A HEALTH STANDARDS INSPECTORATE

A Proposal by the Association of Community Health Councils for England and Wales

and

Action for Victims of Medical Accidents

> "In the past, the inspectors of our public services have usually been members of the profession they oversee. This has made for too close a relationship. The Government wants to give people from different backgrounds a bigger say in future."
>
> The Citizen's Charter Guide.

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A HEALTH STANDARDS INSPECTORATE

THE CITIZEN'S CHARTER: AN OPPORTUNITY TO BE SEIZED BY HEALTH CARE WORKERS

The Association of Community Health Councils for England and Wales (ACHCEW) and Action for Victims of Medical Accidents (AVMA) warmly welcome the emphasis on tougher inspection standards and the move away from self-inspection in the public services which is now a central plank of Government policy. In our view, there is no sector of the public service in which moves in this direction can be of greater benefit to service users than in the health services. This applies particularly to the difficult and presently unsatisfactory area of complaints procedures and the monitoring and ultimate improvement in standards of care.

We believe the Citizen's Charter affords a political base on which a new structure needs to be built to monitor standards and to deal with complaints and, where appropriate, compensation for medical accidents. This proposal for a Health Standards Inspectorate is put forward for discussion by users and providers of health care and all citizens interested in bringing the National Health Service up to the standards of accountability called for by the Citizen's Charter.

AVMA AND ACHCEW: THE EXPERTS

AVMA is the only body concerned exclusively with the problems of victims of medical accidents. In its ten years of existence it has handled over 10,000 cases and has had contact with a further 5,000.

ACHCEW's member CHCs have 18 years' experience of assisting these victims and also of helping patients who have simply had a bad deal from health carers and wish to complain.

It is from this breadth of joint experience, which has included extensive contact with both the medical and legal professions, that the two organisations have elaborated a comprehensive policy to deal with standards in the provision of health care and better procedures to handle complaints and claims: the creation of a HEALTH STANDARDS INSPECTORATE.

PRESENT COMPLAINTS AND COMPENSATION PROCEDURES DO NOT WORK

Presently there is an extensive and, to the patient, bewildering range of procedures designed to meet the needs of users of the service who have cause, or believe they have cause, to be dissatisfied with their treatment. (See Appendix 1)

The very multiplicity of routes, and the inhibiting procedures involved, ensure that only the most determined and articulate can find their way through to an acceptable outcome. In the case of medical negligence, both time and cost operate dramatically against the victim. Many cases take up to six or more years to come to court. Many are settled out of court but often when the

complainant has been stretched on the rack of delay, anxiety and inhibiting cost. And while the complainant struggles with these barriers, the member of the health community against whom a complaint has been made is equally made to suffer uncertainty and insecurity in a totally unacceptable fashion.

The system does not provide that essential of sound administration - fast and affordable justice for both sides. And as claims mount both in numbers and cost, as they have in recent years, the position has worsened, facing health administrators with impossible conflict of loyalty between their duty to victims and their defence of resources to treat others.

In the case of complaints not involving legal action, the bureaucracy wastes the energies of staff and often defeats the users of the service.

THE UNCONTROLLED AND EXCESSIVE COST OF THE PRESENT SYSTEM

The proposals which follow may encounter opposition on the grounds of cost and the uncertainty of future funding in varying economic conditions. Let no one imagine, however, that what happens at present makes any kind of economic sense. Indeed, the waste of private and public funds under our present patchwork of complaint procedures and adversarial proceedings in court is horrendous.

* For every £1.00 awarded to victims by the courts, sums between 50p and £1.28 go in court costs.

* Very substantial costs arise from the delays which are an accepted part of the present system. For instance, doctors whose work is being investigated as a result of complaints about their ability may be suspended from all duties on full pay for excessive periods - sometimes extending to five years or more.

* The reports from medical experts which are an essential part of the litigation process cost up to £2,000 and many medical experts now charge a daily cancellation fee of £2,000 if they have reserved time to appear in court and the case is then settled out of court.

* Current costs are uncontrolled and are obscured in duplication of procedures, in a wide range of different budgets, in valuable time lost at every level of the Health Service and in the great and growing cost of litigation through the courts.

