SUBMISSION BY ACTION AGAINST MEDICAL ACCIDENTS ('AvMA') TO HEALTH SELECT COMMITTEE INQUIRY INTO COMPLAINTS & LITIGATION

Summary of issues covered:

1 Introduction

1.1 Action against Medical Accidents (AvMA) is the national patients' charity which works for better patient safety and justice for people affected by medical accidents. AvMA provides advice and support to around 4,000 people a year through its casework and helpline services and works with the Department of Health, NHS bodies and the health professions to improve patient safety and the response to patients and families when things do go wrong. AvMA has particular expertise and experience in NHS complaints, medico-legal issues and clinical negligence litigation. We accredit solicitors for our own specialist clinical negligence panel, which is recognised by all stakeholders as a mark of specialism.

2 Complaints

2.1 It is impossible to give a scientific answer to that question of why complaints numbers have risen, but from our perspective this will probably be due to the combination of factors, including:

- significant continuing problems with the quality of NHS services in some areas,

- a greater public awareness of complaints procedures and greater preparedness to complain to address causes of harm and potential harm, partly as a result of high profile scandals such as Mid Staffordshire

2.2 In terms of the overall effectiveness of the new NHS Complaints Procedure introduced in 2009, whilst we fully support its intentions and we do see examples of very good practice, our experience is that investigations and responses to complaints are still too often defensive, economical with the truth or inadequate. There is also inconsistency in the way the complaints regulations are being interpreted and a lack of national guidance. There is still too little evidence that lessons from complaints are being put into action.

3 Access to independent review of complaints

3.1 One aspect of the reforms over which we had expressed our concerns was the move to a two-stage process with the only route of appeal following 'local resolution', being the Ombudsman. We felt that unless the Ombudsman has the capacity and will review cases that come to her using the same sort of threshold that had been used by the Healthcare Commission, then many complainants deserving an independent review of their complaint would be frustrated and possibly be worn down by the

process. We remain concerned about this. The Ombudsman only accepted 346 health complaints for investigation in 2009-2010[1]. This is only a marginal increase on 289 for 2008-2009. A further 219 were closed by intervention with the NHS body concerned. These figures represent just 3% of all complaints received by the Ombudsman.

3.2 Bearing in mind that the Healthcare Commission had dealt with 7,827 independent reviews in 2007-2008 (30% of which were upheld)[2] , these figures would suggest that many people are being 'bounced' back to attempt further local resolution with the NHS body they are complaining about. Whilst we accept that in some circumstances this might be appropriate, we are worried that in others it is not. Complainants have expressed frustration to us about this, and some may well feel so frustrated and worn down by the process that they give up on their complaint. There appears to be something of a 'black hole' into which the many complaints which would have been reviewed by the Healthcare Commission and be upheld, with serious recommendations for the NHS body, have fallen.

4 Litigation and Complaints

4.1 AvMA was delighted when, after years of us arguing the case for this, the rules preventing patients having their NHS complaint investigated if they started legal action over an issue connected with their complaint were withdrawn. There is now nothing in the NHS complaints regulations which prevents this from happening and the Department of Health have confirmed the department's position should be that the commencement of litigation, or the intention to, should not preclude an investigation under the NHS complaints procedure. However, we have found that a number of NHS bodies are still wrongly advising complainants that they can not have their complaint investigated if they are taking legal action. We provide examples in the Appendix. Although the Department of Health has, at our request, already written to recommend trusts of the new position, clearly more needs to be done to ram home the message.

4.2 The problem is exacerbated by confusion over what the Ombudsman can investigate. The Ombudsman is governed by different regulations than the NHS complaints procedure, and the Ombudsman is not allowed to investigate a complaint if the complainant has or had "a remedy by way of proceedings in any court of law" (HSC Act 1993 s.4). Unfortunately, some of the Ombudsman's staff have been interpreting this as meaning that the Ombudsman can not investigate cases where the complainant has commenced clinical negligence proceedings or intends to. We give examples in the Appendix.

4.3 Not only is this approach by the Ombudsman out of keeping with the approach of the new complaints procedure, but we believe is an incorrect interpretation of the Ombudsman's own legislation. The remedy which a complainant is seeking from the Ombudsman is not financial compensation, and we are sure that the Ombudsman, whilst she does have a power (rarely exercised) to recommend compensation, would not want to become a major route for those seeking compensation. At the same time, a clinical negligence action can only provide financial compensation and not the other forms of remedy such as explanations, apologies, improvements to services and putting right an injustice, which are remedies available from the Ombudsman.

