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Making It Better:

Complaints and Feedback from Patients and Carers about NHS services in Scotland

Supporting Material

Mapping of Complaints Process for NHS Services In Scotland

CONTENTS

SUMMARY 1

INTRODUCTION 2

NHSSCOTLAND: STRUCTURE AND FUNCTIONS 3

THE NHS IN SCOTLAND: SERVICE VARIABLES AND PATIENT PATHWAYS 5

Service Variables 5
Patient Pathways 8

ROUTES FOR COMPLAINING ABOUT NHS SERVICES 11
The NHS Complaints System in Scotland 12
Parallel Processes of Complaints and Regulation 16
Agencies with Jurisdiction 17
Agencies with Parallel Jurisdiction 26
Agencies with Interest, but without Jurisdiction 28

DIAGRAM OF NHSSCOTLAND FUNCTIONS AND SERVICES 30

REFERENCES 31

SUMMARY

The structures and functions of the NHS in Scotland are complex and patient pathways through them affected by multifarious variables. Patients' perception of their interaction with the NHS is uncomplicated. The NHS complaints procedures are in theory clear and uncomplicated. Accessing the systems may be less straightforward. Effective relationships between NHS Boards and regulatory and other agencies with parallel jurisdiction are essential to avoid duplication, maintain standards and promote learning from complaints across agencies. Social care procedures are least consistent with NHS complaints processes. Elements of signposting could be improved, particularly online, with the Internet being underexploited as a medium.

INTRODUCTION

1 This mapping was undertaken at the outset of the review of complaint handling in the NHS in Scotland in order to set out the context within which complaints are made and considered. The mapping

- describes the structure and functions of NHSScotland
- outlines how the NHS in Scotland – in all its guises and operations – and people in Scotland engage and interact
- gives examples of the many factors and variables which influence these interactions
- sets out the NHS complaints process
- describes the prescribed routes for assistance, resolution and redress when problems arise, and discusses issues around the accessibility of these processes
- describes the operation of other related healthcare complaints processes
- considers the relationship of these other complaints handling processes which are related or operate in parallel to the NHS processes.

NHSSCOTLAND: STRUCTURE AND FUNCTIONS

2 Public health services and some public care services are provided in Scotland by NHSScotland through 14 NHS Boards and 8 Special Boards. Table 1 (below) lists the Boards and describes the functions of the Specialist Boards. A diagram of the functions and services of NHS Scotland is included on page 30 below.

Table 1: NHS Boards and NHS Special Boards

NHS BOARDS	
NHS Ayrshire & Arran	NHS Highland
NHS Borders	NHS Lanarkshire
NHS Dumfries & Galloway	NHS Lothian
NHS Fife	NHS Orkney
NHS Forth Valley	NHS Shetland
NHS Grampian	NHS Tayside
NHS Greater Glasgow & Clyde	NHS Western Isles
SPECIAL BOARDS	
NHS 24 24-hour telephone and online access to health information and advice. Provides out-of-hours referral for patients determined to require further assessment or urgent treatment.	
NHS Education for Scotland Education Services for the 150,000 strong NHSScotland workforce.	
NHS Health Scotland Develops and implements national health improvements strategies.	
NHS Quality Improvement Scotland Translates research into practical improvements, sets and monitors clinical standards and is responsible for community care / social work policy.	
Scottish Ambulance Service Accident and Emergency service, responds to 999 calls and also provides non-emergency transport service.	
State Hospitals Board for Scotland National service for both Scotland and Northern Ireland – providing assessment, treatment and care in conditions of special security for individuals with mental disorders who cannot be cared for in any other setting.	
The National Waiting Times Centre Board A planned care hospital covering the whole of Scotland whose facilities are used to assist in reducing patient waiting times for surgical and diagnostic imaging procedures.	
NHS National Services Scotland Strategic support services and sources of expert advice to NHSScotland and NHS Boards: • Central Legal Office – Team of specialist solicitors • Counter Fraud Services – National team to deter, detect and investigate fraud • Health Facilities Scotland – Provides advice on facilities operation and management • Health Protection Scotland –Monitors hazards / exposures, coordinates protection • Information Services Division – NHS statistics, analysis and IT • National Procurement – Strategic Sourcing, eProcurement and Systems and Logistics	

- National Services Division – Screening programmes and specialist health services
- Practitioner Services – Primary Care payments, scrutiny and patient registration. Covers doctors, dentists, opticians and pharmacists.
- Scottish Health Service Centre – Professional, administration services, conference /event management
- Scottish Healthcare Supplies – Charged with ensuring health care equipment is reliable and safe. Responsible for adverse incident reporting.
- Scottish National Blood Transfusion Service – Blood transfusion services

3 In addition to the 14 Boards and 8 Special Boards, NHSScotland is made up of National and Support Services (Table 2) comprising specialist advisory, policy or strategic functions and projects working across Scotland plus the national hospital facility for spinal injuries.

Table 2: National and Support Services of NHSScotland

National and Support Services
Chief Scientist Office
Health Economics Research Unit
Health Services Research Unit
Implementation (New Deal) Support Group
Nursing Council on Alcohol
Nursing Research Initiative for Scotland
Public Health Institute of Scotland
Scottish Health Council
Scottish Medicines Consortium
Scottish MRSA Reference Laboratory
Scottish Nutrition and Diet Resources Initiative
Scottish Practice Nurses Association
Scottish Resuscitation Group
Queen Elizabeth National Spinal Injuries Unit, Scotland

4 NHSScotland spends over £8 billion a year of public money, which is about one-third of the total spend in the Scottish public sector. It is Scotland's largest employer with almost 150,000 staff in community, primary and acute settings throughout the country.

5 NHSScotland is accountable to the public through the Scottish Government for the quality of its services and for the management of public funds. Its performance and financial management is independently audited by Audit Scotland for the Auditor General.

6 Each NHS Board provides strategic leadership, performance management, delivery of health (and some care) services in their area. The Board is responsible for the entire local NHS system, the provision, commissioning, deployment, management and monitoring of services provided to their local population.

7 NHS Board services in local communities in Scotland are delivered through Community Health Partnerships. Community Health Partnerships aim to provide a "seamless" service by coordinating and integrating primary care, specialist services, and social care services to deliver health services sensitive to the needs of local communities.

THE NHS IN SCOTLAND: SERVICE VARIABLES AND PATIENT PATHWAYS

8 In order to evaluate the accessibility and operation of complaints handling systems, it is necessary to consider the relationship between NHSScotland structures, services and operations and patient pathways through these systems. It is also necessary to distinguish between intended and actual patient pathways and patients' perceptions of these. While NHSScotland structures can be mapped fairly simply, the features and variables influencing patient contact with NHS services and functions are multifarious and complex.

Service Variables

9 The number of variables involved and the extent and degree of complexity should be all but invisible to the patient at point of contact or receiving service. These factors and how they interact are significant for the patient experience in three ways:

- Failures in integration or in communication amongst different components of service can be a factor in poor patient experience or outcome
- The numerous variables in play mean resolving – or even reporting – problems can be complicated and time-consuming
- The dissemination of learning from feedback and complaints has to be applied to, adapted for and directed through many systems.

10 Outlined below are some of the components and processes which contribute to a seemingly limitless number of patient pathways

Location of service delivery

11 An NHS Board can provide services in the community in its own area in facilities which it owns, leases, contracts or which belong entirely to someone else such as:

- Patients' homes
- Care facilities (day and residential)
- Clinics (hospital or community based, NHS and non-NHS facilities)
- Health centres
- GP surgeries
- Pharmacies
- Commercial premises
- By telephone or video link
- Health care practices (NHS / non NHS facilities e.g. dentists, chiropractors)
- Outreach and screening clinics
- Schools and workplaces.

12 Boards also commission services which are delivered in the community in other Board areas, in locations similar to those described above, e.g. referrals to specialist staff in other Board areas who may see patients directly or by video link. A Board may also provide services in the community to patients referred from other areas or may send specialist staff to other areas to assess or treat patients in the community or in hospitals.

