AvMA's Response to Health & Social Care Committee NHS Leadership, performance and patient safety - Call for evidence

Closing date for evidence: 8th March 2024

About AvMA

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. Established in 1982, AvMA provides specialist support and advice to people who have been affected by lapses in patient safety. AvMA works in partnership with government departments, health professionals, the NHS, regulatory bodies, lawyers, and other patients' organisations to improve patient safety and the way injured patients and their families are treated following lapses in patient safety.

AvMA does not provide representation to the public in civil claims although we do arrange for pro bono representation from counsel for inquest cases meeting our criteria. We do not hold a legal aid contract for clinical negligence or exceptional funding. We do routinely advise the public on why their case has been turned down by specialist solicitors, the funding options which may be open to them and the pros and cons of each of those options.

AvMA does provide advice and information to patients and/or their families about the next step options which may be available to them when something has gone wrong with their healthcare provision. We provide this advice through our public facing services, our helpline, written advice and information service (for enquiries which cannot be dealt with by phone), our inquest service and through the numerous self help guides available to the public on our website: https://www.avma.org.uk/help-advice/guides/

Our helpline is open five days a week and is staffed by professional volunteers who have been trained by AvMA in listening to what the public's concerns are about their or their loved one's healthcare. Our services endeavour to identify what the public want from the process and advise on the options available to them.

AvMA also offers a pro bono inquest service to members of the public whose loved ones have died as a result of acts and/or omissions in healthcare. That service has enabled us to identify that even when they have used the complaints process, families are not receiving adequate explanations about what went wrong and what factors contributed to their deceased loved one's death.

Information from AvMA's public facing services has given us an insight into how effective the complaints process is in preventing patient safety incidents from escalating. We have confined our responses to answering that one question.

AvMA's general response to the call for evidence:

How effectively does the NHS complaints system prevent patient safety incidents from escalating and what would be the impact of the proposed measures to improve patient safety, such as Martha's Rule?

Between 2020 – 2023 inclusive AvMA received 8,311 calls to the helpline, 56.5% of those calls concerned issues about the complaints process. We do not collect specific data on whether from the patients' perspective of the NHS complaints system there is evidence that the process prevents patient safety incidents from escalating. However, we have sufficient information to draw conclusions which we believe are important to share with you.

Our data shows that of the 56.5% enquiries about NHS complaints, 38.8% of those concerns were about the public trying to secure an explanation or apology from the process; 76.3% were from members of the public who had received a response to their complaint letter and who wanted further advice. While not conclusive, the level and extent of the dissatisfaction/concerns arising from the complaints process might strongly suggest that far from preventing patient safety incidents from occurring, the process is failing to investigate concerns adequately. If the complaint investigation is inadequate, then it cannot identify the root causes of the problem or whether the problem is a patient safety incident. It follows that if you cannot identify the patient safety incident, you cannot then focus on preventing it from escalating.

It is important to highlight that in our experience the NHS complaint process is not robust enough to head off many issues that subsequently become clinical negligence claims.

Generally, complaints staff do not appear to have the skills, experience, training and gravitas to investigate complaints properly within their own trust. It is AvMA's view that the complaint process would be more efficient and effective if the trust were able to make small awards in recognition of poor care provided. To be clear, this is in

relation to low value claims only. Complex claims where high levels of damages are likely to be awarded should not be settled at complaints stage. Any settlement or small award should make clear that the patient should seek independent legal advice before accepting it.

AvMA firmly believes that an efficient and effective complaints process would significantly reduce the number of litigated clinical negligence claims, this is borne out by evidence. The complaints process should be seen as a safeguard for ensuring the statutory duty of candour has been followed properly and in accordance with the regulations.

The available evidence includes comments from The National Audit Office (NAO) which on 7th September 2017, published a report entitled "***Managing the costs of clinical negligence in trusts".*** The Report noted that the relationship between patient care, patient attitudes and clinical negligence claims is poorly understood. It observed that NHS Resolution and trusts have no real insight into what motivates people to make a claim. Following the publication of the NAO report, NHS Resolution commissioned the Behavioural Insights Team (BIT) to look at why patients make claims.

The BIT report approached 10,000 claimants whose cases had resolved following litigation, the approach was a combination of questionnaires and telephone interviews. 516 fully completed responses and 212 partial responses were received, making a total of 728 respondents. Their feedback made it clear that they considered the hospital complaints process to be unsatisfactory, criticisms included the fact that the process was opaque; there were no regular progress updates and no meaningful outcomes. The comments made clear that better complaint handling may have avoided litigation altogether.

Other comments included that communication was poor, it lacked compassion & professionalism; many people complained that the letters of response were incomprehensible to lay people and left them feeling baffled, more honesty and transparency was required. There was a sense that trusts would not listen unless proceedings were brought. The report also fed back that participants considered that

the apologies they received were inadequate, half hearted & insincere; appropriate explanations and apologies would have prevented the need for a claim.

The BIT report identified that some 76% of respondents were frustrated with the handling of their incident; 87% brought proceedings to prevent similar incidents recurring; 79% were looking for an explanation for incident occurring. 35% of respondents considered litigation necessary to secure financial support in coping with the future.

A failing complaints process is missing an opportunity to stave off litigation. This should be the correct forum to enable the public to get answers to questions about what went wrong with the care provided. It should be possible and expected that lessons are learned from mistakes and that change is made to prevent the same mistakes from happening again. The PFDs being issued by coroners as part of the inquest process is also evidence that the complaints process is not doing what it ought to do. If it were, opportunities to learn lessons would have been identified at an early stage and an Action Plan prepared to set out what has been learned and what will be done to address the failings. Although some trusts do prepare Action Plans the number of Prevention Future Death reports issued by the coroner is evidence that the early-stage investigations are not robust enough.

Exactly how much is learned by way of patient safety incidents from complaints and how many and what changes are being made as a consequence is not clear, there needs to be more transparency around the available data on this. At the moment, we can draw together evidence that the complaints process is not working. If there were some sort of National Oversight Mechanism (NOM) (as recommended by the Justice Committee in relation to the coroners' service) this would help track the effectiveness or otherwise of the complaints process.

As to **what would be the impact of the proposed measures to improve patient safety, such as Martha's Rule?** It is simply too early to say yet, the first phase is not due to be introduced until April 2024. At this stage and this is a provisional view we are concerned that Martha's Rule is at risk of having limited practical effect.

The three proposed components of Martha's Rule are:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.

2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition. This is Martha's Rule.

3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

It would appear that a family will only be able to access a rapid review team if NHS staff has accessed them first. The review is limited to the Critical Care outreach team, but the critical care outreach team will need to have discussions with the specialty that the patient is under - it needs to be a multi-disciplinary team decision. The only consideration for that team is whether the patient meets the criteria for transfer to a critical care unit.

Given that these situations are often time sensitive and therefore urgent situations, it may be that in practice (depending on the size of the hospital) the family may have limited access to a critical care outreach team. The second opinion may therefore be delayed. However, these are preliminary views only. It is therefore vital that in rolling out this new Rule there is a thorough evaluation of how the Rule is working and that such an evaluation must fully take into account feedback from patient's families who have used the new Rule and related mechanisms to be fully informed as to its practical effectiveness.

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