Department of Health and Social Care

Change the NHS consultation

A response by the Association of Personal Injury Lawyers

December 2024

Introduction

APIL is grateful for the opportunity to respond to this consultation on NHS England's new ten-year health plan.

APIL strongly advocates for a coordinated overarching strategy to tackle the issues which cause needless injuries and deaths in the first place. The current fragmented approach to patient safety is not working – significant improvements in patient safety require strong and coherent leadership with an overarching link between patients, regulators, healthcare providers and policymakers.

APIL believes preventing patient safety incidents and needless injury is a key consideration for any health plan. We are concerned that, 10 years past the implementation of the duty of candour, and despite several patient safety frameworks and programmes, the NHS is not effectively implementing the learning that comes out of patient safety incidents.

Recent reforms proposed by past governments indicate a disproportionate focus on reducing the costs of clinical negligence to the NHS. We believe the focus should be on preventing these claims from happening in the first place. The number of patients harmed whilst receiving NHS treatment continues to rise. APIL analysis of NHS England's data shows a 30% rise in the number of patient safety incidents reported to have resulted in severe harm or death in the past 10 years, suggesting no improvement in patient safety.[1] It is time for prevention to become a higher priority for the Government. The introduction of reforms such as fixed costs, capping heads of costs or proposals for no-fault schemes will only serve to increase patient safety issues. A short-term approach to managing the symptoms of poor patient safety prevents accountability and access to full and fair compensation for harmed patients, causing greater reliance on the state and further erosion of the trust placed in our healthcare system.

Question 1: What does your organisation want to see included in the 10-Year Health Plan and why?

Compliance with the duty of candour

APIL supports an open and transparent culture in healthcare, where admissions are made to patients when things go wrong. Often, people who have been injured by medical mistakes simply want to know what happened, that lessons have been learnt to prevent a recurrence to someone else and to be offered an apology. Our members' feedback is that compliance with the statutory duty of candour is currently sporadic, with an inconsistent approach across different trusts.

[1] *National patient safety incident reports*, NHS England, available at https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/

On several occasions, trusts have a written record of a ‘duty of candour discussion’, but the patient is, for reasons that are often unclear, apparently still unaware of what actually happened during care. When apologies are provided, they seem superficial and lack an explanation of the events and what could be done to address the harm caused. There is still a lack of transparency, which we attribute to a fear of repercussions from those in leadership positions or in-house legal teams. There has been substantial research examining the presence of a blame culture in the NHS. Many of these studies challenge the idea that this culture is driven by fear of litigation, pointing instead to other factors, including organisational pressures; fear of regulatory action from bodies such as the General Medical Council (GMC); reputation consequences and impact on career. For example, a 2020 study published in the BMJ Quality & Safety revealed that NHS staff were often hesitant to report errors due to fear of blame from colleagues and supervisors, rather than legal consequences. The study also found that concerns about litigation were less immediate than the anxiety of facing internal retribution, such as harm to one's professional reputation or punitive action within the healthcare setting.[2] More work should be done around education and training to address these internal cultural and structural issues, promoting openness, learning, and accountability.

Leaders’ regulation and better management structures and systems

Meaningful change in patient safety will only be possible once the NHS cover-up culture, often incentivised by those in leadership, is addressed. We note that while there has been an improvement in the perception of fair treatment of staff involved in errors, near misses and incidents, the most recent NHS staff survey 2023 results indicated that 40 per cent of NHS staff still did not think those involved in errors, near misses and incidents were treated fairly.[3] The cultural issues that prevent individual clinicians from reporting incidents to patients must be addressed. The presence of a just culture is essential to building effective teams and establishing good relationships between staff and their senior colleagues and between specialities.

We believe there is a need for regulation, stricter and more contemporaneous monitoring of outcomes, and increased accountability for NHS leaders. Efficient leadership plays a pivotal role in improving the way services are delivered. Leaders and managers should be subject to a set of agreed professional standards and national regulations governing their conduct, responsibilities and development. We recognise that the Government is committed to reviewing NHS performance across the country and introducing league tables. We also support the promise that persistently failing managers will be replaced; and turnaround teams of expert leaders will be deployed to help providers who are running poor services for patients, offering them urgent, effective support so they can improve their service.

Equality of voice for patients and patient-centred care tailored to individual needs

As mentioned above, our members report sporadic compliance with the duty of candour requirements. Patients must be treated with fairness and dignity. Our members' feedback is that they still come across several examples of patients being ignored by staff or systemic mistakes in patient safety. The case study below highlights this issue:

Case study 1

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[2] R Lawton, D Parker, *Barriers to incident reporting in a healthcare system*, BMJ Quality & Safety available at https://qualitysafety.bmj.com/content/11/1/15

[3] *NHS Staff Survey National Results*, available at https://www.nhsstaffsurveys.com/results/national-results/

There was a failure to manage the patient's major haemorrhage to adequate standard. This resulted in periods of hypotension despite fluid resuscitation during the claimant's shoulder replacement surgery, causing total blindness (Non-Arteritic Anterior Ischemic Optic Neuropathy). The trust underwent an investigation and produced a comprehensive investigation report. The result was that the investigation had not identified any failings. The trust fully denies liability.