THE QUEST FOR IMPARTIALITY

Despite the cost, difficulties and delays involved in court actions, an increasing number of complainants have in recent years sought redress in the courts. The reason: the impartiality of the courts - an impartiality which many victims feel they do not get within the self-regulatory system which

operates in the Health Service, and which the Government is now committed to modifying. Evidence for this disturbing assertion is afforded by the number of Health Authorities who have steadfastly denied liability, only to settle out of court, often within hours of the case being called. Such an approach is distasteful, unacceptable and demeaning to complainants and defendants alike. Faced with it, some concerned individuals and organisations have canvassed a system of so-called no-fault compensation. For reasons which will be argued here and elsewhere, this does not appear to us to be an acceptable solution.

THE NEEDS AND WISHES OF PATIENTS

The prime concerns of patients who believe that something has gone wrong in their treatment/care are to know:

* what happened
* why it happened
* whether anyone is to blame
* if so, what action will be taken against that person/ institution
* what action is going to be taken within the system to try to ensure that it does not happen again.

While the question of compensation is important - particularly in a small minority of cases where substantial compensation is required to maintain the quality of life of a patient and of his/her family -
it is usually a consideration which does not take priority over the questions referred to above.

The major concerns of patients can be formally expressed, as issues which must be dealt with by any system seeking to achieve justice for victims of medical accidents, as follows:

* Standards
* Explanations
* Accountability
* Compensation

Three fundamental points must be understood and borne in mind by those devising a system to deal satisfactorily with the true needs of patients:

1] The concerns listed above cannot be dealt with in a piecemeal way - they are all inextricably linked.

2] Compensation is not the most important issue for the vast majority of complainants.

3] The two most important issues are in fact STANDARDS and ACCOUNTABILITY.

STANDARDS are vital because the improvement of standards, and the consequent reduction in medical accidents, present a certain way of improving the situation for the victims of such accidents. (This is made clear by the finding of a confidential enquiry into 1989 peri-operative deaths (1), that 1,000 of these deaths were "avoidable".)

ACCOUNTABILITY is vital owing to the huge measure of dissatisfaction felt among patients that health care staff appear to be accountable to nobody.

THE PROBLEMS OF 'NO-FAULT' COMPENSATION SCHEMES

The conclusions outlined above (which were arrived at quite independently by ACHCEW and AVMA) have made us wary of the approach to the solution of medical accidents inherent in proposals for so-called 'no-fault' compensation (for example, the Private Member's Bill put forward by Rosie Barnes MP in February 1991).

The idea of 'no-fault' compensation is attractive to many, in particular regarding the distressing cases of people in desperate need of money who have suffered from the current length of time and expense involved in taking medical negligence actions through the civil courts.

However, it must be stressed that 'no-fault' proposals fail to deal with either standards or accountability, which, as outlined above, have been found by ACHCEW and AVMA to be of prime concern to patients. It is an extremely serious drawback of the proposals so far put forward that they fail to establish any binding obligation to:

* ask why and how the injury/subject of the complaint happened
* if something untoward has taken place, take steps to ensure that it does not happen again (eg disciplinary proceedings, warnings, retraining, rethinking of the system).

There is a further fundamental drawback to all the 'no-fault' systems so far devised; the disproportionate power of health professionals. For example, under Sweden's no-fault compensation system, compensation is only paid if an accident is found to be avoidable - and it falls to the medical profession to determine this avoidability. It is important to recognise the ambivalence of the position of a doctor called upon to decide whether or not a colleague should be found at fault (and thereby whether or not a patient should receive compensation). It is a cause for considerable concern that 60% of all applications for compensation in Sweden are rejected.

In New Zealand the qualification for compensation is that there must have been personal injury by accident. Whether there has been an accident also revolves around the issue of fault (showing

(1) "The Report of the National Confidential Enquiry into Peri-operative Deaths 1989" Campling, Devlin, Lunn, 1990.

the misleading nature of the term 'no-fault' compensation). If a person died of natural causes there is no accident and therefore no compensation; if he/she died however because of the doctor's treatment, there was an accident and therefore the case qualifies for compensation. Once again, it is often a fellow doctor who has to decide this issue, and experience shows that often that doctor's inclination is to exonerate his/her colleague.
This problem of the disproportionate power of the medical profession is best illustrated by taking a hypothetical case and testing it against, for example, the definition of a compensatable event employed in Rosie Barnes MP's 1991 No-Fault Compensation Bill. That definition covered an injury suffered by a person as a result of a mishap in care "and not as a foreseeable and reasonable result of that care or the person's pre-existing condition".

