

EXECUTIVE SUMMARY – A SCOTTISH PERSPECTIVE

1. The current NHS complaints procedure was introduced in April 1996, following the report of the Wilson review committee. The principles established by the Wilson Committee were accepted by the Government and they formed the basis of the NHS complaints procedure. Although the broad structure of the procedure is the same across the UK, there are operational differences in all 4 countries. This paper identifies the Scottish operational differences and reports on the main policy implications for Scotland of the findings of the evaluation research report.

The NHS Complaints Procedure

2. The current procedure has two stages. *Local resolution* involves the service provider attempting to resolve a complaint as directly and as quickly as possible, with the primary aims of being fair to the complainant and to staff. Local resolution may involve an immediate informal response from frontline staff or it may require an internal investigation, use of conciliation or direct action by a chief executive.

3. If a complaint cannot be resolved locally, a complainant may apply for *independent review*. The right to have a complaint reviewed is not automatic and a request for review is considered by a convener in consultation with an independent lay chair.

- In Scotland, the convener is normally a non-executive trustee of the Trust or Health Board complained against. Requests concerning Family Health Service (FHS) contractors are normally considered by a convener who is a non-executive trustee of the relevant Primary Care Trust (PCT) or island Health Board. An independent lay chair is nominated in all cases by the relevant Health Board.

Main Areas of Operational Differences

4. The main areas where operational differences exist are as follows:

- In Scotland, the Health Act 1999 made it possible for complaints about family health services to be handled by PCT. In the other countries this responsibility lies with the host health authority (England and Wales) or health and social services board (Northern Ireland).
- Clinical advisers/assessors and lay panel members are appointed by the local Health Boards and not the regional offices as in England and Wales.

Objectives of the Evaluation

5. The objective of the evaluation study was: *to provide an evaluation of how the new complaints procedures are operating across all parts of the NHS...and to meet the information needs of policy makers and managers concerned with the future development of the system* (Research Brief).

Methods

6. The researchers have carried out a questionnaire survey of those with experience of operating the complaint procedure (complaints managers, convenors, chief executives, chairs and lay panel members, FHS contractors, conciliators and clinical assessors) and those with experience of using the procedure (complainants, staff complained against, patient interest groups and local health councils (or their equivalent in England, Wales and Northern Ireland). More than 4,000 questionnaires were distributed.

7. Since the research team did not have access to official records, there was no way of identifying the origin of the questionnaires returned. **Thus we are not able to separately identify data from Scotland on complainants.**

8. The research team also conducted more than 300 interviews with complainants, staff complained against, regional and national complaints leads, *staff at the Mental Welfare Commission* and staff in the Health Service Commissioner's Office. Of these, 30 interviews were in Scotland.

Views of those using the complaints procedure

9. The research shows that many complainants express a high level of dissatisfaction with the operation of the current procedure. This is true for complaints which do not proceed beyond local resolution as well as for those which give rise to a request for independent review:

- Among individuals whose complaint was dealt with locally, only one-third believed that their complaint had been handled well. No more than 20%-30% were satisfied with the time taken to deal with the complaint and a majority were dissatisfied with the outcome. A majority thought that the current procedure was either unfair or biased and a high proportion found the process to be stressful or distressing.
- Among individuals who had requested independent review, around a quarter believed that their complaint had been handled well. No more than one in ten were satisfied with the time taken to resolve their complaint and only 13% were satisfied with the outcome. Almost three-quarters believe that the complaints procedure is either unfair or biased. A significant majority found the process to be stressful or distressing.

10. The main causes of dissatisfaction among complainants outlined in the report are operational failures: unhelpful, aggressive or arrogant attitudes of staff, poor communication and a lack of information and support. The most important structural failure is the perceived lack of independence in the convening decision and in the review process generally.

11. In the report, attention is drawn to the fact that patient interest groups are concerned that some potential complainants are deterred by the fear that services will be withdrawn. This is more likely where the provider has a personal relationship with the patient and where a complaint may be thought to signal a breakdown of trust. Some complainants have been removed from a practice list on this basis, although the concern is not restricted to primary

care services. This issue is particularly difficult for rural, often single-handed practices in remote areas such as the Highlands and Islands.

