

CAN I HELP YOU?

Learning from Comments, Concerns and Complaints

Part 1 Introduction

Purpose and Structure of the Guidance	1
Overview of the NHS Complaints Procedure	3
Local resolution	5
Ombudsman review	6
Clinical Governance	7
Equality and Diversity	8
Advice for Patients and the Public	10

Part 2 Learning from Comments and Concerns

A Patient-Focused NHS	12
Active Listening	17
Comments and Concerns	23
Compliments	27

Part 3 The NHS Complaints Procedure

Definition	28
Principles for an effective complaints procedure	29
Who can complain?	31
What can be complained about?	33
What the procedure doesn't cover	35
Staff Grievances	39
When can a complaint be made?	40
Joint complaints	42
Roles and responsibilities	
The NHS Board	45
The Chief Executive	46
Director with responsibility for patient feedback and complaints	47
The Complaints Officer	48
Dealing with a complaint	49
Acknowledging a complaint	54
The Investigation	57
Completing local resolution	63
Learning from Complaints	67
Specific Issues for Family Health Service Practitioners	
The independent contractor and the NHS complaints procedure	68
What can be complained about?	72
Handling complaints	73
The NHS Board	74
Failure to operate a complaints procedure	77
Role of the Ombudsman	78
Monitoring complaints	
Informing the Board	82
Annual Reports	84
National Monitoring	85

Part 4 Information that may be useful in dealing with complaints

- 1 Advice and Support
- 2 Advocacy
- 3 Commissioned services
- 4 Conciliation
5. Confidentiality of patient information
6. Consent
7. Continuing care
8. Criminal investigations and Independent Inquiries
9. Data Protection Act 1998
- 10 'Out-of- Hours' Care
11. Disciplinary action and investigation by a professional organisation
12. Fatal Accident Inquiries/Procurator Fiscal cases
13. Grievance Procedures
14. Negligence claims
15. Private pay beds in NHS Hospitals
16. Publicity
17. Training
18. Unreasonably demanding or persistent complaints

Part 5 The Statutory Directions

PART 1: Introduction

PART 1: Introduction

Purpose and Structure of the Guidance

1. This guidance sets out how the NHS in Scotland should deal with the comments, concerns and complaints of the people who use its services. It is in five parts:

- Part 1: provides an overview of the complaints procedure
- Part 2: places the complaints procedure in context as the final stage of a patient-focussed quality improvement process by which NHS Scotland encourages feedback from the people who use its services
- Part 3: provides guidance on the operation of the complaints procedure
- Part 4: contains information on related policies, procedures, legislation etc which may be useful in dealing with a complaint
- Part 5: contains a copy of the statutory Directions which are the basis of the NHS Complaints Procedure¹.

2. NHS Boards are responsible for ensuring the appropriateness of their actions and their interpretation of legislation when dealing with a complaint. This guidance, which must be read in conjunction with the statutory Directions, is intended as a guide to the mandatory aspects of the procedure, but it is not meant to be all-embracing or to cover every contingency.

Overview of the NHS Complaints Procedure

3. NHS Scotland is committed to delivering high quality, patient-focused healthcare and to using the views and experiences of the people who use its services as part of a process of continuous quality improvement. Wherever possible, the comments and concerns of patients and their families will be dealt with as they arise.

4. However, there will be occasions where an individual will be dissatisfied with the explanation or apology given and want to complain. Where this happens the service provider will attempt to resolve the complaint as directly and quickly as possible, with the primary aim of being fair to both the person making the complaint and to those who delivered the healthcare. The most satisfactory outcomes are achieved when a complaint is dealt with fully and effectively at this 'local resolution' stage.

Local Resolution

5. Local resolution seeks to provide prompt investigation and resolution of a complaint at local level, aiming to satisfy the person making the complaint whilst being fair to staff. This stage should, normally, be completed within 20 working days of receipt of a complaint.

¹ along with the NHS (General Medical Services Contracts)(Scotland) Regulations 2004; the NHS (General Dental Services)(Scotland) Amendment Regulations 1996; the NHS (Pharmaceutical Services)(Scotland) Amendment Regulations 1996; and the NHS (General Ophthalmic Services) (Scotland) Amendment Regulations 1996.