Let us take a fairly common medical accident: the damage to the sciatic nerve during a hip replacement which leaves the patient with foot-drop. Was such an injury "foreseeable and reasonable" given that it can occur for no obvious reason? Or was it caused by the unreasonable act of the doctor in applying too much pressure?

To establish this, an enquiry into fault is needed. The defect of the Rosie Barnes Bill, as in the New Zealand and Swedish systems discussed above, is that such an enquiry would not be held; rather, within the administration system, another doctor could simply certify that foot-drop is a foreseeable and reasonable result of the operation - and the patient would be left without compensation.

The difficulties surrounding this procedure can be illustrated by examining what happened until recently in relation to sciatic nerve damage under the present British system of establishing medical negligence in the civil courts (the Tort system). For the first six years of AVMA's existence, the medical experts consulted regarding such damage always stated that it was a "known complication" and that the doctor was therefore not negligent. As AVMA's knowledge of the operation became more extensive, and experienced solicitors more challenging towards 'experts', the latter discovered that in some cases the disability was indeed caused by negligence. In 1992 a Health Authority for the first time settled such a claim for £65,000 without litigation - thereby demonstrating that it is now accepted that such injuries can be the result of negligence.

THE AVMA AND ACHCEW PROPOSALS FOR A HEALTH STANDARDS INSPECTORATE

The general purpose of the HSI would be 'the regulation of health care'. It would ensure that complaints by health care users were fully and satisfactorily managed; initially by the health care provider/s concerned, and with the maximum possible emphasis on local and speedy resolution. It would further ensure that an enquiry into the circumstances of medical accidents always takes place, and would determine whether, and what, compensation should be paid. It would be responsible for the setting and auditing of standards in the provision of health care.

The Health Standards Inspectorate would comprise a policy making board to which would be responsible an inspectorate, a compensation commission, a disciplinary commission and an administration commission.

The Board

At the top of the HSI structure would be a policy-making body, the Board. This would be an Independent Statutory Body, with the statutory powers needed to enable the HSI to achieve its objectives, established by primary legislation. (Analagous is the Health and Safety Commission and Executive, whose aims derive from the Health and Safety at Work Act 1974).

The Board would be appointed by the Secretary of State and would be representative of health care workers, patient groups, Health Service managers and unions, and would in addition have a substantial lay membership. Its functions would be to:

* enforce standards
* maintain and review standards
* establish policy and procedures for the HSI's Inspectorate and Commissions
* advise Ministers
* initiate inspection
* collect statistics
* have access to audit information
* receive and publish reports from the HSI's Inspectorate and Commissions, and publish an Annual Report
* subject to the approval of the Secretary of State, appoint the members of the HSI's Inspectorate and Commissions

The Inspectorate

The Inspectorate would comprise substantial lay membership as well as representatives of health professionals, patient groups, and Health Service managers and unions. The Inspectorate's duties would be to:

* appoint and manage inspectors
* receive reports from the inspectors
* report to the HSI Board
* make recommendations to Health Service providers and purchasers.

The inspectors appointed by the Inspectorate would have a range of professional skills, and would be stationed both at a national headquarters and at appropriate and accessible sites throughout the country. Since the essence of any scheme for satisfying patients is its accessibility, the major part of the work would be conducted at a local level.

All complaints (whether informal or formal) and claims for compensation, would initially be channelled through the local office of the Inspectorate but complainants would have the right to make a complaint direct to the national office. Notwithstanding this provision which is required to ensure no

complaint or its implications for the Health Service is overlooked, providers will be expected themselves initially to look into the complaint and guidelines on how this should be achieved will be issued by the Commission. (See diagram in Appendix 2.) This would provide the single point of entry to the whole complaints/compensation procedure necessary for it to be truly accessible to the user.

The major duties of the inspectors would be as follows:

* regularly inspect all institutions providing health care
* prescribe what records shall be kept by such institutions and inspect such records
* investigate all complaints referred to them by the HSI Complaints Commission or by patients
* advise on how institutions providing health care might do so in the most efficient and cost-effective manner in the best interests of patients
* consult with service users.

