RESPONSE TO

CARE QUALITY COMMISSION CONSULTATION ON DRAFT GUIDANCE ON REGISTRATION REQUIREMENTS

(Guidance on compliance with the health & Social Care Act 2008 (Registration Requirements) Regulations 2009)

JULY 2009

1 Introduction

Action against Medical Accidents (AvMA) is the independent charity which promotes patient safety and justice. We have extensive experience gained over 27 years in supporting patients when things go wrong and of working in partnership with the NHS to improve safety. We therefore very much welcome the opportunity to respond to this consultation. The registration requirements and their monitoring and enforcement we believe would make a powerful contribution to improving safety.

We have restricted our response to the areas where we believe our experience and perspectives may add most value, rather than attempting to respond to everything.

On the whole, we are impressed with the degree of thought which has gone into the draft and hope you find our suggestions helpful.

2 Section 1: Respecting and Involving People who use services

2.1 As the Care Quality Commission (CQC) will be aware, AvMA have asked for a specific regulation to be created by the Department of Health for any registered organisation to ensure that service users (or, where appropriate, their next of kin) are fully informed of any known error or omission in their care or treatment which has caused or may result in harm. For example, this could be included in regulation 15. Whilst we welcome the positive guidance already being considered by the CQC with respect to 'being open' in its draft guidance, we firmly believe that this is no substitute for there being a statutory requirement reflected in the regulations covering registration with CQC. We hope that we can count on the CQC's support for an appropriate addition to the regulations, which we believe would send the most positive of signals and contribute significantly to the development of an appropriate 'open and fair' patient safety culture. The guidance, we believe, should be more about ***how*** to comply rather than setting out "must do's."

If the regulations are amended accordingly, the guidance in this section may need to reflect this.

2.2 We warmly welcome the guidance under 1C that

"People who use services receive care, treatment and support that is provided in a way that ensures their independence is promoted by …… Involving them in how the service should improve …… after an adverse event relating to their care, treatment and support."

3 Section 4: Care and Welfare of People who use services

3.1 We warmly welcome the intention behind the guidance under 4B that

"People who use services can be confident that …… They are told if a mistake which led to harm or unlawful treatment is made in relation to their care, treatment and support, provided with an expression of regret and an

explanation, and informed about how this may affect them and how the service will manage the situation and minimise recurrence."

However, we think that there needs to be a satisfactory requirement for providers to ensure that people are told in these circumstances. The Guidance should re-enforce how this should be done following a good practice. We think that the guidance needs to be reworded. Firstly, it should not be a question of whether people "can be confident" that this will happen. This would be similar to saying simply that there needs to be a policy or procedure in place. The guidance should be written more affirmatively. For example

"People who use services (or, where appropriate, their next of kin) are always told if an adverse event, error or omission in their care treatment or support has occurred which has caused, or may result, in harm. People who use services are provided with this information as soon as practicable, and have it explained in a way they can understand, together with an appropriate apology and information on how the service will manage the situation and minimise the risk of recurrence".

4 Section 11: "Fitness of workers, staffing and supporting staff"

4.1 In relation to fitness of staff, we recommend that rather than concentrate on there being "**clear"** procedures which are followed in practice, monitored and reviewed" that these procedures are also "**appropriate**"

(We see examples of procedures which are very clear, but quite inappropriate).

5 Section 14: Complaints

5.1 We strongly recommend removal of the exception listed under 14A whereby complaints may not be investigated/resolved if

"the person is a vexatious complainant and has a history of making complaints without sufficient grounds".

This introduces an unhelpful element of subjectivity. We see examples of providers sometimes wrongly labelling a complainant as "vexatious" simply because they strongly disagree with the complaint; the person complains a lot or vociferously. The notion of providers ignoring complaints from people who have a history of making what the provider sees as complaints "without sufficient grounds" is also very worrying. People with mental health problems in particular may be ignored if this guidance were to remain in its current form.

We are not suggesting that there is no such thing as a vexatious complaint or complainant. Any good complaints process should however be able to deal with each and every complaint and identify in an objective way if a complaint has no potential merit at all.

5.2 Again, not just "clear" procedures but "clear and appropriate" procedures.

5.3 We welcome the guidance that

"The procedure enables independent advocates to support people who use the service where they wish or need it"

We recommend that additional guidance is offered to the effect that

"People who use services can be confident that their comments and complaints will be listened to because:

- where needed, if people who use services do not have access to an independent advocate already, the provider will facilitate this at no expense to the people concerned".

We would welcome a discussion with the CQC about ways that the current lack of funded advocacy services for complainants in the independent sector can be addressed. Any NHS patient can use the Independent Complaints Advocacy Service. An arrangement could be devised whereby advice and advocacy services for independent health service providers are paid for by an industry-wide contribution.

5.4 We recommend additional guidance to the effect that

"the operation of the procedure will not be suspended due to the initiation of legal action in respect of a civil dispute, or the intention to do so, without the complainant's agreement".

It would be wrong if a complainant lost their entitlement to an honest investigation, explanation and apology, for example, simply because they needed to recoup compensation. It should not be possible to deter people from seeking their right to seek compensation through legal action by threatening withdrawal of their complaints entitlement.

5.5 Under 14B we agree that people should know

"the steps they can take if they are not satisfied ……"

However, we think the guidance needs to do more to require that there is a suitable step available to be taken. With NHS providers there is referral to the Ombudsman. However with private providers there may be no means to have a complaint independently reviewed, unless the CQC takes steps to ensure this should be the case.

Again, we would welcome a broader discussion with CQC about how independent providers can be helped meet the expectations/requirements involved in registration.

5.6 We recommend that additional guidance is added under 14A to the effect that

"information is made available, from the outset, of how to access independent advice or help with a complaint"

6 Other suggestions for the Guidance (and registration regulations)

6.1 Reporting incidents

We recommend that it is made a requirement that a registered organisation reports defined categories of incidents including incidents which have or may result in harm to a service user or patient to an appropriate body. In the case of the NHS this would be the National Reporting and Learning System run by the NPSA. Guidance could clarify where / how different registered organisations should report their incidents. (Note: this could be linked to the reporting of such incidents to patients / their next of kin which we refer to in 2.1)

6.2 Co-operation with other bodies

We recommend that the guidance and regulations reflect the need for registered organisations to co-operate fully with organisations which have a role in protecting patients / promoting safety. For example we have in mind in particular the regulators of health and social care professionals. Registered bodies should both be required to co-operate fully with their investigations concerning an existing or past employee or contractor, ***and*** to proactively alert health and social care professional regulators about concerns over the fitness to practise of an employee or contractor who is registered with the appropriate regulator.