

Briefing for the Public Petitions Committee on petition [PE2258](#): Independently review NHS complaints handling for greater accountability and learning, lodged by Yvette Rodgers

Brief overview of issues raised by the petition

The petitioner does not regard NHS Scotland complaints processes or the involvement of the Scottish Public Services Ombudsman as adequate. The petitioner is clear that she was not seeking compensation or punishment following a complaint about the care her grandmother received, but wanted acknowledgement of mistakes made and assurance that learning from the process was clearly demonstrated.

Her experience has also led her to question whether the Duty of Candour legislation ensures sufficient oversight when something goes wrong in healthcare. Her particular concerns are therefore about:

- The independence of investigations
- Adequacy of findings presented to families
- How learning is demonstrated and communicated to families
- Adequacy of oversight via Duty of Candour legislation.

NHS Complaints handling

The new NHS complaints handling procedure was established in 2016 and [the National Clinical Director wrote to all health boards and other stakeholders](#) setting out the rationale and the legislative basis: the [Patient Rights Act \(Scotland\) 2011](#). The Act introduced a right for people to give feedback and comments, and raise concerns and complaints about NHS services, and it placed a duty on the NHS to actively encourage, monitor, take action and share learning from the views they receive.

The [NHS Model Complaints Handling Procedure](#) applies to all healthcare settings where NHS treatment is provided, including GP practices, and dental practices. If the person making the complaint is not satisfied with how it has been handled, then they can approach the [Scottish Public Services Ombudsman](#).

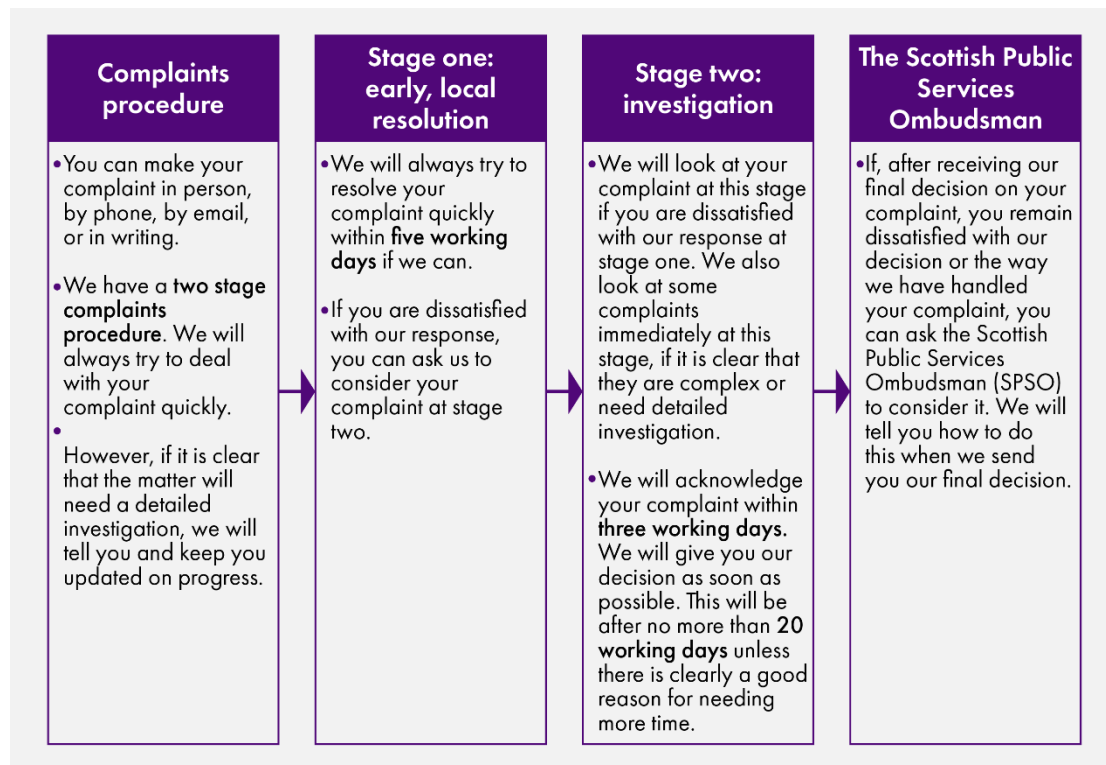
The NHS complaints handling procedure is based on the premise that effective early resolution through responsive action, listening and compassion should negate the move to a more formal complaint.