The Complaints Commission

The HSI complaints system would be based on the major needs of users of the health services, found by both Community Health Councils and AVMA to be as follows:

* uniformity - a single unified system for investigating all formal complaints
* speed - complaints should be investigated, resolved and the results reported to the complainant as speedily as possible
* quality assurance - complaints should be seen as a mechanism to measure standards and a stimulus to service improvements
* the need to satisfy the emotional, practical and financial needs of the complainant.

The Complaints Commission would comprise a substantial lay membership, health professionals, patient group representatives, managers and practising barristers/solicitors. Its major duties would be as follows:

* recommend policy on complaints to the HSI
* make reports to the HSI
* appoint and convene a Complaints Investigation Panel (CIP) to evaluate specific complaints
* implement recommendations from the CIP in conjunction with the Disciplinary Commission
* provide information and publicity on the complaints procedure

The initial investigations made by the HSI inspectors, and then those of the Complaints Investigation Panel, would not be confined to any one aspect of the Health Service; they would be all-embracing, taking in GPs, consultants, nurses, administrators, ambulance drivers and any other individuals or bodies concerned with the treatment of the patient. It would be

a condition of the contract of all health care staff that they should take part in these procedures as required.

After hearing specific complaints, the Complaints Investigation Panel would have the authority to make recommendations to:

* the HSI Complaints Commission - regarding any management and related issues
* the HSI Disciplinary Commission - regarding any disciplinary action towards professionals
* the HSI Compensation Commission - to consider any financial compensation which may be appropriate

The Compensation Commission

Action for compensation for medical accidents would be taken through the HSI Compensation Commission. The Commission would adopt the Rosie Barnes definition of a compensatable event (ie an injury suffered by a patient as a result of a mishap in care "and not as a foreseeable and reasonable result of that care or the person's pre-existing condition"). Compensation paid would comprise a limited lump sum payment with the major portion of the compensation made by periodic payments.

The Commission would include health professionals, patient group representatives, Health Service managers, lay members and practising barristers/solicitors. It would be chaired by a judge. The Commission would decide what compensation should be paid once the Inspectorate and Complaints Commission decide that the injury came within the definition of a compensatable event.

If the claimant rejected the compensation offer, he/she could apply to the Compensation Commission for the claim to be considered again after a Hearing, at which the claimant would have the right of legal representation (with Legal Aid available). The claimant would also have a similar right of appeal if the Complaints Commission decided that the injury did not come within the definition of 'compensatable'.

If the Complaints Commission decided that a person/institution was to blame for the injury, they would be notified and would also have the right to appeal through a Hearing (with the right to legal representation, and Legal Aid if appropriate).

With regard to the enquiries held by both the Complaints and Compensation Commissions, and any appeal Hearings, the procedure adopted would be inquisitorial - rather than the adversarial approach currently in use.

The Disciplinary Commission

The HSI disciplinary system, regarding matters resulting from allegations of misconduct, would be based on the major needs of users of the health services, which both CHCs and AVMA have found to be as follows:

* accountability - the process must be open to public

scrutiny
* lay involvement - this is necessary to avoid the process merely being peer review (as is largely the case at present)
* appeal mechanism - the opportunity to appeal against decisions is essential (for both complainants and those complained about)
* sanctions - the ultimate sanction must be removal from the professional register; in less serious cases there should be provision for re-training and re-education of health professionals, or withholding of the practitioner's salary
* uniformity - the same disciplinary procedures should apply to all health professionals (unlike the various procedures operating at present).

The definition of misconduct which the Disciplinary Commission would employ would include the following:

* reckless and wilfully unskilful practice
* concealing untoward incidents
* failure to keep essential records
* falsifying records
* failure to protect or promote the interest of patients
* failure to act knowing that a colleague or subordinate is improperly treating or abusing patients
* physical or verbal abuse of patients
* abuse of patients by improperly withholding prescribed drugs, or administering unprescribed drugs or an excess of prescribed drugs
* theft from patients or employers
* drug-related offences
* sexual abuse of patients
* breach of confidentiality
* incompetence.

The Disciplinary Commission would comprise substantial lay membership plus representatives of health care workers, patient groups, Health Service managers and unions. Its procedures would be inquisitorial rather than adversarial and its duties would include the following:

* make recommendations to the HSI Board regarding disciplinary matters
* establish committees to deal with allegations of misconduct, or impairment of fitness to practice by reasons of illness
* organise training in adjudication skills for the above committees' members
* implement recommendations made by the above committees.