4.4 We have taken up this issue with the Ombudsman and **we hope that clearer guidance is given to all of her staff to the effect that taking legal action over clinical negligence or the intention to, should not affect in any way the Ombudsman's assessment of a complaint for possible investigation.** The only

[1] 'Listening and learning: Review of Complaints Handling by the NHS in England 2009-2010', PHSO, 2010

[2] 'Spotlight on Complaints', Healthcare Commission, February 2009

exception should be if the remedy being sought from the Ombudsman is financial compensation and the complainant has access to that remedy through a court of law.

4.5 It is very important that complaints are dealt with thoroughly whether or not litigation is intended or in train. Otherwise, vital indicators of poor or dangerous practice could be missed. Also, it is wrong in principle to treat some NHS patients differently because they need to litigate to obtain compensation as a result of negligent treatment.

4.5 **We recommend that guidance on the NHS complaints procedure is issued for all NHS bodies**. This used to be the case with the old procedure and this was found helpful by complaints staff, patients and their advisers. Such guidance need not be over-prescriptive, but having a point of reference such as this can help ensure consistent good practice. It also provides the complainant with the ability to understand and, if necessary, point out if their complaint is not being dealt with appropriately.

5 ICAS

5.1 AvMA provides advice to a considerable number of people who have sought help from ICAS, where this had not led to successful resolution of their complaint or they have been told by ICAS that they can not help them because they are seeking help with issues beyond the remit of ICAS or the NHS complaints procedure. These might include possible legal action, referrals to health professional regulators such as the GMC and NMC, help with inquests, or private sector complaints. These are all areas where AvMA specialises and is in a good position to help. Unfortunately, not all ICAS providers or advocates appear to consistently tell people in these circumstances of our ability to help

5.2 When ICAS was first set up there was a recognition that the kind of more specialist advice that AvMA provides was necessary, as well as the more generic help with 'navigating' the NHS complaints procedure, at the local level, which ICAS provides. Initially the DoH and then ICAS providers via sub contracts commissioned AvMA to fill this gap. Sadly, due to their own pressures, ICAS providers no longer do this, leaving a gap in any specialist funded service, which AvMA is struggling to meet using its own charitable resources. There is already a recommendation to fund specialist advice for members of the public who may want to raise a concern about health professionals' fitness to practice, from the "Tackling Concerns Locally" report on implementing reforms to health professional regulators. No progress has been made in implementing this recommendation. **The successor service to ICAS should include access to providers of these kinds of specialist advice.**

5.3 In terms of the operation of ICAS itself we feel there is a need for a proper independent evaluation. The 'ICAS Impact Report' published by the three ICAS providers in September 2009 provides a useful insight into some of the good work that ICAS does, but is more of a promotional brochure. We found it surprising that AvMA, which has a unique insight from a national perspective of how ICAS is working, was not consulted on this. We do see some fine examples of advocacy work by individual ICAS workers and an impressive professional approach by some providers. However, there is still a degree of inconsistency in the way the service is delivered, and we are concerned about some aspects of the service. These are not necessarily a criticism of the providers themselves, but the way in which the system has been set up/commissioned by the Department of Health. The main concerns about the way ICAS currently operates are:

- inconsistency of quality of service provided by different offices of ICAS,

- failure to have a consistent policy of telling complainants or referring complainants to AvMA or other sources of specialist advice where appropriate,

- the inability of the service to deal with complex complaints which may need to use different processes outside the remit of ICAS, and the lack of a funded source of advice for these cases,

- the reluctance of some ICAS staff to provide 'advice' as opposed to pure 'advocacy' (for example, refusing to offer an opinion on the adequacy or appropriateness of NHS complaint responses),

- a reluctance to use information obtained as a result of complaints to seek improvement from the NHS, or to make this information available to LINKs.

6 Healthwatch

6.1 Healthwatch provides an opportunity to address some of the current weaknesses in the system of patient and public involvement and complaints support. When CHCs were abolished, it was intended that ICAS would be provided or commissioned by Patients Forums as part of an identifiable 'one stop shop'. We would highly recommend returning to this model for Healthwatch. It would make the system less confusing for the public and would mean that Healthwatch would benefit from better intelligence from complaints to inform its monitoring work. The Government has recently announced that it wishes local authorities to commission ICAS type services for each Healthwatch area. **We would urge them to think again, as this could only lead to even more inconsistency of service provision and would miss the opportunity of returning to a more effective, joined up system similar to CHCs.** It also creates a conflict of interest, as some complaints will be about the local authorities' own social care services.

6.2 Whoever ends up providing the complaints advice and support in the future, there should be a requirement to make complaints information readily available to Healthwatch. This requirement should include NHS bodies including Foundation trusts needing to inform Healthwatch about complaints and actions taken to make improvements as a result.

