Every year there are 10,000 serious untoward incidents reported across the NHS, with 338 ‘never events’ identified in 2013-14.

With the introduction of the new Independent Patient Safety Investigation Service (IPSIS), the Government has created an organisation dedicated to addressing the most serious cases - ensuring patients and families get answers and that the NHS learns from its mistakes.

Whilst we recognise IPSIS will only take on a small sample of cases each year, it will inevitably have a much larger role in setting the standard for investigations across the NHS and taking a leading role in the complaints landscape more broadly.

In the light of the recent concerns around Southern Health NHS Trust and the way that untoward incidents and avoidable deaths of vulnerable patients have been investigated more broadly across the NHS, this role has never been more important.

IPSIS has a real opportunity to be a catalyst for change and drive a real shift in culture across health and social care that would see the gap closed between people’s expectations and the reality of what happens when things go wrong and how lessons are learnt.

This briefing builds on our work to date on complaints handling in health and social care and outlines how we see IPSIS operating to ensure it provides consumers with what they want and need.
The Complaints Landscape

In October 2014 we published our ‘Suffering in Silence’ report exploring consumer experience of the health and social care complaints process.

The report found that:

- There are 70 different organisations involved in complaints handling across health and social care, creating an incredibly complex and often frustrating landscape for patients to navigate.

- Two thirds of those who experienced/witnessed poor care in the previous two years said they hadn’t raised a complaint - either because they didn’t know how or because they didn’t think their complaint would be taken seriously.

- People also told us they were reluctant to speak up because they felt nothing would change as a result, with 8 out of 10 saying they would be more likely to complain if they knew it would prevent others suffering the same in the future.

To address these concerns, in June 2015 we published ‘Every Complaint Matters’ - our seven step plan for creating a complaints system that gives patients what they need.

If IPSIS is to succeed in supporting this and help achieve the Government’s wider ambitions to create the safest and most transparent health service in the world, it must follow the principles outlined below both in its own investigations as well as championing best practice across the rest of the NHS.

1) Establish a clear understanding of the independence and purpose of IPSIS
2) Follow the principles for complaints handling set out in ‘My Expectations’
3) Be transparent and put patients / families at the heart of investigations
4) Improve the ability of the NHS to investigate cases at all levels
5) Ensure the system learns from mistakes
• **Establish a clear understanding of the independence and purpose of IPSIS**

When things go wrong with a person’s treatment, the patient involved or their families want answers. This can simply be an acknowledgment and apology, with reassurance that lessons have been learnt and that others will not suffer the same consequences in the future. Sadly, from our conversations with people we know that this still doesn’t happen in many cases.

Sitting at the top of the complaints system, and therefore one of the most high profile bodies, IPSIS will undoubtedly find people coming to it directly when other parts of the system fail to give them the answers they are looking for.

It is vital to establish the independence of IPSIS to help build public trust, as well as clearly setting out the number of cases it will investigate each year, the criteria for choosing these and the purpose behind the investigations.

• **Follow the principles for complaints handling set out in ‘My Expectations’**

IPSIS must be a beacon of good practice in how it handles both its own cases and the broader queries it receives from the public. As a minimum it must follow the principles set out in ‘My Expectations’ to ensure every patient and every family is addressed promptly and with the compassion they deserve.

In particular, when cases end up at IPSIS that it is unable to deal with then it must take appropriate action to redirect the complaint and ensure it reaches the right destination for resolution. It must not become simply another part of the confusing complaints landscape dealing only with its own cases.

IPSIS should also assess the organisation it investigates against the ‘My Expectations’ criteria to judge how effectively the patient or family members’ concerns were addressed in the first instance. This will help to reinforce the need to put the people affected at the heart of the investigation process.

• **Be transparent and put patients / families at the heart of investigations**

It has been argued that to secure the cooperation of those involved in incidents, IPSIS investigations should be conducted privately and subsequent reports not be made publicly available.

Whilst we agree that the privacy of individuals and their data must be maintained under existing information governance arrangements and in accordance with the Secretary of State’s ‘no blame’ approach, we believe it is vital that all IPSIS investigations are conducted with complete transparency.

If conducted behind closed doors, and without patients or families being fully involved, the findings of any investigations risk being called into question and will make it harder for the rest of the system to learn from mistakes.
• **Improve the ability of the NHS to investigate cases at all levels**

As IPSIS will only be able to investigate a handful of incidents it must champion how to conduct effective and transparent investigations when things do go wrong.

This role will require IPSIS to develop credibility within the sector as partner for change, helping providers to improve systems and processes, rather than it being seen as another body set up to simply scrutinise the health service.

This may require IPSIS to look back at a range of historical cases, assess how investigations have been conducted to date and where the system is failing both in how it is conducting such activities and why lessons have not been learnt.

• **Ensure the system learns from mistakes**

IPSIS will not have oversight of the entire complaints system but it does have a clear role to play in ensuring that learning from its own investigations is embedded across the NHS.

It must therefore develop clear channels for disseminating its findings and it recommendations for improvement to both the system as a whole and providers offering similar services to those covered by a particular investigation.

This must be supported by IPSIS tracking complaints data collected by the HSCIC, the CQC, the PHSO and others to identify thematic areas for investigation and tracking the effectiveness of its work in preventing mistakes being repeated.

**Next steps**

Everything Healthwatch does starts and ends with those who use health and social care services.

We therefore look forward to sharing the learning from our public engagement over the last three years with IPSIS and working with the team on:

• How to be an independent part of the system
• Understanding how to be compassionate when dealing with the public and how to help, even in circumstances beyond the organisation’s remit
• Working directly with the public to understand in greater detail how the ‘My Expectations’ work links to the role of IPSIS