Views of those complained against

12. The report suggests that the views of NHS staff who have been the subject of complaint are in marked contrast to those of complainants in the report. A majority of staff thought that the complaint against them had been handled well and they were generally satisfied with the outcome. Staff were well supported by professional and managerial colleagues and the majority thought that the process was both fair and unbiased. The only consistent source of dissatisfaction was that they were not always kept informed of the progress of a complaint against them. A number of respondents noted that they were initially unaware that a complaint had been made against them.

Views of those operating the complaints procedure

13. The evaluation report highlights the fact that a majority of those with experience judge the current system to be superior to the systems in place pre-1996 on most criteria. Chief executives are supportive of the principles of local resolution and most believe that this aspect of the complaints procedure works well. Positive aspects include the encouragement to respond promptly to a complaint, the opportunity offered by complaints to improve the quality of services and the opportunity to meet complainants face-to-face.

14. The research team asked complaints managers, conveners and lay chairs if they agreed with the proposition that the current procedure needs a radical overhaul. When all 4 countries were taken together, 41% of complaints managers agreed that the complaints procedure needs a radical overhaul. Scotland was well short of the average, with 33% agreeing and 56% disagreeing.

15. Among conveners also the number agreeing in Scotland was well below the average (23% as opposed to 45%). The same applies for lay chairs 38% as opposed to the national average of 50%.

Question: Are there distinctive factors in the operation of the procedure in Scotland to explain this difference in response?

16. Among those responsible for operating the procedure the research shows a broad consensus about the elements which need to be improved:

- There is a wide measure of agreement that independent review should be more independent and should be seen to be so. Irrespective of the impartiality of a convener, it is accepted that complainants do not perceive the current procedure to be independent.
- There is a perception that current procedures, particularly those involving independent review, are time-consuming and costly to operate.
- Performance targets relating to the convening decision, the appointment of panel members and drafting a report of a panel are all perceived to be difficult to meet.

- There is agreement that procedures need to be improved to ensure that services improve following a complaint.
- Procedural improvements include the need for quicker access to clinical assessors and, in England and Wales, to lay chairs. In Scotland this was not seen as an issue as the lists are updated regularly. Lay chairs in all countries would like to have better feedback on panel reports and on the outcome of complaints and more opportunities for networking and training. The desire for additional networking and training is common to almost all of the groups involved in operating the procedure.

Policy Implications

Local resolution

17. The evaluation report highlights the fact that the process of local resolution is internal to the organisation, and therefore how well it works varies between organisations depending on the training and attitude of individual members of staff and on the culture of the organisation itself. It concludes that current mechanisms are inadequate to *ensure* that complaints are adequately addressed or that necessary action follows from a complaint when it is upheld.

18. The research also shows that views on local resolution are equivocal. On the one hand there is support for the principles of local resolution and recognition of the potential value of complaints as a source of information for service improvement. There is also evidence that local resolution works well in many cases. On the other hand, many complainants express a high level of dissatisfaction and this is indicative that the current procedure also frequently fails. The key issue is lack of consistency.

19. The report identifies that the level of dissatisfaction among complainants about family health services is higher on most measures than it is for other services. A majority of health council respondents believe that in primary care, local resolution performs poorly or very poorly. One reason for the particular focus on primary care may be the fact that, in comparison with other NHS organisations, most practices are relatively small and informally managed. This is a particular difficulty in some single-handed rural practices. In this situation the attitude of an individual practitioner in shaping the success of local resolution is more decisive than it is in a larger, more formal organisation.