Ombudsman review

6. Where the person making the complaint remains dissatisfied with the outcome of local resolution, they may ask the Scottish Public Services Ombudsman², who is independent of Ministers and the NHS, to review their case. The person complained against can also seek an Ombudsman review in certain circumstances.

Clinical Governance

7. Local clinical governance arrangements must include procedures for ensuring that information gained from patient feedback, including complaints, is used to improve service quality.

Equality and Diversity

8. The White Paper, *Partnership for Care* requires³ NHS Scotland to ensure that its 'services recognise and respond sensitively to the individual needs, background and circumstances of people's lives'. This requirement, which is now underpinned by a statutory duty to 'encourage equal opportunities'⁴, applies to local arrangements for handling complaints.

9. The Race Relations Act^{5 6} also places a legal obligation on public authorities (including NHS Boards) to actively promote race equality in all their work and requires them to ensure that they comply with the general duty to:

- eliminate unlawful racial discrimination
- promote equality of opportunity, and
- promote good race relations

Staff involved in the implementation of this guidance should therefore use the *Equality and Diversity Impact Assessment Toolkit*⁷ to ensure their local arrangements fully meet the needs of potentially disadvantaged individuals or groups⁸: This includes ensuring ready access to translation and interpretation services, including those for people with sensory impairment, and the provision of appropriate independent support and advocacy services for all who need it.

Advice for Patients and the Public

10. NHS Boards should ensure that anyone wishing to make a complaint is provided with a copy of the Health Rights Information Scotland's leaflet *Making a complaint about the NHS* and information on accessing an independent advice and support service.

²Freepost EH641, Edinburgh EH3 0BR Tel: 0870 011 5378: enquiries@scottishombudsman.org.uk and www.scottishombudsman.org.uk

³ Scottish Executive: 2003, page 20

⁴ NHS Reform (Scotland) Act 2004

⁵ The Race Relations Act 1976 (Statutory Duties) (Scotland) Order 2002 www.scotland-legislation.hmso.gov.uk/legislation/scotland/ssi2002/20020062.htm

⁶ The Race Relations (Amendment) Act 2000 www.legislation.hmso.gov.uk/acts/acts2000/20000034.htm

⁷ <http://www.scotland.gov.uk/library5/health/eqdiat-00.asp>

⁸ In line with the legislative framework and current good practice, SEHD and NHSScotland define the equality strands as: age, disability, gender, race/ethnicity, religion/faith and sexual orientation.

PART 2: Learning from Comments and Concerns

Part 2: Learning from Comments and Concerns

Introduction

11. This part places the complaints procedure in context by setting out background on the way in which the NHS encourages feedback from the people who use its services as part of a process of continuous quality improvement.

A Patient-Focused NHS

12. The NHS aims to provide effective and efficient health care to the people of Scotland. The organisations and staff that make up NHS Scotland are committed to providing the highest quality of care possible. However, in the thousands of encounters between the NHS and the people it serves each day, there will inevitably be occasions when we will fail to meet our own expectations or those of the people who use our services. That is why we want to establish a modern, patient-focused healthcare system which:

listens to and acts on complaints from those who feel let down by the service they have received. It must also be quick to learn from what patients⁹ say has worked well for them¹⁰.

13. Our emphasis must be on putting people, their views and experiences at the centre of the planning and delivery of local services; on tackling the shortcomings that concern the people who use our services; and on proactively addressing any comments or concerns they may have about the service they have received.

14. We must work to strengthen the voices and influence of people who use our services. We must use a range of approaches¹¹ and opportunities to hear their concerns, suggestions, worries or comments, learn from them and change the way that things are done. We must encourage the meaningful involvement of those who know how services are currently delivered, and make a special effort to hear from those whose voice is not normally heard or who would otherwise be excluded. We must create a culture where comments and suggestions are welcomed and acted upon by the staff delivering the care.

15. Being patient-focused puts people first. Local services must:

- get to know and respect the people who use their services – and those who care for them¹²
- treat the people who use their services as individuals who should be involved in decisions about their own care
- provide the people who use their services with clear, explicit and accessible information about local standards of service

⁹ In this guidance 'patient' is used to cover patients; people acting on behalf of patients with their consent; the next of kin, or other appropriate person where the patient has died or is incapacitated; and visitors.

