoidable deaths in Scottish healthcare and to bring Scotland into line with legal requirements. Additionally, the public inquiry is required to investigate and address the failings of the many organisations involved in patient safety in Scotland and to provide the legally compliant approach to its future performance.

The issues covered by the documents supplied to the Scotland Office since 30 January 2015 should demonstrate the overwhelming case the public inquiry under the Public Inquires Act 2005. The issues here combine those that led to the Mid Staffordshire and Morecambe Bay inquiries. Here the issues are very much worse in that the Scottish government is embedded in the failings. What might once have been negligence on the application of the law on patient safety it is now one of very deliberate intent to disregard the law. It is only a full public inquiry that can investigate the myriad failures of the bodies involved and to start to remedy what is a dereliction of duty and insult to the people of Scotland.

What most certainly cannot be allowed is the continuance of the failure of the Scottish government to uphold the rule of law, to fail to accept its responsibilities for devolved matters, and to fail to protect the people to the standard that the law requires. The position of the Scottish government and patient safety cannot be left as it is. It is the responsibility of the Scottish government to ensure safe effective healthcare. But when it fails in its duties on patent safety then UK law applies and it is the province of the UK government to make sure that UK law is upheld.