20. The researchers are of the view that to improve performance the culture of all NHS organisations must be such that fair resolution of complaints is an important objective and information generated by the complaints process is valued. Resources must be appropriate to ensure that front-line staff are adequately trained and supported and that complaints can be investigated promptly and with authority. The organisation should be held accountable for its performance in handling complaints and for ensuring that serious mistakes are not repeated. Three factors in particular are identified which are likely to be central to improving performance:

- Those with responsibility for managing the performance of chief executives and chairs should be required to demonstrate that complaints-handling is an explicit part of the performance management framework.
- The board of every NHS organisation should be held accountable for the performance of the organisation in handling complaints. In particular, the board should ensure that: (a) all staff are adequately trained to deal with complaints and are supported in the event of a complaint being made against them. Training in handling complaints should be a compulsory part of induction and continuing education; (b) staff managing complaints are appropriately trained, have adequate administrative resource and access to senior managerial supervision and support; (c) the complaints procedure is integrated into the clinical governance/quality framework of the organisation.
- Consideration should be given to the development of a National Service Framework or its equivalent for the management of complaints. A service framework would provide clear guidance to NHS organisations on the standards which are expected and it would establish a framework for performance management.

21. In the particular context of primary care the report suggests there is a need to ensure more openness and to offer complainants an opportunity to avoid the need to complain directly to the practice. The research team believe that the best way to achieve this is to encourage practices to work together within the structure of a primary care group (or primary care trust) to share information and to offer support in providing acceptable procedures for handling complaints.

- Complaints about family health services should be handled in the same way as complaints about all other services provided by the NHS. The board of a primary care trust or its equivalent should have the responsibility in relation to complaints about family health services contractors, which currently lies with a health authority/board. Primary Care Trusts in Scotland already have this responsibility.

22. The research team has suggested a number of changes which, taken together, are likely to lead to improvements in the way in which complaints are handled locally. Many of these changes are already possible within the current procedure, and part of the emphasis in the future must be on ensuring that current mechanisms are properly enforced. A complete list of suggested changes is given at the end of this Summary.

Independent review

23. As a second stage in the complaints procedure, a system of review offers two important safeguards: it provides an additional opportunity to identify clinical or professional problems which may be overlooked when complaints are dealt with internally and, so long as the review process is linked to a system of monitoring, it offers an opportunity to ensure that necessary changes follow from complaints.

24. The research concludes that in order to offer these safeguards the review process must be *independent* and it must have the *authority* to ensure that recommendations are enforced. The current system does not meet either of these requirements.

25. The research also shows that it does not currently perform well. Of individuals who requested independent review, no more than one in ten were satisfied with the time taken and only 13% were satisfied with the outcome of their complaint. Almost three-quarters believed that the procedure was unfair or biased. Even those involved in the operation of the complaints procedure agree that the review process should be more independent and less time consuming. Again, the report does not show the data for Scotland separately.

26. Suggested improvements in the Report include both procedural and structural changes (details are given at the end of this Summary). However, the fundamental requirements are to ensure that the review procedure is *genuinely independent* and that organisations are *actively monitored* in order to ensure that actions agreed following an independent review are implemented.

27. The researchers conclude that consideration should be given to the proposal that in future both the convening decision and the conduct of a review should be the responsibility of a regional or sub-regional lay panel appointed for the purpose. Panels may be accountable to a national complaints authority *or* to the regional offices of the NHS Executive (in England) and national or bodies in Scotland, Wales and Northern Ireland. Other than local Health Boards, NHSScotland has no sub-national structure.

28. The research also concludes that the regional and national bodies responsible for NHS performance should ensure, through the performance management framework, that an acceptable action plan is produced in response to the report of an independent review and that the plan is implemented.

Planning and Quality Division
Scottish Executive Health Department
15 August 2001