The patient in this case submitted a complaint including the following allegations: "…visited by surgeon and anaesthetist who both apologised…no other information, nor an explanation of their actions has been forthcoming".

"Despite numerous requests from me, to date nobody has had a conversation with my wife and all the conversations have been had with me alone without any support or advocacy at all".

"At no point has anyone actually acknowledged the complete devastation this has caused to me and my whole family".

"I told staff I couldn't see. Despite me continuing to tell staff that I could not see, nobody accepted how serious this was, nor was any explanation forthcoming".

Furthermore, those affected by patient safety incidents are not getting access to clear, independent information about their rights and options. Person-centred care should mean there is a tailored approach to the individual's needs. More needs to be done regarding the emotional and psychological support provided to patients and families when a patient safety incident occurs. Part of the problem lies in the power imbalance between organisations and patients and their families. Too often, those who are injured feel left in the dark about what has happened, and that they are unable to have confidence in what the hospital trust tells them. Many would benefit from speaking to an independent advocate who can understand their needs and offer detailed advice and guidance. Some will go on to seek independent legal advice from a lawyer, but most patient safety incidents will not be actionable as a claim. 14,383 patient safety incidents resulted in severe harm or death in 2022/23 – an average of 39 every day. 745,610 incidents resulted in any degree of harm. In the same year, the NHS received just 13,511 clinical negligence claims.[4] This suggests that less than 2% of safety incidents involving patient harm result in a clinical negligence claim against the NHS. Families and patients in these cases would benefit from independent support, advice and guidance in ensuring that the duty of candour is complied with and that they are able to engage meaningfully in discussions about what happened and what is being done to prevent similar incidents in the future.

Question 2: What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

APIL supports the proposal to shift more care from hospitals to the community when it is clear that the benefits of such change exceed the problems caused by it. It is not always in the patient's interest that care is moved to community settings, for example, due to lack of availability on evenings and weekends, or a loss of technical and specialist expertise from a specialist centre. We are also concerned about execution, especially concerning funding,

[4] *National patient safety incident reports*, NHS England, available at https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/ (latest data published October 2022)

staffing, and ensuring proper communication and follow-up between community and hospital services. For the decentralisation of care to work, well-integrated systems and care pathways are needed. Our members report a lack of joined-up thinking, often resulting in poor coordination, fragmented care, and patients falling through the cracks post-discharge.

The current state of community services is one of the biggest challenges to achieving this shift without compromising patients' access to healthcare. Community Diagnostic Centres (CDCs) and GP surgeries are already facing understaffing issues. GPs are overstretched and often unable to meet patient demand. There is limited availability in general, but especially on weekends, holidays, or evenings. We believe staff shortages need to be addressed before expanding community care further. Research by the King's Fund indicates that staff shortages mean the NHS has to plug the gaps with agency staff. Between 2018/19 and 2021/22, spending on agency staff increased by £600 million.[5] Without adequate permanent staff, continuity of care suffers, and money is spent on agency staff that could be spent delivering other services to patients. The NHS must attract and retain staff with a coherent work strategy that makes it an attractive place to work and continue to work. Fair treatment of staff in the NHS is key for patient safety improvements and creating a culture of transparency and learning, but it is also fundamental to increase staff engagement and morale. Further, increased availability of technology/equipment (e.g. X-ray/CT in the community) will be ineffective in helping to reduce waiting lists if there are not enough trained people to operate such equipment. These concerns have been raised by the Society of Radiographers, for example.[6]

We have concerns that moving more care provision to the community will require more outsourcing of services, such as screening vans. Often, communication is poor between those services and hospitals, resulting in delays, misreporting, or lost diagnostics. A frequent example reported by our members is delayed diagnosis of cancer or other serious conditions due to miscommunications and results of outsourced scans and tests not being reported to the hospital. Delays in diagnosis result in poorer outcomes for patients.

Furthermore, the procedures followed by private providers may not always align with protocols and standards upheld by the NHS. Unfortunately, this lack of coordination and integrated thinking regarding procedures has led to serious consequences, including preventable deaths and the worsening of health conditions. A stark example was provided when a patient tragically died following a CT scan in a van in the car park at Royal Bolton Hospital. The patient suffered an allergic reaction during his check-up. The privately employed CT radiographer in the van called the hospital's crash team on the internal emergency number, but the script for the call was not followed. The miscommunication led to a delay of 17 minutes before the emergency team arrived at the correct location. In addition, the van had no EpiPens and only had adrenaline ampoules, which the staff had not been trained to use.[7] This is deeply concerning. To prevent such incidents, outsourcing arrangements must be accompanied by clear and robust procedures to ensure that diagnostic data is accurately recorded and reliably reported.