The Administration Commission

Administration would be dealt with by the Administration Commission. This would operate in the same way as the Health Service Commissioner (Ombudsman) does at present. The head of the Commission would however be responsible to the HSI Board.

CONCLUSION

It should be emphasized that our proposals are firmly based on the patient's point of view. We do not question for a moment the integrity of health carers and administrators, nor their concern for the problems of victims/complainants. Yet the approach taken by health carers/administrators must of necessity differ from that taken by injured or dissatisfied patients; and all manner of influences may be at work in determining the former's reactions.

As outlined above, accountability has been identified as an issue of key importance for patients. It has been argued by some that the questions of compensation and accountability should be kept entirely separate. Although we agree that these issues need to be dealt with separately, we strongly oppose any system in which compensation is dealt with in a vacuum, without any regard to the circumstances of the accident. We have thus proposed a system which may be characterised as a continuum. It would deal with standards, accountability, discipline, complaints and compensation - recognising that only in a small percentage of cases does the question of compensation arise.

Although these matters would be separate, they would be dealt with under one compehensive body, within which information could be exchanged freely. We believe strongly that the problem of complaints and compensation needs to be tackled in such a comprehensive manner, rather than the piecemeal fashion of many of the various proposals currently being put forward.

We have therefore devised a system which can address all the complex issues involved in this area.

Two important points merit discussion: the role and reaction of health care workers; and the cost involved in setting up the new body.

1) ACHCEW and AVMA's goal is a system capable of being fair to both health care workers and patients; we therefore sincerely hope that many of the former will support our proposals and join forces with all those groupings who have the best interests of the patient at heart.

   It would not, however, be entirely surprising if some health professionals were to respond negatively to the idea of a new body with supervisory powers over them. Yet many other professions are subject to an Inspectorate, and it is surely in the best interests of health care workers not to reinforce the popular prejudice that the medical profession considers itself above outside criticism.

   Further, it is intended that the profession should be fully involved in both setting and upholding standards, and that it should have a major part to play in the accountability and compensation/complaints functions of the new body.

2) It is neither appropriate nor possible at this stage to cost a scheme of this nature. Two fundamental points relating

to cost should however be made:

(i) the scheme should be organised so that if it is in its early stages not fully comprehensive owing to cost, it could be extended as more money becomes available, or as the demands of users become more urgent. This would mean that the scheme could also be expanded into other categories of accident, if society so demands. (The lack of such flexibility is one of the major defects of proposed 'no-fault' schemes; by introducing a specific scheme of that nature, the development of other schemes - eg. regarding accountability - would be excluded). Debate on the present proposal should not be circumscribed by the funding any government is initially prepared to commit to the scheme.

(ii) most importantly, any costing of our proposed scheme remains irrelevant while the cost of the present procedures which it aims to replace remains unknown.

We would need to know how much is being paid out in compensation under the present system and how much the projected future cost is; yet until recently no statistics were collected centrally. We also need to be able to assess the combined costs of maintaining and operating the present complaints and compensations procedures. These include the following, as yet unquantified, costs (all of which would be subsumed under the proposed system):

* paying all the doctors, managers, lawyers, judges and court staff involved in dealing with compensation claims

* maintaining the various NHS complaints procedures and the professional reviews held by bodies such as the General Medical Council.

* time lost by victims attempting to deal with the issues of compensation and accountability.

It should be borne in mind in this regard that there are inter alia no less than 98 Family Health Service Authorities dealing with complaints against family practitioners, and there are 219 District Health Authorities in which independent professional reviews take place to consider complaints of a clinical nature.

The role of all these in the complaints system will be replaced by the Health Standards Inspectorate.