SUMMARY OF POLICY IMPLICATIONS

SCOTTISH PERSPECTIVE AND QUESTIONS FOR CONSULTEES	
LOCAL RESOLUTION	
<p>1. The board of every NHS organisation should be held accountable for the performance of the organisation in handling complaints. In particular, the board should ensure that: (a) all staff are adequately trained to deal with complaints and are supported in the event of a complaint being made against them. Training in handling complaints should be a compulsory part of induction and continuing education; (b) staff managing complaints are appropriately trained, have adequate administrative resource and access to senior managerial supervision and support; (c) the complaints procedure is integrated into the clinical governance/quality framework of the organisation (6.12).</p>	<p>Although boards of NHS bodies are already accountable for their performance in handling complaints under the current Directions, the report suggests that this function is not always carried out as well as it should be. .</p> <p>Question: The views of consultees are sought on what would constitute a robust system of accountability on complaints handling.</p> <p>Question: How can the remit of the complaints procedure be made more clear</p> <p>Question: How can the culture of the organisation be changed to reflect a move from a perceived blame culture to a learning culture.</p>
<p>2. The board of an NHS organisation should insist on receiving appropriate information at least quarterly on the causes of complaints and on the action which has been taken, or is proposed, to prevent recurrence. The board should take responsibility for ensuring that agreed actions are implemented (6.31).</p>	<p>Question: How should boards be more rigorously held to account for complaints handling and their consequent action to improve services?</p>
<p>3. The quarterly report to the board should provide an analysis of the causes of complaints, emerging trends and the action taken (or proposed) to prevent recurrence. This report should be presented to the board in person by the complaints manager or the chief executive (6.16).</p>	<p>There are no particular Scottish implications with this suggestion.</p>
<p>4. The quarterly report to the board should be copied to the local health council (or equivalent), the proposed Patients' Forum in England and equivalent organisations which may be established in Scotland, Wales and Northern Ireland. The chief executive of the trust or health authority/board should invite these organisations to monitor the implementation of action plans agreed in response to complaints (6.31).</p>	<p>There are currently no plans in Scotland to establish equivalent organisations to the Patients Forum in England.</p> <p>Question: Are there organisations in Scotland who should carry out this function?</p> <p>If so who would they be?</p>

5. The regional offices of NHS Executive in England and the appropriate central NHS bodies in Wales, Scotland and Northern Ireland should be required to demonstrate that complaints-handling is an explicit part of the performance management of chairs and chief executives. These bodies should ensure that the information available to them is timely and relevant to this responsibility (6.31).

6. Consideration should be given to the development of a National Service Framework or its equivalent for the management of complaints. A service framework would provide clear guidance to NHS organisations on the standards which are expected and it would establish a framework for performance management (6.12).

7. The same principles should apply to family health services as to other services. The board of a primary care group (PCG), (local health group (LHG) in Wales) or primary care trust (PCT) should have the responsibility in relation to complaints against contractors which currently lies with the health authority. In particular:

- The board should work with practices in order to assist members in ensuring that acceptable procedures are in place to deal with complaints.
- The board should receive information quarterly from practices on the causes of complaints and on action taken or proposed.
- Where appropriate, the board should offer support to practices in dealing with complaints (6.21).

8. The board of a PCG/LHG/PCT should be responsible for providing access for complainants to a named individual whose responsibility it is to handle complaints about member practices (6.23).

Question: How would evidence of good complaints handling be built into the new Performance Management system being developed for NHSScotland?

Question: would a National Service Framework have benefit in terms of providing consistency of complaints handling?

7. Primary Care Trusts in Scotland already have the responsibility for facilitating complaints handled by FHS contractors and for requests for independent review. This responsibility was transferred from Health Boards to Primary Care Trusts in October 1999 by the Health Act 1999.

Question: The views of consultees are sought on the way in which PCTs might facilitate complaints handling by independent contractors and requests for independent review.

Question: Should PCTs have a more defined role in handling FHS local resolution cases?

In Scotland a named individual (sometimes the complaints officer) within the PCT will provide honest broker services in respect of the complaint.

Question: Should the named officer within the PCT have a more defined role in handling complaints about member practices?

Question: Is there a role for LHCCs in supporting local resolution?

