
Organisations & Bodies involved in complaint processes
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ADVOCACY

# Introduction

There are a number of bodies and organisations that exist to support people through the complaints process, to monitor services who deliver NHS and social care support, regulate organisations and individuals involved in that care, treatment and support and who can help when things go wrong.

In this information booklet you will learn about some of these organisations so you can support your advocacy partner to consider when and if to use them - and when you might wish to signpost a person to their support.

# Healthwatch

Healthwatch England is the national consumer champion for both health and social care, and represents the views of patients, service users and the public at the national level.

This includes providing information and advice to the Secretary of State for Health and Social Care, NHS England, Care Quality Commission (CQC), and NHS Improvement.

# Healthwatch

Local Healthwatch ensures that people's views and experiences inform the commissioning, provision and scrutiny of local health and social care services, including through its seat on the local Health and Wellbeing Board.

A Health and Wellbeing Board is in place in each upper tier and unitary local authority in England. It brings together local government (elected councillors and senior officers), the local NHS and other key local partners, to provide strategic leadership for the local health and wellbeing system.

It is therefore a forum in which leaders from the local health and care system work together to improve the health and wellbeing of their local population, and to reduce health inequalities. The public's views and concerns about their local health and social care services help build a valuable picture of where services are doing well and where they can improve.

# Healthwatch

Local Healthwatch can also alert Healthwatch England or the CQC to concerns about specific health and care issues and providers, and can provide people with information about local services and what to do when things go wrong, including on how to complain.

# Action Against Medical Accidents (AvMA)

AvMA is a charity for patient safety and justice in the UK. They provide free specialist advice and support to people when things go wrong in healthcare and campaign to improve patient safety and justice.

If something has gone wrong with healthcare and it has caused harm to a person or a loved one, AvMA will listen, explain the options available and help find the support and information needed.

# Action Against Medical Accidents (AvMA)

AvMA can give advice and provide self-help guides on:

- making a complaint to the NHS or private healthcare
- coping with an inquest
- taking legal action

They are completely independent and rely on volunteers, fundraising and donations from supporters to enable them to help patients and bring about change.

# Action Against Medical Accidents (AvMA)

They also have:

1. a helpline which offers specialist advice from trained volunteers
2. a written advice service. Comprised of a dedicated advisor who can work through the case, offering expert advice and support. This can include advice on taking part in an investigation into the incident; on the potential for a clinical negligence claim and what this involves; and help on professional regulatory matters, such as referring cases to the General Medical Council, Nursing and Midwifery Council and other bodies.
3. an inquest service which may be able to support a person through an inquest into a loved one’s death. It is a small team and are not able to accept every case but even if they can’t offer their full service, they will try to offer helpful advice and information to guide the person through the process.
4. free online resource to find an accredited specialist clinical negligence solicitor

# Action Against Medical Accidents (AvMA)

AvMA also campaign to improve patient safety, access to justice and the way patients and their families are dealt with after something goes wrong.

They led the campaign for a statutory duty of candour and continue to be the leading patient voice on patient safety and justice issues.

# NHS England

‘’From 1 April 2019, NHS England and NHS Improvement are working together as a new single organisation to better support the NHS to deliver improved care for patients.

The new single operating model has been designed to support delivery of the NHS Long Term Plan.

Local health systems are supported by seven integrated regional teams who play a leadership role in the geographies they manage. They make decisions about how best to support and assure performance in their region, as well as supporting system transformation and development.

# NHS England

Their approach to delivering the NHS Long Term Plan will balance national direction with local autonomy to secure the best outcomes for patients. Local implementation will be led by the clinicians and leaders who are directly accountable for patient care and making efficient use of public money.

This will ensure local health systems have the ability and accountability for shaping how the Plan is implemented''.

For more information please see https://www.england.nhs.uk/about/about-nhs-england/

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# Patients Association

The Patients Association is an independent patient charity campaigning for improvements in health and social care for patients. It covers all health and care issues, working directly with patients; as members and supporters. They have a helpline that supports people each year with concerns and queries about the health and social care system.They also speak to government, the NHS and other stakeholders about patients' priorities and concerns, to ensure that the patient voice is heard and acted upon.