¹⁰ *Our National Health: A plan for action, a plan for change, page 53*

¹¹ See 'Building Strong Foundations' www.show.scot.nhs.uk/involvingpeople/readinglist.htm

¹² Royal College of Nursing, 2004, <http://www.rcn.org.uk/london/downloads/notjustafriend.pdf>

- listen to, understand and act upon the views, comments and expressed needs of the people who use their services
- keep the people who use their service informed and involved
- maintain politeness and mutual respect at all times
- ensure that their services are accessible to all.

Local services must also:

- train and support their staff to respond flexibly and sensitively to the specific needs of individuals
- ensure quick and effective action is taken to improve services
- provide feedback on the action taken.

16. At all times NHS staff should treat patients, carers and visitors politely and with respect. However, violence, racial, sexual or verbal harassment of staff should not be tolerated.

Active Listening

17. An important way to improve services is to listen to, understand and act upon the views and experiences of the people we serve. In our review of the previous NHS Complaints Procedure¹³, we heard that many people do not actually want to enter a formal complaints procedure. However, they often felt they had no other recourse in order to communicate effectively with the people who could change things. Their evidence showed that the procedure was ineffective in its objective of delivering quality improvement because many observations, worries or concerns never reached the system. People told us:

- “I don’t really want to complain ... but I do not want this to happen to anyone else”
- that they felt so disempowered that they would never complain – or even voice their real concerns – because they did not want to make a fuss or draw attention to themselves or because they worried that their care could be prejudiced in the future.

18. As the people who use our services may have interesting and informative contributions to make to help improve these services, NHS organisations must develop feedback systems that encourage them to express their views. They must become more responsive to the needs of the people they serve and focus on action to meet these needs by:

- encouraging suggestions and comments as opportunities for change
- ensuring that individuals are given the help they need to have their voice heard
- providing staff with the training and support to consistently display sensitivity and understanding to people who are at a vulnerable and stressful point in their life
- empowering staff to listen to and act upon the suggestions of the people they care for

¹³ Reforming the NHS Complaints Procedure
<http://www.show.scot.nhs.uk/complaints/Consultation%20Document.pdf>

- letting people who use services see action being taken to change a negative experience into one that empowers
- forming a partnership between staff and patients that will improve the quality of care for everyone who uses that service.

19. It is communication that links every part or process of health and healthcare and good communication is key to delivering a patient-focused NHS. However, communication skills are such a fundamental part of everyday life that they are too often taken for granted. The reports of the Ombudsman repeatedly show that communication failings have a very significant impact on an individual's treatment and general wellbeing. Effective communication with our patients, their families and carers when they are anxious and vulnerable is a skill which requires care and attention.

20. The way in which we communicate is particularly important for people who may be marginalised whether on the grounds of their race, disability, sexual orientation, age, gender or religion. It is essential that local services develop an inclusive communications approach which meets the specific requirements of individuals from these groups.

21. The most effective way of improving the quality of local services is therefore to listen to, understand and act upon the views and concerns of the people using our services. This requires local services to:

- be open and honest
- show sensitivity and understanding
- use the appropriate method of communication¹⁴ for the situation and the individual
- use appropriate language for each group or individual
- listen to what is said and be sensitive to the reaction of others
- provide effective feedback.

22. NHS Boards should therefore ensure that all local services, including Family Health Services, have effective 'patient focused' arrangements in place to encourage feedback¹⁵ from the people who use these services and that this feedback is dealt with quickly and sensitively in a way which ensures that lessons are learnt and shared.

Comments and Concerns

23. Patients often raise issues about which they are unhappy, without wishing to make a formal complaint. In many instances, they will simply be concerned and wish to receive an explanation and – if something has gone wrong – an apology. As these suggestions may be made to any member of staff, it is important that all staff are trained to welcome patient's views and see them as an opportunity to improve their local service.

¹⁴ including providing appropriate translation or interpreting services for people whose first language is not English or who use British Sign Language etc.

¹⁵ Comment cards or similar arrangements should be freely available in waiting areas, wards etc to encourage feedback. They should be available in a range of formats to ensure maximum accessibility and should include space for an address if the patient would like a reply.