[The NHS complaints procedure is a two-stage process](#): stage 1 being 'early, local resolution' and stage 2 'investigation'. The document explaining the process is a

long, detailed document including details of what a complaint is, the process, governance and guidance.

People are encouraged to raise a concern as soon as it arises, with the staff dealing with their care and treatment. If someone doesn't feel able to do that, or is not satisfied with the response, then they can move to stage 1 of the more formal process. The visual below provides the key stages and timings of the NHS model complaints handling procedure.

Figure 1: overview of model complaints procedure



Independence of investigations

The NHS complaints handling procedure states that everyone involved must be clear about the scope and expectations from any investigation. It acknowledges that there might be a mismatch between the complainant's expectations and what outcome might be possible, and what is possible within the 20-day response window, making a discussion essential early on.

Health Boards have dedicated complaints-handling staff teams. They will take details of any concerns or complaints and will then contact the staff involved to understand the issue from their perspective. These staff are independent inasmuch as they are not directly involved with any of the care and treatment the person has received. They will then collate the information and provide the written response to the complainant.

Some Health Boards (eg NHS Grampian) use Independent Contractors to deal with complaints in addition to their own complaints handling staff.

The procedure sets out the roles and responsibilities of the Feedback and Complaints Manager, and of Feedback and Complaints Officers.

Adequacy of findings presented to families

The findings at Stage 2 are not coming directly from the staff involved in the person's care and treatment. The procedure is set out as a 20-day process (in the case of a Stage 2 complaint). So, at Stage 2, the opportunity for a person to deal directly with the staff involved has passed and the case is taken on by a complaints handler in the dedicated team. However, a full response covering the agreed scope of the complaint should be provided to the family.

Recording, monitoring, reporting, learning from and publicising complaints

The procedure states that:

“Complaints provide valuable feedback. One of the aims of the complaints handling procedure is to identify opportunities to improve services across [the organisation]. We must record all complaints in a systematic way so that we can use the complaints data for analysis and management reporting. By recording and using complaints information in this way, we can identify and address the causes of complaints and, where appropriate, identify training opportunities and introduce service improvements.”

The procedure is a prescribed, time-bound process. Alongside the complaints handling, health boards are required to report regularly on complaints and concerns via a 'Complaints handling and learning from feedback' annual report.

These reports cover the numbers of complaints, how many were escalated to the Scottish Public Services Ombudsman (SPSO), performance in terms of timelines and complaint themes.

The reporting is through clinical governance oversight, with ultimate responsibility lying with the Chief Executive and Executive Directors, and the reports have to be published on the Health Board's website. The reports provide some examples of learning, service change and training provided, but how learning is implemented is not covered by the procedure in a prescriptive way.

Under the relevant sections, the detail is on how complaints should be recorded, how records should be kept, how they should be monitored and reported.

With regards to learning, the procedure states:

“At the earliest opportunity after the closure of the complaint, the complaint handler should always make sure that the person making the complaint and staff of the service involved are given feedback and, where applicable, understand the findings of the investigation and any recommendations made.

As a minimum, we must:

- use complaints data to identify the contributory factors to complaints;

- take action to reduce the risk of recurrence;
- record the details of corrective action in the complaints file; and
- systematically review complaints performance reports to improve service delivery.
- Where we have identified the need for service improvement:
 - an action plan should be developed where appropriate;
 - the action needed to improve services must be prioritised for implementation;
 - an officer (or team) should be designated the ‘owner’ of the issue, with responsibility for ensuring the action is taken;
 - a target date must be set for the action to be taken;
 - the designated individual must follow up to ensure that the action is taken within the agreed timescale;
 - where appropriate, performance in the service area should be monitored to ensure that the issue has been resolved; and
 - we must ensure that our staff learn from complaints.”

There are no explicit reporting requirements for these learning points that need to be published in the annual reports on complaints.

Scottish Public Services Ombudsman (SPSO)

The [Scottish Public Service Ombudsman Act 2002](#), as amended, sets out the basis on which the SPSO oversees the complaints processes of public services as well as what they can investigate, their powers, and what they must not investigate.

