NHS 10 Year Health Plan – AvMA response

Q1, What does your organisation want to see included in the 10-year Health Plan and why?

AvMA is *the* UK patient safety charity that supports people adversely impacted by a medical accident. We have been in existence for over 40 years and in that time advised tens of thousands of people who have been medically harmed and in need of support and an outcome that meets their needs. Sadly, despite numerous steps taken over the years by various Governments and including through numerous inquiries, some of which we have given evidence to, it still remains the case that far too many people are avoidably harmed by the NHS each year. Getting precise data from the NHS is much harder than it ought to be. However, data from NHS Resolution shows that in 2023/24 the total paid out in compensation and associated costs on all NHS indemnity schemes was £2.87 Billion. And of course, this is only the sums relating to those who get as far as making a successful claim – many people give up way before that as they encounter the numerous bureaucratic procedures used deliberately or otherwise by the NHS to deny what happened.

NHS complaints data for 2023/24 shows a record number of nearly 242,000 complaints and within this data it is almost certainly the case that many, for example, prescribing errors and clinical care (including errors) resulted in harm to patients which may or may not have gone to litigation.

It is also the case that there is a body of evidence that shows links between patient safety incidents and healthcare inequalities. It is widely reported for example that Black and Asian women's experiences of poor communication and discrimination during healthcare interactions may be a factor in explaining some of the inequalities that exists in maternal healthcare outcomes that are well reported. And poor communication is one of the themes that we see through our casework as an issue in patient safety incidents. Not surprisingly therefore, we also see a regular caseload of issues involving those who are vulnerable, may lack capacity, such as those with mental health issues or learning disabilities, where communication barriers can be present, as a feature of avoidable patient safety incidents.

In terms of what we would like to see included in the new 10-Year Health Plan, first and foremost we believe that the NHS, starting with its national leadership and those who have ultimate accountability for it, should acknowledge that this harm occurs and that it is a national priority to eliminate it wherever possible by putting patient safety at the heart of the Plan. In so doing it will also help to tackle the healthcare inequalities that arise in patient safety incidents. Afterall, a plan that cannot keep patients safe – not least the most vulnerable - can never be truly credible. And in doing this, the NHS needs to invest in its clinical and non-clinical staff to shift the culture from one that sees patient harm as a "risk and problem to be managed" (and which leads to inadequate responses and, at worst, cover-ups that have been uncovered time and time again by too many public inquiries). Instead, it needs to have a just and restorative culture that acknowledges that harm will occur from time to time and that when it does, it is the responsibility of a caring service to take responsibility to mitigate that harm and provide support to the patient and family just as it would with any other condition requiring treatment. Through such investment, which is not without its cost, the monies expended on developing such a restorative culture and response from staff would, we are certain, be more than offset in savings to the exorbitant cost of NHS

litigation. We set out in our answer to Question 5 a way in which this could be practically achieved.

More generally, fixing the NHS will require ensuring that it is a genuine patient-centric, user-led service. The people we support are too often left stranded and unsupported by the very institution that harmed them instead of providing the healing and care they were expecting. Dealing with a bureaucracy such as the NHS is bad enough even when its staff and their values are aligned towards the patient. But we know that is not always so. For this reason, we believe it is imperative that patients, and their families and loved ones, have access to good sources of independent advocates and support for them when harm occurs. The NHS is piloting this within maternity care (albeit not all the models adopted are truly independent which undermines their impact). And whilst we appreciate that maternity services were a priority, we do not believe this is the only area of NHS care which would benefit from such a service as again the costs attached to it will almost certainly be recouped through lower levels of complaint and litigation costs.

Turning now to complaints, our experience of supporting people who have been poorly served by the NHS is that the complaint system is not uniformly fit for purpose. With nearly a ¼ million complaints annually to the NHS we believe there has never been a more important time to review the complaints process up to and including the stages that lead to the Health Ombudsman where we find that body struggling to remain effective under a weight of legislation that is outdated and antiquated. We believe that a review of complaints is necessary and that key to any effective system is a robust and properly resourced independent stage that does not leave the NHS "marking its own homework". Without that confidence in the NHS will not be restored.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- **Quick to do, that is in the next year or so**
- **In the middle, that is in the next 2-5 years**
- **Long term change, that will take more than 5 years**

Our answer to Q1 outlined a small number of policy changes we would like to see enacted which we strongly believe could radically transform patient safety and ultimately go a long way to reduce the cost of litigation. None of our proposals, we believe, would need to take longer than 2-5 years to be properly embedded and for patients, staff and the NHS to see a real difference which could also be measured by way of cost savings and increases in patient engagement.