13 An NHS Board may deliver services through hospitals or other facilities under its management in its area or through hospitals contracted to provide services within or outwith its area. Each of these facilities may provide inpatient, day patient or out patient services exclusively or in combination.

Models for service delivery

14 NHSScotland services are delivered at local level through Community Health Partnerships and Community Health and Care Partnerships. Each of these Partnerships may have different contractual arrangements with their different service providers. A Community Health Partnership or Community Health and Care Partnership may also provide services to other Community Health Partnerships (and other Boards). The services offered by each Partnership may be variously organised and accessed by:

- professional specialism (e.g. physiotherapy)
- client group (e.g. persons with learning difficulties requiring multi-disciplinary input)
- location / facility (e.g. Health Centre offering a range of services at base and remotely)
- by provider (e.g. local authority)
- a mixture of all of the above.

15 Community Health Partnerships, the communities and patients they serve will also interact with other NHS Board services such as acute services, public health services and specialist health services as well as with NHS Special Board services such as NHS 24, Scottish Ambulance Service and Scottish National Blood Transfusion Service.

Relationships with Service Providers

16 Clinical, non-clinical, support and regulatory services can be provided to an NHS Board by:

- Individual or agency contractors, businesses, public sector, non-profit sector agencies based within the area (e.g. GPs)
- Individual or agency contractors, businesses, public sector, non-profit sector agencies based outside the area (e.g. companies which supply and maintain equipment)
- Its own staff or contractors working exclusively or across Boards and / or disciplines (e.g. Managed Clinical Networks)
- NHS Special Boards (e.g. Scottish National Blood Transfusion Service)
- National and Support Services (e.g. MRSA Lab, Queen Elizabeth National Spinal Injuries Unit)
- Regulatory bodies (e.g. Audit Scotland, Human Fertilisation and Embryology Authority).

17 Each NHS Board draws on Special Board (e.g. Scottish Ambulance Service) and national NHSScotland functions (e.g. counter fraud measures, information and statistical services) to support its operations. NHS Boards also provide or commission a range of non-clinical services (e.g. procurement, administration, financial management, performance management, strategic planning) which support their role and operational service delivery through their own services, Community Health Partnerships, contractors and other partnerships.

18 NHS Boards have a range of relationships with the people who deliver services on their behalf. Services can be provided to patients in an NHS Board area by:

- directly employed NHS Board staff such as hospital nurses

- individuals or businesses contracted by the local Board to provide services e.g. most dentists, GPs, opticians, pharmacists
- volunteers
- students and trainees
- non-profit agencies contracted to provide particular services e.g. Macmillan Cancer Care
- commercial agencies contracted to provide services
- public sector agencies
- individuals or businesses contracted by or employees of another NHS Board
- employees of joint NHS and other agency teams or projects.

19 NHS Boards' relationships with staff, contractors and agencies can be any combination of:

- Exclusive – e.g. a radiographer who works only as an NHS employee for one Board
- Shared – e.g. an art therapist who works across several NHS Boards
- Non-exclusive – e.g. a consultant surgeon who works part-time in the NHS and part-time in private practice
- Complex – e.g. a GP who works sessions as a staff grade physician in a hospital who also has a Health Board Primary Medical Services contract; a non-profit agency which provides funding for clinical research projects, contracts to provide residential care services and provides services in patients' homes
- Regulatory – e.g. maintaining the Performers List for dentists and doctors (who may also be on lists for other Board areas).

Scrutiny, governance and regulation of NHS functions in Scotland

20 Apart from internal clinical governance, audit and performance management arrangements, complaints processes, services or functions provided by an NHS Board can be:

- Regulated by external agencies (e.g. Human Fertilisation and Embryology Authority)
- Subject to statute (including statutory reviews) (e.g. Mental Health Act Reviews)
- Inspected or audited by agents of the Board (at different levels) (e.g. GP advisors)
- Inspected or audited by other NHS Boards (e.g. Practitioner Services for pharmacists, opticians)
- Inspected or audited by non-NHS external agencies (e.g. Care Commission).

21 Besides fulfilling the requirements of organisational standards of conduct and performance, people involved in delivering NHS Board services can be, in any number of combinations:

- Regulated by professional bodies (e.g. General Dental Council)
- Regulated by statutory agencies (e.g. Standards Commission)
- Subject to a code of conduct by a professional body (e.g. andrologists, counsellors)
- Subject to the terms of their employment by or contract with the NHS or contract with an agency contracted by the NHS
- Subject to special requirements of competence and/or probity by NHS Boards (e.g. inclusion on Performers Lists, Ethics Committee research requirements)
- Subject to special requirements of competence and/or probity by other entities (e.g. approved social workers, licensed taxi drivers).

22 Materials, treatments, equipment and facilities used in the care and treatment of patients are in certain instances:

- Regulated by external agencies (e.g. Human Tissue Authority)
- Subject to statute (e.g. storage and issuing of controlled drugs)
- Subject to review (e.g. treatments provided under special funding or license arrangements)
- Inspected or audited by non-NHS external agencies (e.g. Care Commission)
- Subject to manufacturer operating instructions and maintenance schedules (e.g. sterilising equipment)
- Subject to manufacturer guarantees and warranties (e.g. contact lenses).

Funding Relationships

23 NHS services in Scotland provided to patients can be:

- Exclusively funded by the NHS directly or by contract (e.g. district nursing)
- Partially funded by the NHS and partially self-funded (e.g. NHS eye test given by an optician alongside contact lens services)
- Partially funded by the NHS and partially funded by other bodies (e.g. respite care).

Patient Pathways

24 Services and systems can contribute various elements to patients' experiences. They can be:

- Clinical or Non-Clinical
- Promotional or educational
- Provided by directly managed services or contracted or commissioned
- Person specific (e.g. chiropody appointment) or community (e.g. health promotional material) or targeted to all or some of a narrowly or broadly defined group (e.g. health education, locality drop-in clinics for substance misuse)
- Consensual or compelled (e.g. assessment under Mental Health Act)
- Provided to identified patients or anonymously (e.g. patients attending GUM clinics, some counselling services)
- Provided exclusively or in combination or in parallel with other services
- Provided to people as carers, parents or guardians as well as to patients.

25 The bulk of patient services provided by NHS Boards, directly or commissioned, are to patients resident in their area. However, NHS Boards also provide services to patients from other NHS Board areas needing specialist care; patients from other parts of the UK requiring specialist care; visitors to the area unexpectedly requiring treatment and patients in transit between locations.

26 NHS patients in Scotland can thus receive care exclusively from or in combinations of:

- services under the management of an NHS Board (directly, commissioned or contracted)
- services provided through Partnership arrangements (e.g. local authority home care)
- services from other agencies over which the NHS Board has no control (e.g. Department of Work and Pensions, private health care).

27 Patient pathways of care may thus involve:

- transitions between and amongst services, professionals and sites (NHS and non-NHS)

- experiencing several services and interactions in parallel
- being in different stages of interaction, engagement or transition – awaiting assessment, services or discharge
- receiving services as a user and as a carer simultaneously.

28 Patient contacts with individual NHS staff, locations and services may be:

- Unacknowledged (e.g. unconscious patient and paramedic)
- Fleeting (e.g. hospital porter)
- Intermittent (e.g. occasional GP visits)
- Regular (e.g. district nursing service)
- Constant (e.g. long-stay patient).

29 Patients' control over which professionals they engage with in the NHS may vary. It can be:

- Circumscribed (e.g. registered with a GP)
- Open (e.g. able to select optician of choice)
- Limited (e.g. by availability of NHS contracted dentists working locality)
- Prescribed (e.g. designated forensic psychiatrist).

30 The foregoing section outlines only some of the elements involved in NHS Board relationships with patients. In a limited way, it demonstrates the inordinate complexity of relationships, variables and factors which impinge on even apparently straightforward health service provision. To understand the operation of, scope and demands on the NHS complaints handling systems it is essential to recognise this complexity. Providing an effective complaints service, however, means creating and maintaining a simple model that provides clear, easily accessible, channels through the complexity

31 For example, a simple 20 minute chiropody appointment which a patient attends, receives treatment and leaves happy about, may be the product of a series of complex contractual arrangements with a practitioner, with the management of the facility where it is provided, of negotiations with the Community Health Partnership, budget planning, procurement and planning. The weight and complexity of the infrastructure is of no consequence to the patient: as long as they got what they came for; they need not be aware of it or troubled by it.