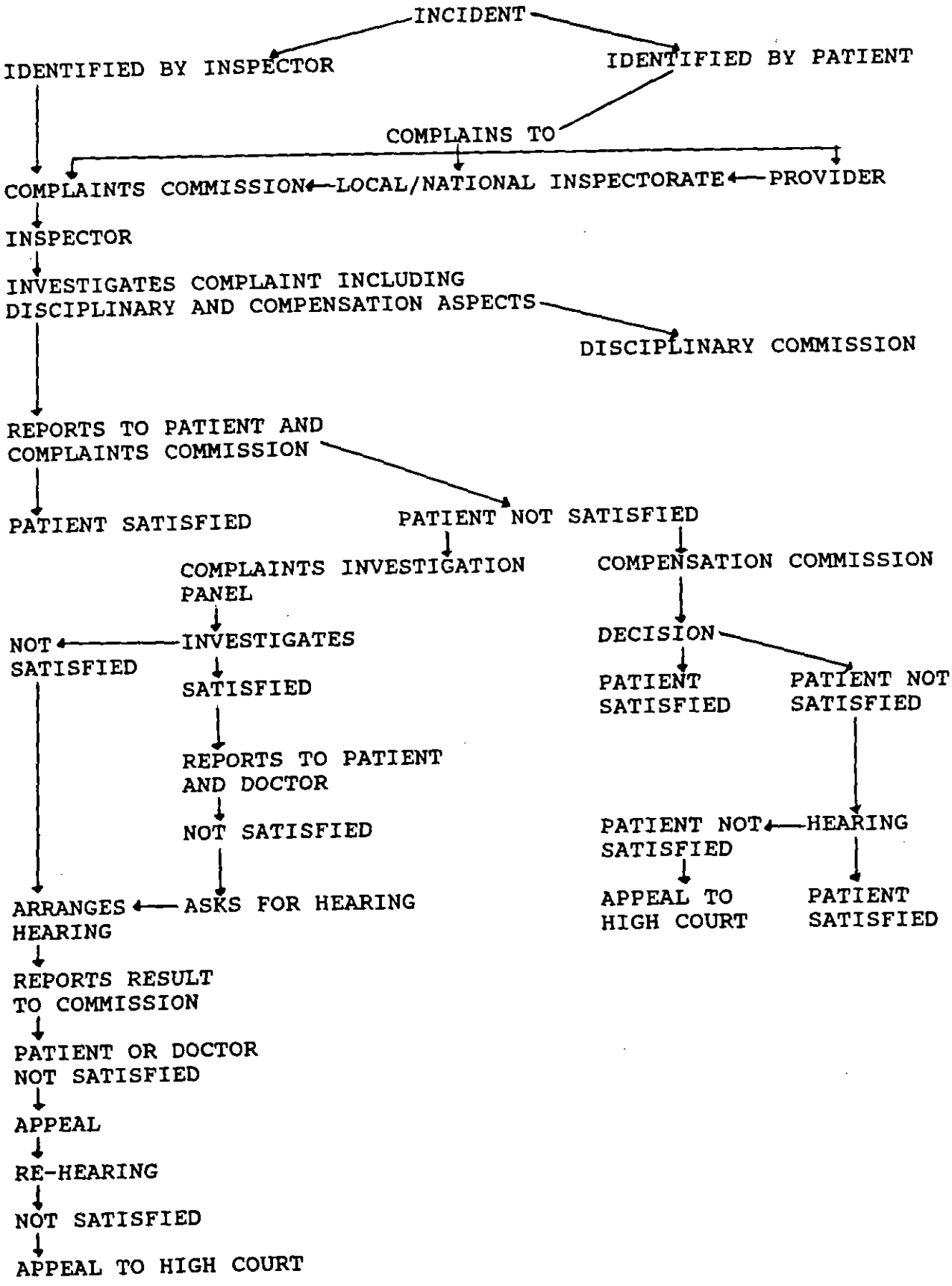
APPENDIX 1: THE PRESENT LABYRINTH OF COMPLAINTS PROCEDURES

Victims and complainants are at present faced with an extremely complex and fragmented labyrinth of procedures, administered by discrete bodies dealing with different health professionals. The current procedures are as follows:

* Family Health Services Authority - formal
* Family Health Services Authority - informal
* Hospital: Administrative Review
* Hospital: Clinical Complaints Procedure
* Health Services Commissioner (Ombudsman)
* Civil Courts
* Professional Conduct Review

The various professional bodies set standards of conduct for, and have the power to discipline, health professionals. The General Medical Council performs this function for doctors; the United Kingdom Central Council for nurses midwives and health visitors; the General Dental Council for dentists; the General Optical Council for opticians; and the Royal Pharmaceutical Society for pharmacists. The GMC is currently seeking to introduce a measure of reform into its antiquated and inadequate procedures for dealing with medical incompetence.

APPENDIX 2: DIAGRAM DEMONSTRATING PROPOSED OPERATION OF HSI COMPLAINTS/COMPENSATION PROCEDURE



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