<p>9. Where primary care groups do not yet exist (as in Northern Ireland), alternative approaches will need to be considered to improve the handling of FHS complaints (6.25).</p>	<p>Does not apply to Scotland.</p>
<p>10. Less discretion should be available to individual organisations to decide the functions of, and resources available to, the complaints manager. More detailed guidance should be offered from the centre, based on an analysis of current best practice (6.36).</p>	<p>Scottish guidance currently recommends that the complaints officer should be a sufficiently senior person to do the job with authority. An identified budget and staff should accompany the role and it should not be an 'add-on' to another full-time role occupied by the same individual. As things are at present, the role of the complaints officer who deals with hospital and community services complaints can be quite different from the role of the complaints officer who deals with FHS complaints.</p> <p>Question: Are changes required in the role of the complaints officer in FHS complaints and hospital and community services complaints?</p>
<p>11. The complaints manager should play a central part in ensuring that front-line staff are adequately trained and supported in dealing with complainants. Training should be provided on a regular basis (6.37).</p>	<p>11. The guidance on complaints highlights the role of the complaints officer in regard to training of front-line staff.</p> <p>Question: Views are sought on the balance between national and local training and whether the need for regular local training should be re-emphasised?</p>
<p>12. Wider use of conciliation should be encouraged. Organisations should review their policy on offering conciliation and should assess the availability of trained conciliators locally. Trusts and health authorities/boards, in conjunction with the relevant regional or central NHS bodies, should then address remuneration, recruitment and training needs (6.44).</p>	<p>The Directions include provisions ensuring that NHS Boards make trained conciliators available.</p> <p>Note: Conciliation is only possible where it is acceptable to both parties.</p> <p>Question: Views are sought on how the use of independent conciliators can be improved?</p>
<p>13. There does not appear to be any compelling reason why targets for a full response to a complaint at local resolution should be shorter for FHS contractors. Performance targets should be the same in all sectors (6.46).</p>	<p>Question: Should local resolution performance targets be the same for all sectors and, if so, what would be an appropriate length of time?</p>

14. It is not reasonable that staff should be subject indefinitely to the threat of a complaint and, subject to the exercise of discretion in appropriate cases, the existing time limits on complaints should be retained (6.49).

15. Central NHS bodies in England and Wales should disseminate examples of good practice in dealing with vexatious complainants (6.52).

The time limit in the Directions for bringing a complaint is 6 months from the date of the incident complained of or of becoming aware of a need to complain. This is subject to a maximum time limit of 12 months from the date of the incident but there is discretion to waive these limits in appropriate circumstances.

Question: Should the existing time limits on complaints be retained?

15. Guidance on vexatious complaints has already been issued by the Scottish Executive.

INDEPENDENT REVIEW

16. The criteria for granting an independent review should be publicised and should be applied consistently throughout the NHS (7.19).

17. Although a decision must be made in each country, consideration should be given to the proposal that in future both the convening decision and the conduct of a review should be the responsibility of a regional or sub-regional lay panel appointed for the purpose (7.27).

18. A further decision must be made in each country about the framework within which a lay panel would be accountable. Two options have been suggested:

- Panels are accountable to the regional offices of the NHS Executive (in England) or to the relevant national or sub-national bodies in Scotland, Wales and Northern Ireland.

Scottish guidance already recommends nationally agreed criteria for convening an independent review. **Question Is further guidance required on the convening decision?**

Question: Should the convening decision and the conduct of a review be the responsibility of a regional or sub-regional lay panel appointed for the purpose?

18. We would not consider this to be a suitable role for the Scottish Executive as we are directly responsible to Ministers and therefore the procedure would not be independent. A national complaints authority might be created or adapted from one of the bodies we have already, eg CSA.

Questions: The views of consultees are sought on the suggestion of establishing a national complaints panel/authority or regional panels?

- Panels are accountable to regional or sub-regional offices of a new national complaints authority which is independent of the NHS locally and regionally (7.29).

If established should a national complaints authority be located within a national NHS organisation for example? If so which one?

Could the Scottish Executive fulfil this function or, as it serves Scottish Ministers, would this compromise the procedures independence?

Where should responsibility for ensuring the implementation of the action plan lie?

19. If regions are to have greater responsibility for independent review, there must be a clear statement of the minimum standards which are expected and a commitment from the centre that regional directors will be assessed on their performance in managing the independent review procedure (7.32).

This would apply in Scotland equally.

20. Further consideration should be given to the suggestion of the Health Committee that an independent review panel should have formal powers to summon witnesses and take evidence. In addition, the Health Service Commissioner should be consulted about the feasibility of a ‘fast-track’ procedure and, if appropriate, might be asked to suggest a protocol for referral (7.40).

