**SUBMISSION TO THE CLWYD/HART NHS COMPLAINTS REVIEW**

Introduction

Action against Medical Accidents (AvMA) is the specialist charity for patient safety and justice. We advise circa 3,500 people a year who have been affected by something going wrong in healthcare and causing harm. We have extensive experience and expertise regarding the NHS Complaints procedure and other processes available to patients or their families when things have gone wrong. We are unique in that we only deal with complaints where there is a serious concern that there has been a lapse in patient safety.

We think that the starting point for reviewing and reforming the way the NHS deals with complaints should be Robert Francis QC's recommendations from the Mid Staffordshire Public Inquiry. This must be a top priority. This paper outlines suggestions which complement or re-enforce those of Robert Francis QC, drawing on AvMA's experience and expertise in this area.

Duty of Candour

There is a fundamental need for a more open and honest approach to investigating and responding to complaints. This will require a shift in current culture and behaviour which tends to be defensive or not treat complaints seriously enough. The implementation of a statutory Duty of Candour will greatly assist in bringing about this change if it is robust enough to ensure that every organisation and every staff member in it has to take it seriously, and is held to account if they do not. This should be accompanied with support and training for staff based on the existing *Being Open* policy developed by NPSA and involve patients' organisations.

Need to end use of risk of litigation to excuse lack of candour

Currently, the lack of clear guidance on complaints handling allows NHS bodies to refuse to investigate and respond to complaints if litigation is intended. This is completely contrary to the policy objective of being open and honest when things go wrong. The clear inference is that people will not be offered the full facts if they intend to seek compensation.

The Department of Health should take immediate action to make clear to NHS bodies that they should respond fully and truthfully to complaints whether or not there is a potential or actual clinical negligence claim concerning an incident connected to the complaint.

Monitoring/Audit

Every NHS body should be required to arrange an annual audit of complaints. This process should involve independent third parties including patients' representatives (via Healthwatch and/or national patients' organisations) and commissioners. The audit should consider how well the process was conducted and what evidence there is of action taking place as a result

of the complaint. Where audit reveals there has been a serious mishandling of a complaint or a lack of candour in investigating and responding, action should be taken to deal with those responsible and inform the complainant.

Each NHS body should invite feedback from its complainants about how the complaint was dealt with.

Role of PALS

The role of PALS (as an internal trouble-shooting/customer care service) should not be confused with the complaints handling function. Information about PALS should make clear it is not independent and give information about where people can get independent advice and support with complaints. There should be no suggestion that people have to go through PALS before they access their right to complain formally or are put in touch with independent sources of advice (as is sometimes the case currently).

There needs to be more consistency in the availability of help from PALS.

NHS bodies should be required to have an adequately resourced PALS service.

Complaints Staff

Complaints staff are often under-valued and under supported for what is an incredibly demanding and very important job. There should be a recognised qualification/accreditation for complaints staff and they should command a sufficiently high grade/salary appropriate to the services responsibility and complexity of the job.

Consistency, Guidance and Standards

The Department of Health should provide comprehensive guidance for the NHS on how to operate the NHS Complaints procedure. Every NHS body (including Foundation Trusts and primary care practices, and private providers treating NHS patients) should have the same requirement to follow the complaints procedure and the guidance and to report publicly on complaints.

National standards for complaints handling should be agreed and NHS bodies should be assessed that they are meeting these standards.

Board Level Consideration of Complaints

Every NHS board should receive regular reports on complaints that have been received and responded to. These reports should be considered in public and should provide sufficient detail for the board to be able to identify issues/trends in complaints, rather than just statistics.

Independent Advice and Support

The current model of NHS Complaints Advocacy should be reviewed. Locally, NHS Complaints Advocacy should be available through a local ‘one stop shop’ (local Healthwatch) which local people can easily identify, and which will also use complaints information to inform its representation of patients/seek improvements.

Robert Francis’s recommendation that funding for Healthwatch be ring fenced should also apply to NHS Complaints Advocacy.

In addition to local NHS Complaints Advocacy, more specialist advice and support should be commissioned from an appropriate national organisation for more serious/complex or specialist complaints, as suggested by Robert Francis QC.

Information on where to access independent advice (both from local providers and more specialist national advice agencies) should be proactively made available to patients.

Regulation of Complaints Handling

The CQC should be more pro-active in monitoring adherence to good practice in complaints handling. It should take action where this is seen to be insufficient. We note with disappointment that in spite of large numbers of trusts reporting to the Information Centre that they either upheld no complaints or that they upheld all complaints, that this has not led to formal enquiries with those trusts to find out why this is the case.

Role of the Health Service Ombudsman

We welcome the recent announcement from the Ombudsman that she intends to take on more cases for investigation. We believe it is vital that the Ombudsman has sufficient resources and its threshold is low enough to allow dissatisfied complainants a realistic prospect of having their complaint independently reviewed.

"Complaints Hub" / "Single Portal"

We noted with interest that the Ombudsman and regulators have been discussing this concept. To our knowledge, these discussions have not so far involved representatives of the people whose needs such a service is supposed to help meet. There has been formal multi-stakeholder discussions of this concept (or something similar) since Dame Janet Smith first recommended it in her report on the Shipman Inquiry. These have concluded that the higher priority rather than a sophisticated "hub" or "portal" for complaints of all kinds, is an independent, specialist national helpline and advice service. (See report of the *Tackling Concerns Locally* working group set up by the DH as part of the health professional regulation reforms). This would not only be able to advise and signpost people to the most appropriate place for their complaint, but help them in making their complaint. Such a service would require funding but would need to be independent of the NHS and other official bodies.

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