‘’**Their purpose is to** ensure that everybody can access and benefit from the health and care they need to live well, by ensuring that services are designed and delivered through equal partnership with patients.’’

# Patients Association

They also have a selection of advice and information leaflets for patients and their family members.  These are a great source of information that you can use when providing advocacy support.  Some of the information leaflets include:

- **Legal Advice:** Advice on how to take legal action if the person or a family member received treatment that caused either injury or harm and was the result of negligence.
- **Seeing Medical Records**: Explains how to get copies of medical records in England and Wales
- **Making the most of a GP Appointment**: tips on how to prepare, what to ask and how to remember information
- **Patients Association Nutrition Checklist**:helps to identify those living in the community at risk of under-nutrition
- **Finding Trustworthy information online**: Advice sheet when accessing information on line and ensuring it is accurate and reliable

# Patients Association

- **You and Your Dentist**: Information on how to find a dentist and use their services, including costs, and how to make a complaint
- **Shared decision making**: a person's rights in making choices about medical treatment.
- **Private Health**care: an overview including how to make a complaint
- **Sepsis fact sheet**: common symptoms
- **Planning for future care**: information on advance decisions
- **Log term conditions**: A condition that cannot be cured.
- **Understanding medicines:** what it is and how it works
- **Self-management**: A guide to a set of approaches which help a person manage their own health

For more information please see https://www.patients-association.org.uk

# Coroner

Coroners are independent judicial officers who investigate deaths reported to them. They will make whatever inquiries are necessary to find out the cause of death, this includes ordering a post-mortem examination, obtaining witness statements and medical records, or holding an inquest.

A death is reported to a Coroner in the following situations:

- a doctor did not treat the person during their last illness
- a doctor did not see or treat the person for the condition from which they died within 28 days of death
- the cause of death was sudden, violent or unnatural such as an accident, or suicide
- the cause of death was murder
- the cause of death was an industrial disease of the lungs such as asbestosis
- the death occurred in any other circumstances that may require investigation

# Coroner

A death in hospital should be reported if:

- there is a question of negligence or misadventure about the treatment of the person who died
- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause
- the patient died as the result of the administration of an anaesthetic

A death should be reported to a Coroner by the police, when:

- a dead body is found
- death is unexpected or unexplained
- a death occurs in suspicious circumstances

# Coroner

A death should be reported by the Governor of a prison immediately following the death of a prisoner no matter what the cause of death is.

A Coroner will first gather information to investigate whether a death was due to natural causes and if a doctor can certify the medical cause of death.

The Coroner will ask the police to gather the information about the death. This will usually include speaking to the family of the deceased, anyone who was caring for the deceased and anyone who was there when the death happened.

# Coroner

If the reason why a doctor cannot certify the death is simply because they have not treated the patient in the last 28 days, then the Coroner will discuss the cause of death with the doctor. If a Coroner is satisfied that death was from natural causes and no further investigation is necessary, then they may accept the medical cause of death that a doctor gives and issue a Coroner's notification to allow the death to be registered.

If a doctor cannot certify the medical cause of death then a Coroner will investigate the death and may order a post-mortem examination to be carried out.

# Private Healthcare Complaints Process

If things go wrong when receiving private health care the Independent Healthcare Sector Complaints and Adjudication Service (ISCAS) has a three-step complaints process for those who subscribe voluntarily to their scheme.

ISCAS looks at complaints for privately funded care, whether paid for through a Private Medical Insurance (PMI) scheme or self-funded. ISCAS can only consider complaints about subscribing providers once Stages 1 and 2 of the local complaint's procedure has ended without resolution.

# Private Healthcare Complaints Process

Doctors have a duty to cooperate fully in a complaint investigation. ISCAS can also deal with complaints about doctors who are part of the Independent Doctors Federation (IDF) where the complaint has been through Stages 1 and 2 of the IDF procedure.

At stage 3 the complaint needs to be within 6 months of receiving the final response at stage 2 and ISCAS aims to complete its adjudications within 3-6 months. The person making a complaint does not pay for the complaints process.

For more information please see iscas.cedr.com.

# Please return to your e-learning for the next section of learning

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