32 The difficulty arises when the patient does not get what they came for. Either their expectations are not met or they are significantly inconvenienced or upset or worried or even harmed – or they perceive some of these things to be the case. If a receptionist makes what they consider to be an offensive remark while the patient is sitting in what they consider is a less than clean waiting area, the patient wants something to happen that will:

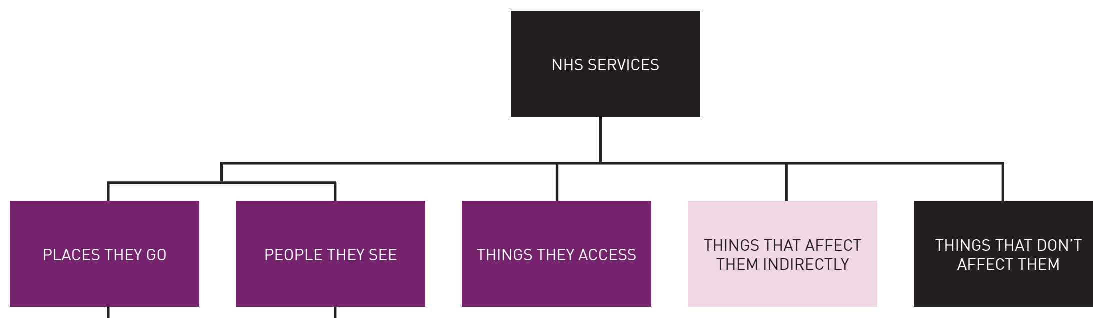
- Address the hurt they or others feel
- Ensure it does not happen again
- Affirm or restore their confidence in the professionalism of the NHS.

33 At that point, it is of no interest to the patient that the receptionist is employed by the GP practice based in the clinic from which the NHS Board peripatetic chiropody service operates, that the GP (who is not their GP) is contracted by another part of the NHS Board as a Health Board Primary Medical Services contractor, that the clinic is part of the local Community Health Partnership is part-owned by the Board, that some areas of it are cleaned by a cleaner employed by the GP practice and others by a service contracted by the Health Board. He just wants

somebody to sort it.

34 This simple example illustrates an important precept about managing complaints in the NHS: **the NHS looks different to patients.** To patients, the map of the NHS is probably quite simple and looks like Figure 1.

Figure 1: Patient Perception of NHS Board Services and Functions



35 Notwithstanding all the complexities, contexts and variable elements of the patient experience described above, patient perception of engagement with NHS services and functions actually boils down to:

- locations they attend (e.g. chemist shop, GP surgery, respite care)
- people they see (e.g. GP, optician, porter, cleaning staff)
- services or information they access (e.g. NHS 24, information by telephone, online)
- things they are aware of, which they know may affect them but they do not have direct contact with (e.g. public health, laboratory services)
- things they are aware of, specifically or vaguely, but which they perceive do not affect them (e.g. NHS administration, services for conditions they are unlikely to have).

ROUTES FOR COMPLAINING ABOUT NHS SERVICES

36 When a problem arises in a patient's experience, the potential complainant immediately has up to three issues to manage:

- The circumstances or condition which brought them or the person they are looking after in contact with the NHS
- The process of complaining
- The consequences of the failing or omission.

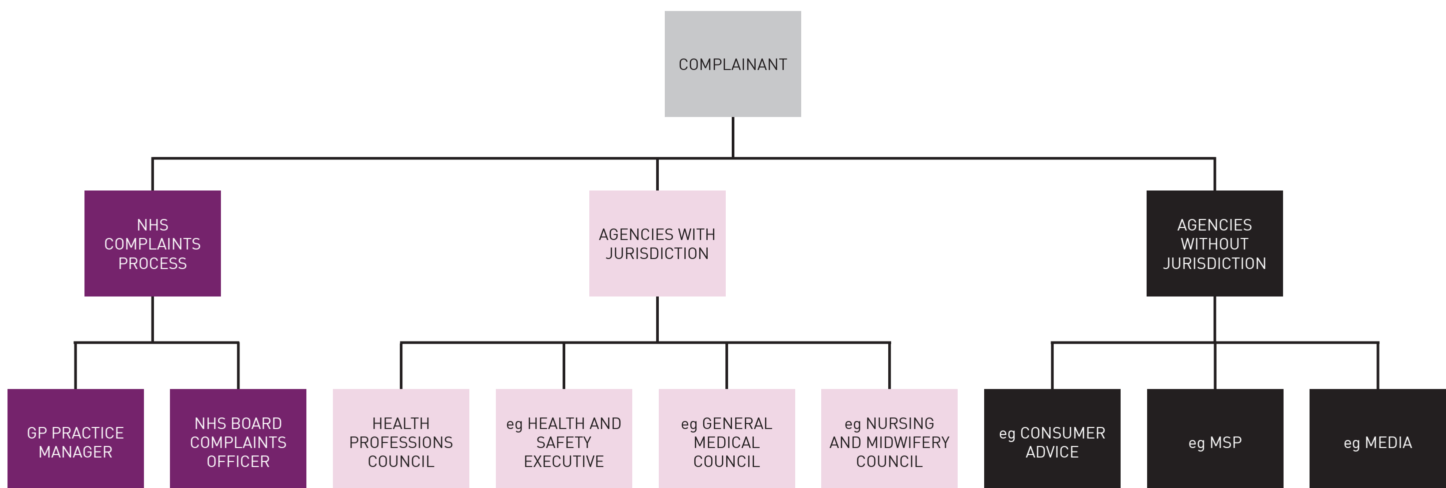
37 People who are ill, worried about being ill or worried about other people being ill may thus have considerable inertia to overcome at an already stressful time in order to make a complaint. The pressures on them may increase if they go on to express concern or initiate a complaint and:

- they have difficulties accessing information about or assistance to complain
- they encounter resistance or unhelpfulness
- they have ambivalent feelings about a service or staff they value.

38 Essentially, when the aforementioned difficulties are overcome, a complainant will follow one or more of **three** routes when initiating or progressing a complaint about NHS Services:

i) The NHS Complaints Process
ii) Agencies With Jurisdiction e.g. regulatory bodies
iii) Agents with an Interest (but without jurisdiction) e.g. MSP, the press.

Figure 2: Potential Routes for Complaints about NHS Services



39 A complainant may opt to follow one of these three routes or to pursue two or more in parallel. As will be discussed below, once a complainant succeeds in accessing the NHS complaints system, the process is relatively straightforward, although reaching the point of access may not be.

The NHS Complaints System in Scotland

40 The NHS complaints process is inherently straightforward and is simple in its conception. In summary the process is:

- A patient can raise the matter with someone close to the problem or with an NHS Board Complaints Officer
- Their complaint is acknowledged in 3 days
- They have a full response within 20 days (10 days for GP, Dental and Optical Practices and Pharmacies)
- If they are not satisfied they can take the matter to the Scottish Public Service Ombudsman
- Permission may be given by the Courts for a judicial review of a decision by the Ombudsman if there are grounds to believe it may be wrong in law.

41 The strength and simplicity of the system is that the same process covers all areas of the NHS in Scotland – NHS services and functions, NHS Boards and Special Boards, and National and Support Services. The statutory direction for managing NHS complaints is **Directions to Health Boards, Special Health Boards and the Agency on Complaints Procedures** ("the Directions"). It provides for complaints to be made about any matter connected with the exercise by an NHS body of its functions or the provision of services by a primary care provider, i.e. registered medical and dental practitioners, nurses, midwives, pharmacists, ophthalmologists and opticians or any other Health Board Primary Medical Services (HBPMS) contractor. The Guidance for NHS Boards on the implementation and operation of complaints systems is **Can I Help You? Learning from Comments, Concerns and Complaints** ("the Guidance"). The NHS guide for patients, carers and their representatives is the booklet **Making a Complaint about the NHS** which covers the essential details of the NHS complaints process.

