Building a Brighter Future
for Injured People

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2 December 2024

By email only: hpp@avma.org.uk.

Dear Sir/Madam,

The Harmed Patient Pathway

APIL welcomes the opportunity to respond to this consultation by Action against Medical Accidents (AvMA) and the Harmed Patients Alliance (HPA) on the Harmed Patient Pathway.

We support the six proposed commitments for the pathway, which have 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. However, APIL is concerned that, while the commitments are well-founded, their implementation by NHS trusts might be limited, undermining their effectiveness in practice and ability to make a meaningful impact on harmed patients and their families. We agree that the support of leadership will be key to implementing the pathway. Leaders should commit firmly to the pathway, ensure its ongoing monitoring, and conduct outcome assessments. APIL believes there is a need for regulation, stricter monitoring of outcomes, and increased accountability for NHS leaders to ensure that the duty of candour, patient safety programmes or principles, and this pathway are embedded within NHS trusts.

We also note that numerous consultations on the topic of patient safety improvements have been published over the past year, and our response to this consultation should be read in conjunction with those responses, namely our response to the Patient Safety Commissioner's draft Principles of Better Patient Safety[1].

While we support the commitments and the development of the pathway, our longstanding position on patient safety remains that there is an urgent need for a coordinated overarching strategy to tackle the issues that 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, for example, the Patient Safety Incident Response Framework (PSIRF) referred to in the consultation document, the NHS Patient Safety Strategy, and the National Patient Safety Improvement Programme. We believe that significant improvements in patient safety and the patient experience will only be

[1]APIL response to the Patient Safety Commissioner's call for evidence – The Principles of Better Patient Safety available at https://www.apil.org.uk/files/pdf/ConsultationDocuments/4243.pdf
APIL response to the Department of Health and Social Care's call for evidence – Duty of Candour review call for evidence available at https://www.apil.org.uk/files/pdf/ConsultationDocuments/4231.pdf

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made once there is strong and coherent leadership, with an overarching link between patients, regulators, healthcare providers, and policymakers.

<u>Comments about the proposed six commitments</u>

APIL strongly agrees with commitments 1, 2, and 3 regarding compassionate and honest communication, independent advice and support, and meaningful involvement of harmed patients and families in investigations.

Commitment 1: We ensure compassionate and honest communication with harmed patients and their families that supports dignity, trust and just relations.

Commitment one should work in tandem with the statutory duty of candour requirements. Meaningful apologies can make an enormous difference to those who are injured or bereaved, by acknowledging that harm has occurred and that someone is sorry for what has happened. Since the introduction of the duty of candour in 2014, compassionate and honest communication with those affected by harm is already a statutory requirement when things go wrong. However, our members report that compliance with the duty has been sporadic, with an inconsistent approach across different trusts. A robust implementation of this pathway and other programmes, along with a culture of transparency and openness within the NHS, will be more achievable once staff, managers, and leaders consistently adhere to the requirements of the statutory duty.

Commitment 2: We do our best to ensure that harmed patients/families get the support they need, including access to specialist independent advice and support.

Commitment 3: We support meaningful involvement of harmed patients/families in investigations or other review processes related to their treatment.

We have concerns that harmed patients and their families are not currently receiving clear, independent information about their rights and options. Person-centred care should involve a tailored approach to individual needs - it is essential to provide more comprehensive emotional and psychological support to harmed patients and their families. 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 are unable to have confidence in what the hospital trust tells them. Those affected by harm would benefit from speaking to an independent advocate who can understand their needs and offer detailed advice and guidance. Some may seek independent legal advice from a lawyer, but most patient safety incidents will not be actionable as claims. In fact, APIL's data analysis suggests that less than 2% of safety incidents involving patient harm result in a clinical negligence claim against the NHS[2]. Families and patients in these situations would benefit from independent support, advice, and guidance to ensure that they understand the investigation process, make informed decisions about their involvement, and engage meaningfully in discussions about what happened and the lessons to be learned.

[2] 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. This suggests that less than 2% of safety incidents involving patient harm result in a clinical negligence claim against the NHS.

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Commitment 4: We provide harmed patients/families with opportunities to contribute to patient-safety and patient-experience improvements in a meaningful way.

APIL strongly supports the principle that harmed patients and their families should be given meaningful opportunities to contribute to patient safety improvements. Those who have suffered as a result of medical mistakes have a unique and invaluable perspective, and their voices should be central in efforts to drive change and improve healthcare practices. It is essential that healthcare providers actively and compassionately engage with patients and families throughout the complaints and investigation process. This engagement not only ensures that their concerns are properly heard and addressed but also helps to build trust in the system. Patients and families who have experienced harm have insight into what occurred at every stage of a person's journey through the healthcare system, which is key to identifying systemic issues that may not be immediately obvious to healthcare professionals or managers.

We suggest this commitment could include a requirement that complaints and investigation reports be disclosed to patients and families by a set date. Our members' clients often find the Patient Advice and Liaison Service (PALS) complaints system and comparative internal complaints systems to be too slow. A properly managed complaints system is essential for patient safety improvements, and to make patients and families feel heard and confident that steps are being taken to prevent a similar incident in future. For example, this could include clear deadlines such as completion of a rapid review within 14 days, acknowledgement of the complaint within 28 days, and delivery of the investigation report within three months. We believe this could also be beneficial for healthcare practitioners. The longer the investigation is delayed, the more details fade from their memory, and it may also become a psychological burden for them. To achieve the best learning outcomes, investigations should be conducted promptly.

Commitment 5 We respect that harmed patients/families may choose to use external or parallel processes to seek answers and accountability as well as to improve safety for others. We will not allow this to change or needlessly delay our engagement with them.

We strongly agree with Commitment 5. APIL believes that injured people and their families should always be empowered to make informed decisions. Independent legal advice from the outset is essential to ensure that families are informed of all of their options, and for ensuring fair treatment and fair compensation for harmed individuals and their families. As mentioned above, those affected by harm are often at a disadvantage when negotiating with a large body, such as the NHS. Independent legal advice from the outset helps balance this dynamic, ensuring that those affected by harm understand their rights and options and are not pressured into accepting a less favourable outcome. This is particularly important given that there might be conflicts of interest in the NHS Resolution's assessment of what happened as it is directly affiliated with the NHS. If applied correctly, Commitment 5d will also prevent defensive behaviour from trusts that harmed patients and families so often encounter.

We note that the pathway's stance is the promotion of "exploration of the use of restorative principles and practices in any alternative dispute-resolution process to try to achieve a non-adversarial, safe and dignifying experience for all affected thereby avoiding the compounded harm and significant financial costs associated with traditional legal processes". While we acknowledge that ADR can be beneficial, it is important that families receive early

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independent legal advice so that they can fully understand their options and any implications of choosing an alternative method of dispute resolution.

Commitment 6 We promote a just and restorative culture in our organisation that is fair to harmed patients/families and to staff, and we have policies, systems, and support for staff to enable this.

We also support commitment six regarding just culture. Our members have frequently encountered a pattern in which healthcare staff make admissions and provide an apology to patients and their families early on, but as the investigation progresses and lawyers are instructed, liability is denied, and it can take years for an admission. Meaningful change to patients' experiences will only be possible once the NHS cover-up culture, often incentivised by those in leadership and in-house legal teams, 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 still did not think they were treated fairly.[3] Leaders must demonstrate fair treatment of staff so that they feel safe to raise safety concerns. Staff who feel supported to be open and honest will be better equipped to communicate compassionately with those who have been harmed.

We hope that our comments prove useful, and if you have any further queries, please do not hesitate to get in touch.

Yours sincerely,

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