PE1844/F
The Patient Advice and Support Service submission of 5 February 2021

The Patient Advice and Support Service, recognises that at the initial stages an internal NHS complaint and investigation can be the most effective way to identify issues, seek an apology and hope that learnings are absorbed by the NHS and disseminated, but also recognises that the Duty of Candour and a culture of no blame has yet to make significant inroads into the NHS.

The Patient Advice and Support Service recognises that the SPSO does provide an element of external oversight and has the power to investigate complaints against the NHS by service users and their families and issue recommendations.

This option does however rely on the complainant having the resilience to take a complaint through an SPSO process that can stretch over 2-3 years, and therefore it is not an appropriate option for some.

However, GPs investigate their own complaints with no oversight or collation of the issues, and the SPSO is the only body to which people can appeal when the GP's own investigation is inadequate.

There therefore appears to be an absence of checks and balances for problems encountered with primary health care.

The Patient Advice and Support Service recognises the value in the current consultation process to implement the recommendations of Baroness Cumberlege's Report, and supports the creation of this role, but notes that it may be limited to medicines and medical devices, and therefore whilst independent, the remit may be limited to certain types of harm.

The Patient Advice and Support Service notes the current legislative framework and the resulting outcomes such as the Patients Charter and the Duty of Candour, but also notes the gaps between these expressions of intent and the practice. There is for example, a significant gap between the numbers of adverse events recorded by Health Boards and the very small number of cases where the threshold for applying the Duty of Candour is considered to have been crossed. There also appears to be no centralisation of the issues complained about through either Care Opinion or those complaints sent directly to the health boards, although the response times are collated centrally. The Patient Advice and Support Service would therefore see a value in the central collation of the complaints received by both the Health Boards and Care Opinion, and an independent review of these complaints, potentially though an extension of the remit of the Patient Safety Commissioner. There also appears to be no centralised dissemination of the learning from the complaints process or Care Opinion, and therefore would advocate for a formalised process across the Health Boards, with potential oversight by an independent body such as the Patient Safety Commissioner.

Finally the Patient Advice and Support Service notes the time limits which apply to taking a complaint against the NHS or following the SPSO process, and notes that harms caused by inappropriate or negligent medical treatments can evolve over time

and accumulate, and would therefore prefer to see an absence of time limits within the remit and powers of the Patient Safety Commissioner.