What can people complain about?

42 Service users, carers and their representatives **can complain** about:

- NHS functions (of the local NHS Board, NHS Special Boards, NHSScotland National and Support Services)
- NHS services (from the local NHS Board, NHS Special Boards, NHSScotland National and Support Services) including sub-contracted services
- Anything which is provided by the NHS
- Anything which is provided through organisations funded by the NHS.

What can't people complain about?

43 Service users, carers and their representatives **cannot complain** about:

- Private healthcare treatment.
- Services not provided or funded by the NHS.
- Something about which they are taking legal action
- Any matter which is being or has been investigated by the Scottish Public Services Ombudsman;
- An alleged failure to comply with a request for information under the Freedom of Information (Scotland) Act 2002
- Any matter about which an NHS body is taking or proposing to take disciplinary

proceedings - though provision is available to suspend investigation of a complaint pending the outcome of any of these processes
- Matters subject to a criminal investigation, serious incident inquiry or Fatal Accident Inquiry – though again provision is available to suspend investigation of a complaint pending the outcome of any of these processes.

Who can complain?

44 Those who can make a complaint are:

- anyone who is having or has had NHS care or treatment
- anyone currently receiving NHS care or treatment
- anyone who has visited NHS facilities
- anyone who has used NHS facilities
- any person who is affected or likely to be affected by the action, omission or decision of an NHS body
- in certain circumstances, (see paragraph 71), anyone acting on behalf of someone who meets the above criteria.

45 Complaints can be made on behalf of someone else if:

- the patient has given their agreement to the complaint and the patient has agreed to having their health records looked at by staff;
- they are a parent, guardian or main carer of a child not mature enough to understand how to make a complaint or they are an authorised agent of a local authority with statutory care of the child or of an agency accommodating a looked after child
- they have a power of attorney or guardianship order for the welfare of someone who cannot make decisions about themselves
- they are the relative of or someone with a relationship with a patient who has died
- the patient is incapable of making a complaint and they are acting on or concerned about their welfare
- they are acting as an official advocate of the patient (specifically in this context someone independent of the NHS).

Timescales

46 Complaints can be made:
- within six months of the event, or
- within six months of realising there is a valid reason to complain but no longer than 12 months after the event.

Form of complaints

47 The Statutory Directions specify that a complaint must be "made in writing to a complaints officer or any member of staff of the NHS body which is the subject of the complaint" (Direction 8). The Guidance, however, states that complaints can be made "in writing, by phone or in person" (paragraph 49). A few Boards adhere strictly to the Direction and require complaints to be made in writing. Others take a more flexible approach, in some cases in respect of how the written complaint is submitted (i.e. by fax, email, pre-printed / online form or textphone). Others, in line with the Guidance, accept complaints made in person or by phone to an officer

who will take down the details and ask the complainant to review them, or provide assistance, or direct the complainant to sources of assistance to put the complaint in writing.

Who will accept a complaint?

48 The Directions require that "Arrangements shall be such to ensure that the complainants are treated courteously and sympathetically by any person dealing with complaints" (Direction 7). The Guidance and Directions thus acknowledge that complaints can and will be raised with any member of staff and not just designated Complaints Officers. Subsequent elements of this Survey will explore the implications of this situation for receiving, managing and learning from complaints.

49 The Directions stipulate that Boards and their contracted primary care providers must appoint designated Complaints Officers who will receive and arrange investigation of and response to complaints. Neither the Directions nor the Guidance make any comment on what constitutes the competencies to fulfil this role nor do they specify any particular qualification, training or form of accreditation. The Guidance (paragraph 48) describes in general terms some of the areas of knowledge a complaints officer should have or acquire.

50 Family Health Service practitioners, (GPs, dentists, opticians and community pharmacists) are required under their contracts to have a complaints process which is fully compliant with the Directions. It is recognised that the nature of the relationship between patients and these primary care providers can make it difficult for patients to complain – for example where it is a single-handed GP practice or where the practice manager is a member of the family of the GP complained about. For this reason, provision is also made for complainants to take their complaint about primary care services directly to their NHS Board.

Information required from complainant?

51 Those making a complaint are required to provide the following information:

- the full name and address of the patient
- the full name and address of the person making the complaint if different
- as much information as possible about what happened, where it happened and when.

Responding to a complaint

52 The response time is three days for an acknowledgement for the complaint. The acknowledgement should indicate:

- what action (if any) has been taken already to look into the complaint
- what action will be taken to look into the complaint
- the offer of a chance to talk to a member of staff
- information about independent advice and support and information about conciliation if appropriate
- the confidential nature of the complaint and give advice about health records
- further information which is required
- further information which may be required.

53 The full response to the complaint has to be made within 10 working days if it is made to:

- GP surgeries,
- NHS dental surgeries,
- NHS optician practices
- Pharmacies.

54 A full response has to be provided within 20 days of the complaint for all other NHS services. If the time scales are exceeded the complainant should be advised. The response must:

- Show the complaint has been looked into
- Ensure all points raised have been explored
- Give an apology where things have gone wrong
- Say what action might be taken to prevent the problem recurring
- Explain why nothing more can be done if appropriate
- Offer the chance to talk to a member of staff if there is anything in the letter which isn't understood
- Provide information about the Scottish Public Service Ombudsman role in case the patient is not happy with the result.

Escalation to SPSO

55 Where the person making the complaint remains dissatisfied with the outcome of local resolution, they may ask the Scottish Public Services Ombudsman to investigate. (The person complained against can also seek an Ombudsman review in certain circumstances.)

56 The Scottish Public Services Ombudsman can in theory investigate any complaint of alleged, sustained hardship or failure endured as a result of maladministration or service failure by NHS Boards and their contracted providers. They will normally only take up a complaint when it has been fully considered by and exhausted the NHS Board's local resolution process and within 12 months of the events or within 12 months of the complainant becoming aware there were grounds for complaint (although this time requirement can be waived in exceptional circumstances).

Assistance for complainants

57 Three types of independent assistance are funded by NHSScotland to help patients in the complaints process:

- Assistance to make a complaint
- Assistance to pursue a complaint through the process
- Assistance to resolve a complaint.

58 The first two forms of assistance are advocacy to express a complaint and engage with the complaints process, the third is independent conciliation to bring about a mutually agreed outcome.

59 From 2007, Citizens Advice Scotland have been working in partnership with NHSScotland to provide assistance to people wishing to make a complaint about NHS services. Funding has been made available by local NHS Boards to the Citizens Advice Scotland Independent Advice and Support Service. Independent Advice and Support Services can provide information

on the NHS complaints process, help people express their complaint in writing, facilitate resolutions, access advocacy and assist in referring matters to the Scottish Public Services Ombudsman. While Citizens Advice Scotland offices have always been able to provide information and advice on making complaints in the NHS, it has not been a significant part of their workload.[12]

60 NHS Boards are also required by the Directions to establish arrangements for a local independent conciliation service to assist in the early resolution of complaints. Conciliation can be offered where both parties agree to it. Costs of conciliation for both parties are borne by the NHS Board.

61 Other sources of non-NHS funded assistance to complainants include voluntary organisations supporting people with particular medical conditions and Scotland Patients Association which provides individual patients with advice and support as well as having a wider campaigning role. Action against Medical Accidents provides a national hotline for advice and legal advice for people who believe their treatment has been negligent or has occasioned harm. This includes advice on pursuing a complaint through the NHS process. However, once a patient initiates a legal action or claim against an NHS Board or provider, their complaint can be no longer pursued.

62 Advocacy help is also available through a network of advocacy groups across Scotland which can assist patients and carers put forward their complaints to the NHS in Scotland.

63 On a similar model, the Scottish Government in partnership with the Scottish Consumer Council has also established Health Rights Information Scotland (HRIS) to provide assistance to people by producing patient information and to publish information about health rights as new issues emerge or as gaps are perceived in current provision. For example Inspection of Child Protection Services nationally has identified the lack of a child friendly leaflet on NHS complaints procedures to be an issue. Health Rights Information Scotland is prioritising this task in the current year.