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[5] *Staff shortages: what's behind the headlines?* The King's Fund, February 2024 available at https://www.kingsfund.org.uk/insight-and-analysis/blogs/staff-shortages-behind-headlines

[6] *SoR welcomes Labour Budget – but warns it does not address 'fundamental cause' of crisis*, Society of Radiographers, available at https://www.sor.org/news/government-nhs/sor-welcomes-labour-budget-%E2%80%93-but-warns-it-does-not

[7] *Royal Bolton Hospital Man died after routine check-up*, The Bolton News, available at https://www.theboltonnews.co.uk/news/24339206.royal-bolton-hospital-man-died-routine-check-up/

Geographical inequalities present another significant challenge. Individuals living in rural or disadvantaged areas continue to face disparities in healthcare access and outcomes. While we acknowledge that various factors contribute to health inequalities, it is essential to pinpoint areas where NHS services are either unavailable, of lower quality, or less accessible. These areas should receive additional funding to ensure that individuals are not subject to a 'postcode lottery' in healthcare provision. We recognise that moving more care to community settings will be particularly beneficial for patients in rural areas, who often have to travel long distances to hospitals for diagnostics.

Question 3: What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

APIL recognises that effective integration of technology in health and care has the potential to improve the quality of care, reduce waiting times, and provide faster, more accurate diagnostics, ultimately leading to better patient outcomes. We believe the use of technology will improve early detection and preventive care. AI and advanced diagnostic tools have been reported to provide valuable support to healthcare practitioners, improving patient outcomes by enabling earlier and more accurate diagnoses.[8] However, careful planning is required to ensure the patient's experience is not compromised. The implementation and maintenance of healthcare technologies come with significant financial costs and complexities.

One of the key challenges is the fragmentation of IT systems within the NHS. Many trusts operate multiple, often incompatible, computer systems. For example, MRI and CT scanners may be managed by different vendors, complicating data sharing and system integration. Furthermore, numerous IT failures in the NHS have been linked to deaths and hundreds of instances of serious harm. A freedom of information request conducted by the BBC revealed that around 200,000 medical letters had gone unsent due to widespread problems and glitches with NHS computer systems.[9] The Health Services Safety Investigations Body also reports that since 2018, nine of their reports included specific findings and safety recommendations relating to electronic patient record (EPR) systems and that they encounter some level of EPR issues in nearly every investigation.[10] Very few of the systems have patients in mind. An efficient EPR system for healthcare professionals is fundamental for patient safety, and patients should also be encouraged to be involved in their care and understand and access their records.

The digital transformation of healthcare risks leaving behind certain patient groups, especially those who struggle with technology due to limited digital access, or individuals who are not digitally literate. The government must ensure that new digital health solutions do not exacerbate health inequalities. The availability of face-to-face care options must not be compromised, and care should be tailored to the needs of individuals.

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[8] https://transform.england.nhs.uk/key-tools-and-info/digital-playbooks/cancer-digital-playbook/an-AI-support-tool-to-help-healthcare-professionals-in-primary-care-to-identify-patients-at-risk-of-cancer-earlier/ https://annalise.ai/2024/06/transformational-ai-diagnostic-tool-made-available-to-radiologists-in-over-40-nhs-trusts/

[9] *NHS computer issues linked to patient harm*, BBC available at https://www.bbc.co.uk/news/articles/c4nn0vl2e78o

[10] https://www.hssib.org.uk/news-events-blog/electronic-patient-record-systems-recurring-themes-arising-from-safety-investigations/

Question 4: What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

APIL strongly agrees with the proposal to focus on preventing sickness, not just treating it. We believe this shift requires systemic change, significant investment in early intervention, and a cultural change in how healthcare is approached.

While we believe early intervention and preventative measures should be prioritised in care, a major challenge to preventing sickness is the lack of resources and funding, which hampers efforts to focus on early intervention. For example, some patients often have to wait over three years for a routine scan test that should have been done earlier (or at a certain age).

APIL believes that focusing on prevention will save NHS money in the long run. For example, diabetes type 2, a largely preventable disease, is currently consuming a significant number of resources due to its complicated and costly treatment. By investing in prevention (e.g., educating people about metabolic health, weight management and nutrition), the number of diabetes type 2 cases could be reduced, and the associated healthcare costs could be lowered. A key element in prevention is health education.

We are concerned that the wider social and economic disparities in healthcare access and education are a significant barrier to prevention. Communities with lower socioeconomic status, face poorer health outcomes due to lack of educational resources and targeted prevention programs. Addressing these inequalities is crucial for effective prevention.