The Health Service Commissioner will be consulted about the suggestion of a ‘fast-track’ procedure.

Question: Consultees views are sought on the suggestion that independent review panel should have formal powers to summon witnesses and take evidence.

21. The board of a NHS organisation should take *active* responsibility for all aspects of complaints-handling. The board should receive a copy of an independent review panel (IRP) report relating to the organisation (or to a member practice in the case of a PCG/LHG/PCT). The board should accept responsibility for ensuring that an action plan is produced and that agreed actions are implemented (7.43).

Patient confidentiality may be an issue here. It would be necessary to ensure that no personal health information was disclosed to the board. This could be possible in Scotland as the current Directions allow for the reports of clinical assessors to be split into 2 parts – the summary report (excluding all personal health information) and the confidential report.

Question: The views of consultees are requested on the suggestion and the possible patient confidentiality issues raised.

22. The regional and national bodies responsible for NHS performance should ensure, through the performance management framework, that an acceptable action plan is produced following recommendations of an IRP and that the plan is implemented. Regional and national bodies should receive copies of all relevant IRP reports *and* the action plan which is produced in response to a report (7.43).

23. IRP reports and action plans should be copied to the local health council (or equivalent), the proposed Patients' Forum in England and equivalent organisations which may be established in Scotland, Wales and Northern Ireland. One of the functions of the local health councils/Patients' Forum should be to monitor compliance with agreed action plans (7.43).

24. In England, a report of an independent review panel, together with the agreed action plan, should be copied to the Commission for Health Improvement (CHI)(7.43).

25. There should be a review of the training offered to all those involved in the complaints procedure. There is a need for more central guidance in order to reduce the extent of variability between organisations in the amount and type of training which is offered. There may also be a need to make some training compulsory, particularly for convenors, chairs and other lay members (7.46).

Questions: How should this be built into the new Performance Assessment Framework being developed for NHSScotland?

Could the Scottish Executive check independent review reports and action plans or, as it serves Scottish Ministers, would this compromise the procedures independence? (see also 18 above).

Question: Is there a role for LHCs in monitoring compliance with agreed local action plans?

Does this affect your response to the question in paragraph 22?

There is no direct equivalent "inspectorial" body to CHI in Scotland. The Clinical Standards Board role focuses on setting quality standards and service accreditation.

Question: Would this be an appropriate role for a national complaints authority if one were established?

Central financed local training is offered to complaints personnel in all Boards and Trusts each year. Not all NHS organisations take up this offer. The provision of local training is also variable.

Question: Should national and local training be compulsory?

26. In Scotland and Northern Ireland the list of clinical assessors was recently updated but in other parts of the UK it is acknowledged that the list is out-of-date and in need of revision. This should be addressed as a matter of urgency by the NHS Executive centrally. Consideration should also be given to whether current fee rates for assessors and advisers are adequate (7.50).

Scottish lists are already updated regularly.

Which organisations would be best placed to maintain these lists

27. Consideration should be given to standardising expenses and subsistence payments for chairs and lay members and to replacing loss of earnings compensation with an annual retainer or a fixed fee per case (7.53).

Applies equally in Scotland.

The following are additional issues suggested by Members of the Implementation Working Group.

CULTURE CHANGE

28. There needs to be a culture shift from 'blaming and naming' to 'learning and changing'. Complaints should be seen as everyone's business and not just for those with 'complaint' in their job title.

Question: The views of consultees are sought on how a culture change might be made where complaints are welcomed, taken seriously, replied to timeously and lead to an improvement in service?

INFORMATION TO COMPLAINANTS

29. There is a need for information to set out more clearly the stages and processes within the procedure: what can and cannot be achieved through the procedure; roles and responsibilities and expected timescales. Dissatisfaction with the complaints procedure may result from unmet expectations which were never made clear in the first instance.

Question: The views of consultees are sought as to ways in which this and other necessary information should be provided for complainants.

Planning and Quality Division
Scottish Executive Health Department
15 August 2001