64 While neither the Scottish Independent Advocacy Alliance nor Health Rights Information Scotland deal with individual patients, they enable the provision of advice, information and support to patients to assist them to understand their rights in respect of the NHS in Scotland, the routes available for them to express complaints and ways to access support to pursue them.

65 The drive for such initiatives and the funding which has enabled them has come from the Scottish Government. This is healthy recognition at the highest level of the value of patient complaints and demonstrates a commitment to allowing all patients access to a robust system to challenge the performance of the NHS in Scotland when services or processes fall, or are perceived to fall, below standard.

Parallel Processes of Complaints and Regulation

66 Initiating a complaint can cause a patient or carer to lose sight of their simple model of the NHS (Figure 1, para 34) and give them a glimpse of the complexity that lies behind the simple visit to their doctor. The process of complaining may amplify the seeming complexity of the NHS structures and processes for the patient or carer. To add to the pressures, they may encounter a variety of other regulatory, safeguarding and complaints handling processes.

67 Extensive and multiple forms of regulation and scrutiny are necessary because of the nature of the services and interventions the NHS provides and because of the complexity of the systems through which it provides them. Each separate process provides important safeguards. Some arise from statute, some from guidance, some from codes of conduct, some from contractual arrangements. Problems potential complainants face include:

- It is not always obvious what options to complain exist
- It is not always obvious how to access them
- It is not always clear which processes are the appropriate ones to pursue
- The way of accessing processes varies
- The information they require varies
- There may appear to be overlaps of function
- There may appear to be differences in operating practices
- There are different response timescales
- Some processes can work in parallel
- Some processes are sequential and can only be initiated if others already have been (e.g. contact with the Scottish Public Services Ombudsman)
- Some processes cannot be pursued if others already have been.

68 A difficulty patients may encounter is the **number** of agencies which potentially can have a locus in a complaint. Some of the agencies regulate the professionals, others may regulate the operation or licensing of the premises, yet others regulate the processes they operate or equipment they use and others may manage their terms of employment. Additionally, there may be other agencies with potential jurisdiction in the aspects of matter which are not related to health care but which affect the patient e.g. a local authority which operates the premises used by the practitioner. Consequently, the complainant may end up involved to differing degrees with several processes.

69 A complainant may also opt to follow a route involving agents with an interest but without direct jurisdiction, possibly because these may be more obviously accessible. These agents may or may not direct them back into the NHS or other agencies' processes, and possibly even assist them through these processes. Alternatively, a complainant may follow through either of the "non-NHS" routes without the matter ever becoming an NHS complaint. For example, a patient may complain to the press or to their MSP who may publicise or investigate a matter without it ever coming to the attention of an NHS Board complaints officer. A complainant following such a route may also be directed back into the NHS complaints system instead of, or in parallel to, pursuing the complaint through other agencies.

Agencies with Jurisdiction

70 As described above, some NHS services, many people who provide them, some of the methods and means of care and treatment they use are subject to various statutory provisions, processes of accreditation, audit, inspections, review and regulation. The agencies responsible for this scrutiny thus have, or may have, jurisdiction (to varying extent and degree) in matters raised by complainants.

71 In addition to the agencies who regulate professionals, premises, processes and products (or a mixture of these), other NHS Boards or Special Boards may have an interest or responsibility in a patient complaint if they have been involved along the patient pathway. Local authorities may also have a role where a concern is raised about someone receiving a

mix of health and social care services in the community or services are being provided by a team comprising a mix of health and local authority staff (e.g. Community Mental Health Teams).

Professional regulation

72 Admission to, and approval to continue practising in, certain health care professions is regulated by statutory bodies listed in Table 4. The Health and Social Care Act (2008) makes provision for the establishment of a General Pharmaceutical Council which will take over the regulatory role of the Royal Pharmaceutical Society Great Britain in 2009. Legislation has already been enacted to expand the role of the Health Professions Council (HPC) in due course to regulate other professions allied to health and social care (e.g. acupuncturists, sports therapists). The responsibilities of the regulatory bodies, and the number of complaints they handle is also shown in the table below.

Table 4: Responsibilities of the regulatory bodies

Regulatory Body	Responsibility	No of UK Professionals (2007)	No of UK Complaints
General Chiropractic Council (GCC)	Statutory regulation of chiropractors including investigation of complaints	2,290[3]	**64** complaints (2006)[4]
General Dental Council (GDC)	Regulates dental professionals in the United Kingdom i.e. dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists	35,015 Dentists 6,130 Others[5]	**2,399** "queries" **797** "reports"[6] (2006)
General Medical Council (GMC)	Registers and regulates doctors in the UK	243,770[7]	**5,168** referrals **3,163** investigations (2007)[8]
General Optical Council (GOC)	Registers and regulate ophthalmic opticians, optometrists, dispensing opticians and optical businesses	17,887[9] (individuals and corporate bodies)	**129** investigations (2006)[10]
General Osteopathic Council (GOsC)	Regulates practice of osteopathy in UK	3,739 approx (2006)[11]	**18** referrals (2007)[12]
Nursing and Midwifery Council (NMC)	Registers nurses, health visitors and midwives	686,886[13]	**1,487** investigations (2007-08)[14]
Royal Pharmaceutical Society of Great Britain (RPSGB)	Professional and regulatory body for pharmacists and registers pharmacy technicians in a voluntary basis	47,971 Pharmacists 6,446 Technicians[15]	**523** investigations (2007-08)[16]
Health Professions Council (HPC)	Maintains register of accredited practitioners who have reached a certain standard and can use a protected title, including Arts Therapists, Podiatrists, Dieticians, Occupational Therapists, Physiotherapists, Radiographers, Speech and Language Therapists	179,481[17]	**322** complaints (2007)[18]

73 Each regulator operates a very similar three stage process of complaints handling, although the terminology and precise terms of reference for each stage varies amongst them and some of the functions are slightly differently delineated in terms of falling into one stage or another. The stages are broadly:

- Filtering/ triage/ initial assessment – where it is determined whether the complaint falls within the jurisdiction of the agency and whether investigation is necessary and possible

- Investigation/ assessment – where the circumstances are explored, the practitioner's response to the allegations is taken into account and the degree of seriousness of the complaint is considered. Some regulators (e.g. General Medical Council) will involve an independent or lay element at this stage. In these intermediate stages action may be taken to deal with some less serious complaints, for example the General Chiropractic Council sending the professional a letter of advice or warning

- Fitness to practice/ disciplinary hearing – where a panel (usually a mixture of lay and professional adjudicators) hear the facts of the case and determines on the basis of the facts admitted and proved whether action has to be taken against the practitioner's registration. Only a very small number of initial complaints (generally around less that 10%) get to this stage in any regulatory body.

74 Regulatory bodies have a different focus than NHSScotland in respect of patient complaints. The regulators are not concerned with achieving resolution or redress for complainants. Their goal in responding to complaints is to establish whether the fitness to practise of a professional is impaired to the extent that action needs to be taken on their registration. They are in effect looking at the implications for the safety of patients (and in some cases for colleagues) of a practitioner's shortcomings. They are also considering the wider public interest in terms of upholding the standards and the wider reputation of their profession.

75 In reaching their decision about a professional's fitness to practise, the regulators also have a duty to consider the professional's own interests (e.g. where there are issues of health or safety involved).

76 The proportion of complaints from patients and carers varies markedly across the regulatory bodies depending on the profession. For example, only 9% of referrals to the Nursing and Midwifery Council about nursing professionals in 2007-08 came from the public, the vast majority coming instead from employers (53%) or the Police (29%)[19]. By contrast, 83% of referrals to the General Medical Council about doctors in 2006-07 came from members of the public nd 16% came from employers and Police combined (no separate figures were available)[20]. Both the number and proportion of public referrals about nurses have fallen in the last three years while the number and proportion of public referrals about doctors has grown slightly in that period.