Question 5: 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 to 5 years

• Long term change, that will take more than 5 years

Quick to do, that is in the next year or so

<u>Centralised and coordinated patient safety strategy</u>

APIL's longstanding policy on patient safety is that there is an urgent need for a coordinated overarching strategy to tackle the issues which cause needless injuries and deaths in the first place. The current approach to patient safety is extremely fragmented, with a multitude of programmes, frameworks, reporting schemes and organisations. These include the NHS Patient Safety Strategy, the National Patient Safety Improvement Programme, the National Learning Report, the Care Quality Commission, and the Health Services Safety Investigations Body (HSSIB), among others. We maintain that for there to be improvements in patient safety, strong and coherent leadership around patient safety is needed, with an overarching link between patients, regulators, healthcare providers and policymakers.

<u>Centralised tracking of Prevention of Future Deaths Reports</u>

We recommend that Prevention of Future Deaths (PFD) Reports be centrally analysed and stored, allowing patterns in patient safety to be more easily identified. The central database should be publicly available and searchable. At present, these reports are published without

a coordinated analysis to extract key learning, relying instead on academics or not-for-profit organisations without a standardised approach.

Better data collection and monitoring

Best practices should be shared widely, and benchmarking data must be collected to effectively monitor and analyse outcomes and performance. Leaders should be committed to the contemporaneous collection and analysis of data to respond in a timely way to areas of concern and highlight and share good practices. Too frequently, organisations rely on retrospective analysis of data, by which time it can be too late or later than it should be to respond to the issue. Better data collection and contemporaneous analysis would require investment of time and resources and joined-up practice with other healthcare providers and organisations. Data improvements will also be useful to address healthcare inequalities. The quality of ethnicity data should be improved and used to identify the specific health needs of Black and minority ethnic groups locally and monitor access to and outcomes of care, to support action where needed.

Reducing waiting lists and delays in treatment

Tackling long waiting lists, especially for surgeries, by increasing resources such as surgeons and hospital beds. The earlier treatment is performed, the better the outcome, the lower the failure rate, and the less expensive further interventions. We believe reducing delays is fundamental to improving patient outcomes.

In the middle, that is in the next 2 to 5 years

Supporting the implementation of the Harmed Patient Pathway

APIL supports the implementation of the Harmed Patient Pathway as part of the Patient Safety Incident Response Framework (PSIRF). The pathway, if effectively implemented, has the potential to be a valuable resource for healthcare staff in recognising that harmed patients require tailored care and optimising their recovery, easing suffering and preventing further distress.

National Standards and better communication in healthcare

We strongly support the creation of consistent national standards for care across the country to address disparities in local policies, funding, and referrals. Improved communication between healthcare providers and between local trusts could help reduce variations in care quality.

National Oversight Mechanism for Learning from Incidents

We support the establishment of a national oversight mechanism that would help healthcare trusts learn from incidents, improving patient safety and fostering an environment of openness. There is a Private Members' Bill for the National Oversight Mechanism that proposes to establish an independent body to operate a national oversight mechanism to monitor recommendations arising from investigations into state-related deaths, including inquests, public inquiries and official reviews. This could build on the establishment of a searchable database of coroners’ reports and prevention of future death reports.

Improved Support for Vaccination and Immunisation

We believe the compensation system for patients who experience adverse effects from vaccines should be reformed. This will increase confidence in the national immunisation programme and reduce hesitancy and contribute to eliminating preventable diseases. The Vaccine Damage Payment scheme should be expanded to cover more vaccines and make the process much faster, fairer, and comprehensive and generally update to make it fit for purpose for the modern era where vaccines are a key public health measure.

Stricter enforcement by the Care Quality Commission

We believe that enforcement by the Care Quality Commission (CQC) regarding patient safety incidents and compliance with the duty of candour should be stronger. Since the statutory duty of candour's implementation in 2014, the frequency of prosecutions for breaches has remained notably low. The first recorded prosecution to reach court was as recently as October 2020, underscoring the pressing need for a more robust enforcement mechanism.

The current leniency in enforcement fails to sufficiently uphold the principles of honesty and openness. This has a direct impact on patient safety. We note that the CQC is already reforming their regulatory framework and is working to be more transparent in how ratings are calculated.

Other policy ideas

Legal aid for representation on inquests

We acknowledge that this falls outside the Department of Health and Social Care's remit, but we strongly believe it is time to review the rules on legal aid for representation at inquests.

There should be a level playing field where bereaved families have access to legal advice before an inquest and representation during the hearing. Bereaved families need access to legal representation so that they are able to engage fully with the inquest process and obtain answers about their loved one's death. Families will face hospitals, local authorities and other public bodies which have legal representation funded by the public purse.

We believe the Government should introduce non-means-tested legal aid for bereaved families at inquests where a public body is represented.

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