Section 16A(2) of the Act states that certain public services must have a complaints handling procedure in respect of any action taken by them. Section 16B(1) enables the Scottish Public Service Ombudsman to publish model complaint handling procedures (MCHP) and section 16C(2) stipulates the public service must ensure their complaint procedure complies with this.

Duty of Candour – oversight and governance

[Scottish Government guidance](#) sets out:

“The duty of candour provisions of the [Health \(Tobacco, Nicotine etc. and Care\) \(Scotland\) Act 2016 \(The Act\)](#) and [The Duty of Candour Procedure \(Scotland\) Regulations 2018 \(The 2018 Regulations\)](#) set out the obligations on and the procedure that those providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident in providing those services that results in, or

could result in, death or harm (or additional treatment is required to prevent injury that would result in death or harm).”

“The organisational duty of candour procedure **must** be carried out by the responsible person as soon as reasonably practicable after becoming aware that an individual who has received a health, care, or social work service has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in, or could result in:

- the death of the person
- a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (“severe harm”)
- harm, which is not severe, but which results in:
 - an increase in the person’s treatment
 - changes to the structure of the person’s body
 - the shortening of the life expectancy of the person
 - an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days
 - the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days”

Under the legislation, a ‘responsible person’ needs to be identified, which can be an organisation, such as a Health board, or an individual.

There are a number of steps that must be followed:

- Identify and contact relevant persons (those affected).
- Notify the relevant person by providing an account of the incident and what actions will be taken.
- Arrange a meeting with the relevant person, and provide an opportunity to ask questions in advance. An apology should be made and the further steps being taken should be outlined, and a further opportunity to ask questions should be given.
- Carry out a review.
- An option to hold a final meeting with the relevant person.

Responsible persons are required to prepare and publish reports about the incidents, the organisation’s compliance with the duty of candour procedure and information

about policies and procedures and changes that have occurred as a result of the procedure.

There is a connection between the complaints procedure and the duty of candour responsibilities, although these are not explicit. What they share is a focus on process. This focus on process presents a potential risk that they are treated as separate, discrete processes, with separate reporting structures, outwith a broader organisational consideration of improvements to services, service delivery and wider clinical safety and cultural concerns. Executive Directors see reports on the metrics of these processes, but not necessarily detailed feedback on any service or other changes, and it is not clear how or whether the learning and outcomes of investigations feed into wider organisational change.

The Explanatory Notes accompanying the legislation indicate where higher responsibility sits:

“In order to assist with monitoring the extent to which the duty of candour procedure has been followed, there is a power for certain bodies to require responsible persons to provide them with information. These same bodies are to be notified when the annual reports are published. The particular bodies with the power to require information (and who are to be notified) vary depending on the responsible person. So, for example, Health Boards are linked to the Scottish Ministers, independent health service providers are linked to Healthcare Improvement Scotland, while providers of care services or social work services are linked to Social Care and Social Work Improvement Scotland (SCSWIS, which operates under the name of the Care Inspectorate).”

Key Organisations and relevant links

- [NHS Inform](#) has public-facing information on complaints handling in NHS Scotland.
- [Scottish Public Service Ombudsman \(SPSO\)](#) - The Scottish Public Services Ombudsman has a wide remit, covering a variety of functions and services.
 - the final stage for complaints about most devolved public services in Scotland including councils, the health service, housing associations, prisons, water and sewerage providers, Scottish Government and associated public bodies, universities and colleges
 - specific powers and responsibilities to publish complaints handling procedures, and monitor and support best practice in complaints handling.
 - Independent National Whistleblowing Officer for the NHS in Scotland (INWO) – final stage for complaints about how the NHS considers whistleblowing disclosures and the treatment of individuals concerned.
- [Patient Advice and Support Service \(PASS\)](#)

“The Patient Rights Act provided for the establishment of the Patient Advice and Support Service (PASS). PASS operates independently of the NHS, and provides free, confidential information, advice and support to anyone who uses the NHS in Scotland. The service promotes an awareness and understanding of the rights and responsibilities of patients and can advise and support people who wish to give feedback, make comments, raise concerns or make complaints about treatment and care provided.” (quoted from the NHS Complaints Handling Procedure document)

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The purpose of this briefing is to provide a brief overview of issues raised by the petition. SPICe research specialists are not able to discuss the content of petition briefings with petitioners or other members of the public. However, if you have any comments on any petition briefing you can email us at spice@parliament.scot

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