77 Using the figures for matters which may have some basis for complaint, it can be estimated that UK regulatory bodies receive around 6,500 complaints a year. Figures are not consistently available for Scotland but it can be estimated from those that are (e.g. Nursing and Midwifery Council) that Scottish based practitioners will account for 5% - 8% of all referrals (based on figures published by the Nursing and Midwifery Council and provided to Craigforth by the General Medical Council). Thus, at most 520 professionals across all health care professions in Scotland will be referred to their regulatory body each year. Only about 50 of these will ever get near a disciplinary / fitness to practise hearing.

78 These figures need to be further adjusted because the raw figures include NHS and non-NHS personnel. While complaints relating to doctors or nurses will predominantly relate to NHS staff, complaints about other professionals rarely involve NHS staff. (A very small number of complaints involving e.g. opticians, dentists or pharmacists may relate to both the practitioner's work across NHS and private practice). A more likely number of NHS related complaints would be around 500 NHS health care practitioners referred to their regulatory body each year, and around 50 facing a regulatory hearing each year.

79 As a proportion of all 150,000 NHSScotland staff, about 95,000 of whom will be registered healthcare professionals, the numbers who come to the attention of their professional body are very small. The table below shows the staff specific complaints about Hospital and Community Health Services made to NHSScotland in 2006-07.

Table 5: NHSScotland Hospital and Community Health Services complaints - issues raised by staff group, 2006- 07[21]

Staff / Service Group	Staff Specific Complaints	Overall Complaints
Medical (including surgical)	964	3,537
Dental (including surgical)	56	172
Nursing, Midwifery, Health Visiting	753	1,545
Professions Allied to Medicine	166	481
Scientific/Technical	21	128
Ambulance (including paramedics)	2	28
Ancillary/works/trades	56	418
NHS Board administrative staff / members	84	233
Division/CHP/PCO administrative staff	108	262
Other	80	543
Total	**2,290**	**7,347**

80 In addition, in the Primary Care Sector, a further 2,528 complaints were made about medical services, 442 about dental services and 14 about administration. This data is not collected in any more detail by the family because "as Family Health Services practitioners are independent contractors, it was nationally agreed that information collected would be less detailed".[22]

81 There is no comprehensive data set that allows an analysis of how many complaints made by patients and carers in Scotland about nurses and doctors are also referred to the Nursing and Midwifery Council or the General Medical Council by either the patients or the relevant Board, and at what stage. Nor is it possible to say how many complaints are made directly or exclusively to the regulators by either patients / carers or by the Boards. The following is an attempt to roughly quantify the scale of referrals to the General Medical Council and the Nursing and Midwifery Council and the relationship between the number of complaints made under the NHS complaints procedure and referrals to these two regulators.

82 Based on Nursing and Midwifery Council data, 62 nursing professionals were referred to the regulatory body by employers in Scotland in 2006-07. It is assumed that the majority of these employers will be NHS Boards. There were 753 complaints about nursing staff made to NHS Boards in the same period. Not every person referred to the Nursing and Midwifery Council will have been subject of a patient or carer complaint: some referrals may have arisen from unrelated disciplinary matters.

83 Even if all 62 referrals to the Nursing and Midwifery Council by Scottish employers had also been the subject of patient complaints, this would only represent 8% of all patient complaints. And if added to the 10 referrals to the Nursing and Midwifery Council by Scottish patients in

the same period, and assuming all of these were also subject of an NHS complaint, the proportion of nurses complained about in NHS complaints who are also referred to the Nursing and Midwifery Council would still only reflect 9% of all patient complaints. The exact overlap between NHSScotland nursing staff subject of a complaint by patients and NHSScotland nursing staff referred to the Nursing and Midwifery Council by their employers (and by patients) cannot be accurately quantified. What can be said is that no more than 9% of all nurses subject of a patient complaint in Scotland are also referred to their regulator.

84 With regard to doctors, the data is even less precise. Based on General Medical Council data that 5% of doctors referred to them are registered at a Scottish address[23], and that an estimated 16% of 3,163 General Medical Council investigations are initiated by employers, at the very most 25 out of 158 Scottish doctors investigated by the General Medical Council in 2006-07 had been referred to them by NHS Boards. (This will be an over-estimation given that the "16% of 3,163 referrals" figure represents all referrals to the General Medical Council by all "public authorities" i.e. including Police as well as NHS Boards).

85 It is known there were 964 complaints about doctors made by patients and carers in Scotland to NHS Boards. It is not known, however, how many of the 2,528 "medical" complaints recorded in Family Health Services relate to doctors, although, it is reasonable to assume that they almost all would involve a doctor either in a clinical or managerial role in their practice. Acknowledging that the exact overlap between Scottish doctors subject of a complaint by patients and Scottish doctors referred to the General Medical Council by their employers or contractors cannot be accurately quantified, what can be said is that no more than 4% of all doctors subject of a patient complaint in Scotland are also referred to their regulator by either the patient or their employer / contracting NHS Board. A doctor is also at least more likely to have been referred to the General Medical Council by a patient than by an employer/contractor while a nurse is more likely to have been referred to the Nursing and Midwifery Council by her employer than by a patient.

86 Only a small number of complaints about GPs or nursing staff employed directly by practices ever reach NHS Boards. These are usually as a result of escalation of a complaint originally made in a practice rather than a direct referral. NHS Boards are therefore much less likely to refer GPs or (the small number of) nurses directly employed by them to the regulatory bodies. Boards will tend to become aware of problems leading to regulator involvement in GP practices as a result of being notified by the regulator. Patients have more contact with GPs and yet are less likely to complain about GPs than about hospital doctors. However, patients are much more likely than NHS Boards to have complained about doctors to the General Medical Council. This may be a consequence of several features – a greater awareness of the General Medical Council's regulatory role and a tendency to see the General Medical Council as an escalatory rather than parallel route for complaints about doctors or a perception of the General Medical Council as offering a degree of independent scrutiny.

87 Regulators will generally encourage complainants who have not gone through the NHS complaints process to engage in local resolution of their complaint where appropriate. It is important to recognise, as described above, that the regulator has a different focus and that their processes do not exist to resolve or escalate complaints arising elsewhere. Practitioners referred to regulatory bodies will always be alerted to any investigation and given the opportunity to respond to the complaint at the earliest stages. They will be made aware of the full details of the complaint and its source so that even if they have been unaware of a problem or complaint they will have the chance to respond and to resolve it.

88 Resolution by a professional or NHS Board of a complaint referred in parallel or alternatively to a regulator will not necessarily terminate the regulator's proceedings. The fact that a professional has manifestly ceased an earlier practice which has given rise to a complaint may not mean his fitness to practise is unimpaired: a regulator may consider the original shortcoming was so serious as to have undermined public confidence in the profession and may therefore take action against that practitioner's registration.

89 Regulators have to notify the employer (or contracting NHS Board) of any professional subject to an investigation. Some delays or gaps may arise, if for example a nurse is contracted to an agency and working indirectly for the NHS as a locum. The Guidance states that if the Board becomes aware that a complaint under investigation has become subject of a regulator's inquiry that the investigation of the complaint will be suspended unless continuing would not compromise or prejudice the process. Sometimes it may be agreed between a regulator and Board that the NHS complaints process should be completed before the regulator initiates or completes an investigation. At other times it may be necessary for the regulatory process to take precedence, not least in order to protect the public from a potentially unsafe practitioner.

90 The Regulatory bodies have agreed memoranda with the NHS regarding the coordination of investigation of complaints. There is nothing to stop patients referring practitioners directly to their regulator without engagement with the NHS complaints process. This provision is necessary as some matters may be so serious that they require rapid intervention by a regulator. Complaints about practitioners may also relate to professionals working partially or wholly outside the NHS.

91 Boards may also have to manage parallel disciplinary or legal processes relating for example to the suspension of a practitioner or the suspension of their contract. These considerations may have little significance for patient or carer complainants except when the effect of parallel processes causes prolonged delays in the investigation (and / or resolution of a complaint). This may be compounded when the feedback it is possible to give complainants is restricted because of issues of confidentiality (e.g. where a disciplinary process is underway) or possible conflict of interest (where patient may be a witness in a regulator's fitness to practise hearing).