7 PALS

7.1 We strongly advise PALS should not be seen as a 'gateway to complaints'. We see the benefit of PALS as acting as an internal customer care or 'trouble-shooting' service. It has become very clear through the Mid Staffordshire inquiry that PALS can be used inappropriately as a barrier to people having their complaint properly investigated. **There should be no implication that people have to go through PALS before they can complain formally. PALS should provide information on how to complain and also on sources of independent advice such as ICAS and AvMA.**

8 Primary Care

8.1 We are particularly concerned about the oversight of complaints in primary care, where PCTs had been given a role. There is great inconsistency at individual GP practice level. **Who will fill this gap and what role will there be for the GP Commissioning consortia?**

9 NHS Foundation Trusts

9.1 We believe that the current anomaly whereby NHS Foundation Trusts do not have to report on numbers of complaints should be addressed. **All trusts, Foundation or not, should have to report not only on numbers of complaints but on subject matter; outcomes; and measures taken as a result of complaints.**

10 Litigation: costs

10.1 AvMA's currently completing a detailed response to the Ministry of Justice consultation on taking away legal aid from clinical negligence cases and reforming how conditional fee agreements and other legal costs are funded. However, we think it important to point out at this stage our key comments on this issue.

10.2 We agree that the cost of clinical negligence litigation has increased significantly as a result of more cases being settled on CFA's than through Legal Aid. The NHS Litigation Authority and others agree that settling a case on a CFA is, generally speaking, several times more expensive than settling a case brought on Legal Aid. **We believe that there has been a lack of joined up thinking across government departments. The Ministry of Justice is seeking to save £17 million by taking clinical negligence out of scope for legal aid. We would estimate that at least that amount might be saved for the NHS if access to legal aid was increased for all clinical negligence cases, rather than most claimants being forced to use a CFA.** Instead, the combined effect of taking away legal aid and implementing Lord Jackson's proposals on CFA's will mean that many people will not be able to take legal action at all. The reduction of people's ability to access justice may also deprive the NHS of opportunities to learn lessons and an important incentive to improve safety.

11 Alternatives to Litigation

11.1 AvMA has recently served on the Scottish Government working party looking at a possible 'no-fault' compensation scheme and has also considered this and other alternatives to litigation extensively over the years. **We firmly believe that there should be alternatives to litigation. We would summarise the options as follows**:

1 A full blown no-fault compensation scheme as run in other parts of the world such as Sweden.

2 The NHS Redress Scheme provided for by the NHS Redress Act 2006 which has never been brought into force. Whilst AvMA would have designed this scheme differently than it appeared in the Act, appropriate regulations could still make it a scheme that would benefit many of the would-be claimants. The scheme would also encourage and support an open and learning 'patient safety culture'.

3 Other forms of schemes to deal with relatively small compensation payments. AvMA was part of the 'Resolve' pilot scheme for settling small claims and has been involved with the Welsh "Speedy Resolution" Scheme. It would be perfectly possible to introduce similar initiatives. We understand that the NHS Litigation Authority itself is looking at one idea of settling small claims on a fast-track basis using a jointly instructed medical expert.

4 AvMA has found that where NHS trusts able to make an ex-gratia payment following a complaint in recognition of the pain and distress caused, this has been extremely useful. It is a pragmatic way of a trust making an appropriate gesture and avoiding further unnecessary costs. This may be an appropriate way of dealing with cases up to a limit of, say, £10,000.

12 Open reporting and learning culture

12.1 The current regulatory system tolerates cover-ups and denial and does little to encourage openness and learning. Since the Committee's report on Patient Safety, in which it recommended reconsideration of a statutory Duty of Candour (with patients/families when things go wrong), there have been some significant developments. In April 2010 it became a statutory requirement for all NHS trusts to report patient safety incidents which cause harm to patients to the national reporting and learning system. In many respects this is to be welcomed. However, very controversially, a decision was taken not to make it a statutory duty to tell the patient or family anything at all about the incident. This sends a very worrying message about how seriously the Government takes 'Being Open with patients'.

12.2 The Government have made a commitment in the NHS White Paper to "require hospitals to be open about mistakes and always tell patients if something has gone wrong". However, Ministerial statements, notably in the adjournment debate on this subject on 1st December 2010, have made it clear that the so-called 'requirement' may not in fact be a statutory duty but some form of further 'guidance'. **To be taken seriously, a requirement to be open needs to be a clear and enforceable statutory duty. This is the single most important way of improving approaches to complaints and litigation and promoting patient safety.**

12.3 As regards litigation's specific effect on an open reporting and learning culture, we believe that this is an important factor. The fear of litigation (quite wrongly) is sometimes allowed to justify being less than honest. The development of less adversarial ways of compensating patients would help in this regard. However, it should be made crystal clear that fear of litigation can never justify being less than fully open and honest with patients when things go wrong.