The first suggestion, building on our answer to Q1 is to create a structure to support harmed patients such that their harm is not additionally 'compounded' by the way the NHS treats them as so often happens now (and can lead to additional claims for litigation). AvMA, in conjunction with patients represented by the Harmed Patients Alliance, have devised a Harmed Patient Pathway. The commitments which underpin it we have been consulting on in the autumn of 2024. Subject to support and feedback for the proposals we expect to launch the final version of the scheme in 2025 along with a "How to guide" for staff to assist them with implementing it. This Pathway complements the work of the Patient Safety Commissioner on her recently developed Principles of Patient Safety and has been endorsed by a range of healthcare professionals and bodies through our consultation as well

as receiving strong support from patients who have previously been harmed as a consequence of a medical accident. And finally, the Pathway complements the work by NHS England on the development of their Patient Safety Incident Response Framework (PSIRF) which acknowledges the need for effective compassionate engagement with all patients involved in harm. Such a Pathway is not a 'tick-box exercise' to be implemented. Given its focus on re-framing how patients are to be seen and treated when harmed, alongside the restorative practices that underpin it, it will require care and planning, alongside training, to be implemented effectively. However, we would stress that the benefits use case is a strong one and will pay dividends with reduced costs of litigation.

Our second suggestion relates to the statutory Duty of Candour which has been in place since 2014. We have evidence that shows it is poorly understood and, as a consequence, often poorly implemented by many trusts. The Duty should be made to work effectively by ensuring effective resources and training to support its implementation and follow-up sanctions that bite where trusts are found to not be open, honest and complying with the statutory requirements.

The third suggestion, again referenced in Q1, is the need for there to be effective independent advocacy support for patients who have been harmed by a medical accident. The NHS has acknowledged this and is running a trial for such advocates in maternity services. We believe that such a service cannot be limited to maternity alone and needs to be extended across the NHS and all service areas. Such a service, to be truly effective needs to be independent otherwise its impact will be degraded through a lack of trust. Again, we believe this can be implemented quite quickly and easily within 2-5 years.

The fourth suggestion relates to reforming the NHS complaint system as per our response to Q1 above. We believe that a review of complaints is necessary and that key to any effective system is a robust and properly resourced independent stage that does not leave the NHS "marking its own homework". Without that confidence in the NHS will not be restored. Undertaking such a review could be a quick win and certainly any resulting changes could be implementable within 2-5 years. Such a review should encompass the role, resources and powers of the current Health Ombudsman which is struggling to retain its credibility given its limited resources and antiquated powers. Furthermore, we believe there is mileage in exploring the opportunity to use the complaints process, combined with some form of Alternative Dispute Resolution mechanism, such as mediation, to explore opportunities to resolve at least some low value litigation claims without resorting to the courts and expensive litigation. AvMA is currently working up a proposal for a pilot of such a scheme.

Our fifth suggestion relates to situations where people die as a consequence of a medical accident. Here we too often find that the coronial process for healthcare inquests is not fair and equitable. This is because the family has no support, legal or otherwise in their representation at a Coroner's inquest. We provide families with a free service that will support people in navigating a complex legal system although demand for the service is such that we are unable to provide representation to everyone who comes to us and as such even those we support in navigating the process often remain without representation. Legal representation is only available in limited circumstances for families and as such there is an inequality of arms given that the NHS and medical staff will be afforded legal representation. Related to this, a coroner may, where they identify concerns that could be repeated if not addressed, issue a Prevention of Future Deaths (PFD) report. However, there is no mechanism for these to be tracked and followed up to ensure that any recommendations made by the Coroner are addressed and remedied. For this reason, we support the call for a National Oversight Mechanism to ensure that PFDs are actively monitored, followed up and

actioned so that the real value of these reports in terms of providing assurance, increased public safety, and confidence in the NHS can happen. The Government could enact such a recommendation and implementation should be achievable within a 2–5-year time horizon.

Our final and sixth suggestion relates the roles and resources for bodies charged with patient safety. The Government has already asked Penny Dash to undertake a review of such bodies, and we will, like others, offer comments and suggestions to that review. But aside from any recommendations that arise from the review, we would simply say that whoever has responsibilities for patient safety going forward in the public realm, needs to have sufficient resources to discharge that responsibility. Giving organisations powers without the necessary resources to undertake effective enforcement work is counter intuitive at best and disingenuous at worst. And if the review concludes that there is a continuing role for a Patient Safety Commissioner for England then the powers, which are limited to the safety of medicines and medical devices, are too narrow should be properly defined alongside the necessary resources to support the agreed work and remit.

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