92 In July 2008 the Health and Social Care Act received royal assent. Most of its provisions are more relevant to health care in England and Wales. Two key provisions, however, are amongst those applicable to Scotland and will affect the landscape of professional health care regulation.

93 First, the Office of the Health Professions Adjudicator will be established. This new body will take over the adjudication of fitness to practise cases from regulators, initially the General Medical Council and General Optical Council, with others expected to follow in due course. This will result in the separation of the adjudication of cases from their investigation and prosecution. The impact on complainants will not be significant, they will still refer problems about doctors and opticians to the same two regulators. However, the public perception of the independence of such bodies should be enhanced.

94 Second, the Act creates the role of "Responsible Officers" (RO) and requires designated bodies in the United Kingdom that provide, or arrange for the provision of, health care or employ, or contract with, doctors to nominate or appoint such officers. The Responsible Officers role will provide an interface between the health care providers and the medical regulator and amongst other things the role will include work with the General Medical Council to identify and handle cases of poor professional performance by doctors. (At present, the General Medical Council

has no specific powers to instigate an investigation unless a matter is reported to it or it learns of a concern from a publicly available source – i.e. it reads about it in the tabloids).

95 The Responsible Officer's role is likely to be linked to clinical governance roles in most Boards. The Survey work of this project will include asking NHS Boards about the integration of the Responsible Officer's role with complaints processes. Working well, the Responsible Officer will have a key role in promoting high standards of medical practice and in disseminating across systems learning from individual complaints made to regulators. The detail of how the Responsible Officer role will fit with the present systems is still to be provided.

Regulation of Processes and Materials

96 As described above materials, treatments, equipment and processes used in the care and treatment of patients are in certain instances subject to regulation e.g. use of radioactive substances, creation and storage of embryos. Table 6 below shows the regulatory authorities in this field. All such specialist processes as well as routine work undertaken by NHS Board employees or contractors will be subject also to the requirements of health and safety legislation. Additionally materials and equipment used may be subject to maintenance schedules and warranty provisions. This means that in certain treatment regimes up to 14 different organisations may have some form of jurisdiction or interest. NHS patients should never normally have to be in contact with these agencies, though it may be relevant for them to know that such agencies are involved in the investigation of a complaint in order to affirm their rights to make separate complaints where such provision exists within the relevant agency.

97 The key responsibility for ensuring the identification of systemic weaknesses or recurring problems related to equipment, materials or specialist processes arising from a complaint lies with the complaints handling officers. The responsibility for notifying relevant agencies with jurisdiction or addressing the local impact of such problems lies with Boards or the independent primary care practitioners involved.

Table 6: Authorities Regulating Treatments, Processes and Materials in Health Care

Regulatory Authority	Responsibilities
Health and Safety Executive	HSE (in conjunction with local authority Environmental Health Divisions) has responsibility for regulating the health, safety and welfare "for those at work and for those affected by work activity, including the public."
Human Fertilisation & Embryology Authority	HFEA regulates safety and practice in IVF treatment and embryo storage and research.
Human Tissue Authority	HTA regulates the removal, storage, use and disposal of human bodies, organs and tissue from both living and deceased persons. It is also responsible in Scotland for approval of living donation of organs and for the licensing of establishments storing tissue for human application.
Medicines and Healthcare Products Regulatory Agency	MHRA regulates the licensing and utilisation of medicines and medical devices. It receives reports of adverse incidents or adverse drug reactions.
Scottish Environment Protection Agency	SEPA regulates, licences and inspects processes involving ionising radiation (e.g. radiography, nuclear medicine) and the storage and disposal of clinical waste.

Other Agencies with Jurisdiction

98 A small number of other agencies may also have jurisdiction in aspects of complaints which relate to the functions of NHS Boards, Board members, the availability of information, personal data held by health care agencies and activities carried out on behalf of NHS Boards. These are listed in the table below.

99 Investigation of complaints made to an NHS Board relating to the areas listed below would in most cases be suspended until the relevant regulatory body completed its inquiries. In cases other than those relating to freedom of information or personal data, it would be unlikely that a patient would have contact directly with any of these agencies. The more likely scenario would be that a Board or other public authority would refer to one of these regulators any relevant issue emerging from a patient complaint.

Table 7: Other Regulators with Potential Jurisdiction in NHS Complaints

Regulatory Body	Responsibility
Standards Commission for Scotland	Investigates complaints relating to Members of Scottish Public Bodies (e.g. NHS Board) breaching their code of conduct (e.g., failing to register an interest, breach of confidentiality)
Auditor General for Scotland through Audit Scotland	Audits the administration of finances of public bodies in Scotland (e.g. NHS board)
Commissioner for Public Appointments	Oversees all public appointments in Scotland and investigates complaints related to appointments to bodies such as NHS Boards.
Scottish Information Commissioner	Deals with complaints relating to access to information held by public authorities.
UK Information Commissioner	Responsible for data protection regulation for any agencies operating in both Scotland and another part of the UK and for Data Protection rights (personal information) for the whole of the UK.
Office of the Scottish Charity Regulator	Regulates charitable organisations including those providing contracted health care services.

Agencies with Parallel Jurisdiction

Local Authorities

100 As described above, increasingly the boundaries between some aspects of social care and health are becoming blurred. Complications can arise for complainants receiving services which are jointly provided by health and social work staff or which are provided by a local authority under contract to or in partnership with an NHS Board. The development of social care complaints processes in Scotland has been slower than the development of equivalent processes in England and there has never been a full review of social work complaints in Scotland as there has been in England.

101 The complaints process in social work and social care is different from the complaints process in the NHS, not least because there are more routes through the process and more stages. A complaint about a care service may go through four formal stages in a local authority (including internal reviews and committee) before reaching the Scottish Public Services Ombudsman compared to the two stage NHS process. To complicate matters further, at each earlier stage a referral can also be made to the Scottish Public Services Ombudsman. Complaints can leave the care system at different stages and move straight to the Ombudsman. There is also no mechanism for the organisation signing off social care complaints and so there can be a greater risk of the organisation not owning the issue or not engaging with the learning from it.

102 The Guidance makes it clear that when such a situation of "joint complaints" arises, **"the NHS organisation and the local authority social work department must agree who will take the lead and work together to ensure that all matters raised are investigated"** (paragraph 42)

Scottish Social Services Council

103 The rate of referral of NHS practitioners and contractors to regulators by their employers or by the public, discussed above, is massively higher than referrals to the care professions regulator, Scottish Social Services Council (SSSC). The Scottish Social Services Council came into being in 2003 and has over 138,000[24] people registered. In 2006-07 the Scottish Social Services Council held 3 conduct hearings and imposed one interim order.

104 Unlike health care regulators, when the Scottish Social Services Council investigates a complaint against an individual they do not automatically notify their employer or contracting agency. There is also no formal requirement for employers to notify the Scottish Social Services Council of the details of any complaints initiated or upheld against individuals.

Care Commission

105 Since 2002, the Scottish Commission for the Regulation of Care ("the Care Commission") has regulated all adult, child and independent healthcare services in Scotland. NHS services, provided or commissioned, come under its auspices if they include: adult placement services; care at home; care homes for children and young people, older people, people with physical and sensory impairments, for people with learning disabilities, people with mental health problems, people with drug and alcohol problems; hospice care; independent hospitals and specialist clinics; nurse agencies; short breaks and respite care services.

106 The Care Commission will investigate complaints from anyone[25]. By statute the Commission is not an escalatory body like the Scottish Public Services Ombudsman and so can become involved at any stage in the lifetime of the complaint; accordingly sometimes the Commission will be working in parallel to the NHS (or local authority) complaints procedures where a patient or carer has complained to both the contracting Board and to the Care Commission. The Guidance (paragraph 44) states that complainants raising issues about regulated care homes with NHS Boards should be referred to the Care Commission. The expectation is that the Care Commission will liaise with the complainant and the relevant Board.

107 The Care Commission's complaints process is more complex than the NHS process. It has up to five stages including internal reviews and committees and, as with local authorities, complaints can be escalated by the complainant to the Scottish Public Services Ombudsman at more than one of the latter stages.

108 Provision exists for the Care Commission to suspend its investigations if it appears that another agency (e.g. Police, NHS Board, regulatory agency) has primary jurisdiction. There is also provision for the Care Commission to alert all placing authorities (e.g. NHS Boards, local authorities) of a complaint with implications for all the residents of an establishment.

Police and Procurators Fiscal

109 Where a patient complaint raises issues of criminality, the Police will be immediately notified by the relevant Board or Practice notified and the investigation of related complaints suspended pending the outcome of the criminal inquiries.

110 Where a patient death raises issues of public safety or matters of general public concern, particularly if it appears hazardous circumstances or systems may have caused or contributed

to it, a Procurator Fiscal can apply to the Sheriff Court to hold a Fatal Accident Inquiry (FAI) once any criminal investigation of the death is complete. The Sheriff will determine the cause of death, any precautions by which the death might have been avoided; and any systemic factors that caused or contributed to the death. A Fatal Accident Inquiry cannot make any findings of fault against individuals. Management of complaints to the NHS which involve a case subject to a Fatal Accident Inquiry will be suspended until the Inquiry issues the Sheriff's determination.

Agencies with Interest, but without Jurisdiction

111 Where patients have problems of, or uncertainties about, accessing a complaints system, or lack confidence in the objectivity of the NHS process, they may approach individuals, or agencies for assistance to highlight or resolve their complaint. Complainants may approach an elected representative at local or national level or an advocacy group or the Press for assistance prior to or in the course of making a complaint. These agencies or representatives may have concerns relating to the broader public interest arising from matters raised by individuals.

112 NHS Boards and contractors are limited by consent and confidentiality regulations in the extent to which they can receive complaints or disclose information about complaints to third parties. The Board or Practice would always have to be satisfied that the interested party was acting with the patient's consent and that there was express consent, if so required, for the substance of the complaint or feedback on the complaint to be discussed with that party.

113 Where matters of public interest are raised generally with NHS Boards or Family Service Providers by representatives or interested parties these will not be considered under the complaints procedure. Where a solicitor is acting on behalf of a complainant, the matter cannot be progressed through the complaints process if litigation is involved.

Issues about Parallel and Alternative Routes of Complaint

114 The existence and operation of complaints processes in parallel with NHS complaints systems, is inevitable. Regulatory and other agencies with jurisdiction have different statutory responsibilities and a different focus to the NHS in relation to complaints.

115 The operation of each of the parallel complaints systems relating to healthcare is remarkably similar and straightforward in the majority of cases. The interface amongst these systems is, in theory, also relatively straightforward. The exceptions are the local authority social work system, the Care Commission system and the social care regulatory system. The multiple stages of and routes through local authority and care complaints systems appear to be unduly complex, and the absence of a requirement for the social care regulator to notify employers of a complaint appears to be out of line with other regulators. At this stage it is not clear whether in practice this ever arises as an issue.

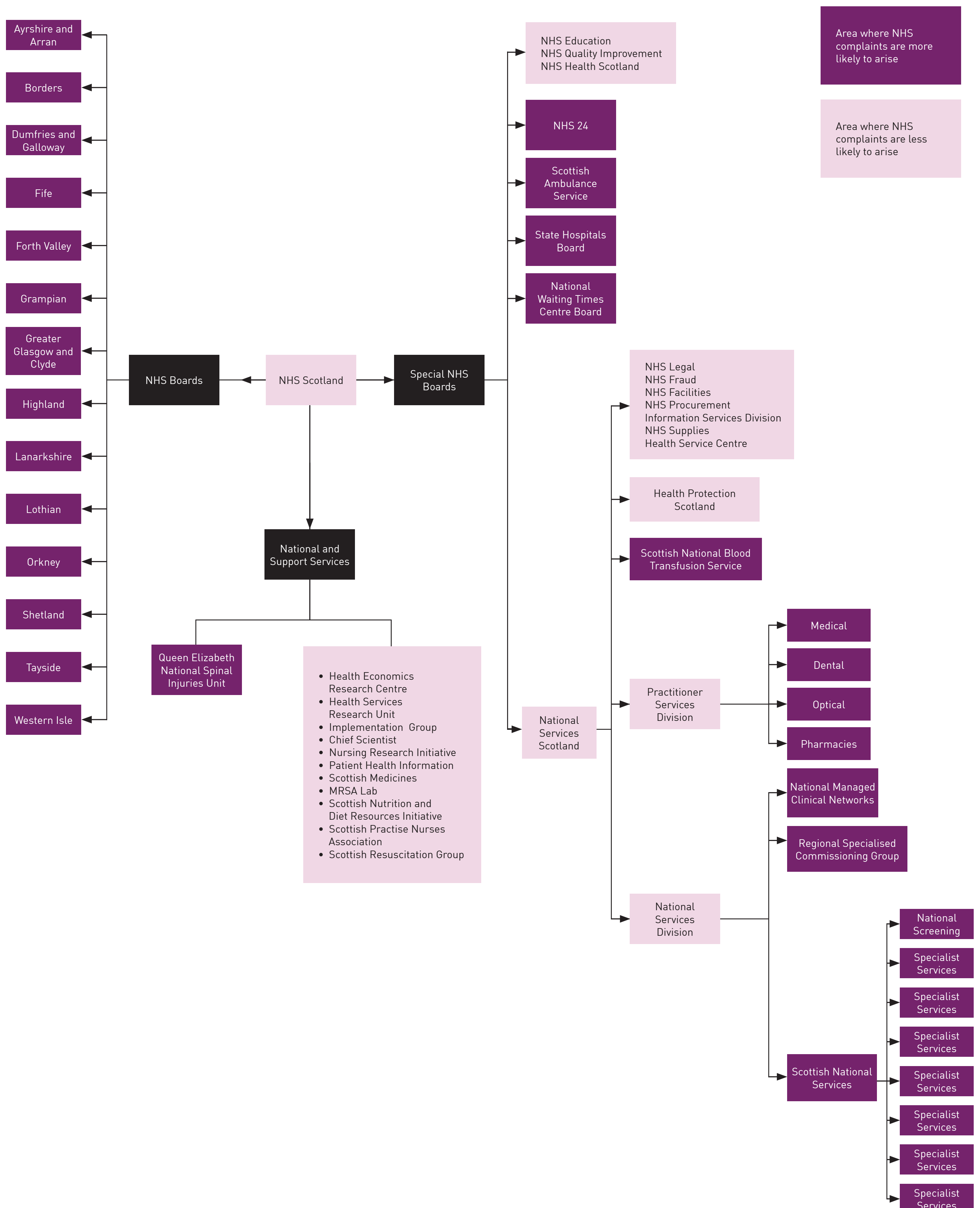
116 Multiple potential routes for complaints may mean:

- Patients can intentionally or inadvertently engage with more than one agency – and each agency either may be aware or unaware of others' involvement
- Patients can opt to pursue matters with one agency in preference to others or in ignorance of others' existence
- Not every agency with a legitimate interest in a complaint will necessarily be alerted to it.

117 The indications from the data of the two biggest regulators, the Nursing and Midwifery Council and the General Medical Council, are that relatively few matters are dealt with in parallel across the NHS and the main regulators. The Guidance and the existing Memoranda of Understanding amongst regulatory agencies require and promote the exchange of information amongst all relevant agencies.

118 It is clear that the interaction and exchange of information amongst agencies is not and should not be a patient / complainant responsibility. Good communication amongst all the stakeholders in health care performance is essential not simply to ensure all proper steps are taken to resolve complaints, but also to maximise the opportunities for identifying patterns which indicate persistent or systemic problems affecting patient safety or patient care and to minimise overlap or duplication. Good communication amongst stakeholders is equally crucial to make certain that the learning from complaints is acquired, absorbed and dispersed across all the relevant stakeholders, their systems and their staff. The factors which encourage and inhibit this process will be considered in more detail in the light of the Surveys of patients and NHS complaints handling staff.

DIAGRAM OF NHSSCOTLAND FUNCTIONS AND SERVICES



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