24. Staff should respond positively and appropriately if a patient raises a concern. Staff should:

- ensure that the patient's immediate health care needs are being met before dealing with the suggestion or comment rapidly, sensitively and confidentially
- discuss the matter of concern with the patient, encouraging them to speak freely
- provide an honest and objective response. The response should be given verbally, unless the patient has requested a written reply or the member of staff considers a letter is appropriate. Oral responses should be given on the spot or, where this is not possible, a timescale for a way forward should be agreed with the patient. The response should include an explanation, an apology where appropriate and indicate what is being done to avoid the problem happening again. Any oral or written response about a clinical matter should be agreed with an appropriate clinician
- where a patient has requested it, issue a written response, approved where appropriate by a clinician or senior member of staff. Details of the concern and a copy of the written response should be sent to the organisation's complaints officer
- consider, based on their assessment of the situation, the nature of the concern, and their knowledge of any previous similar situation(s), what action is appropriate to share the information and ensure that the organisation learns from the process.

25. Staff should also understand that where they feel unable to respond themselves that they can:

- call on the support of an appropriate senior member of staff, or
- offer the patient the option of discussing the matter with someone not directly involved in their care, for example someone from another ward or department, the practice manager, someone from the organisation's complaints staff or an independent advice and support organisation.

When asked to provide this type of support, staff should, ideally, respond immediately, but where this is not possible a timescale for a way forward should be agreed with the patient.

26. If the patient remains unhappy after receiving an oral or written response, they should be advised of the next appropriate step and given a copy of the Health Rights Information Scotland's leaflet *Making a complaint about the NHS*. This may involve the offer of speaking with a more senior member of staff or writing to the organisation's Complaints Officer. Complaints staff will be able to assist the patient put their complaint in writing or, if they wish, put them in touch with an independent advice and support service.

Compliments

27. The potential value of complimentary remarks should not be underestimated. Local arrangements should be put in place to identify, recognise and where appropriate share the learning from good individual or team practice.

PART 3: The NHS Complaints Procedure

Part 3: The NHS Complaints Procedure

This section provides guidance on the operation of the complaints procedure.

Definition

28. A complaint is an “*expression of dissatisfaction requiring a response*”¹⁶. However, as there is a very fine line between a complaint and a concern, it is advisable to give people the opportunity to decide if they wish the matter they are raising to be considered under the NHS Complaints Procedure.

Principles for an effective complaints procedure

29. NHS Scotland aims to operate a complaints procedure which is credible, easy to use, demonstrably independent¹⁷, effective and sensitively applied. Making a complaint can be stressful both for those making the complaint and for the staff involved. Local arrangements must therefore be fair to both sides, supporting the person making the complaint and the staff named in the complaint. They must also ensure that the NHS can learn and grow positively from the experience.

30. To be effective local arrangements must:

- be well publicised and accessible to all
- provide an opportunity in a supportive, open environment, for investigation and resolution of a complaint with the minimum of delay, with the aim of reassuring the individual making the complaint, being fair to staff complained against and supporting organisational learning
- contribute to achieving a patient-focussed health service where comments and suggestions are welcomed as a learning opportunity
- ensure that everyone, regardless of their race, age, religion, sexual orientation, gender or any disability or sensory impairment, has equal access and support in raising a complaint through the provision of readily available advice and support services, including advocacy, interpreting and translation, and the provision of information in other formats, including British Sign Language, Braille, etc
- have clear lines of accountability for complaints management and be integrated into the organisation’s clinical governance and quality improvement arrangements
- provide a response that fully addresses the matters raised in the complaint within a reasonable time frame.

Who can Complain?

31. Complaints may be made by:

- a patient¹⁸ or former patient

¹⁶ Citizen’s Charter Complaints Task Force

¹⁷ Our National Health, page 53

¹⁸ or a person likely to be affected by a decision taken by an NHS organisation (see also paragraph 34)

- any appropriate person in respect of a patient who has died, eg the next of kin or their agent
- someone on behalf of an existing or former patient¹⁹. eg a patient's parent, carer, guardian or a visitor; an MP, MSP or local Councillor; or an advocate or member of an independent advice and support organisation.

Where someone other than the patient or their authorised agent wishes to make a complaint, they should be advised that they must be able to demonstrate that they have obtained the patient's (normally written) consent to:

- make a complaint on their behalf;
- members of staff examining the patient's health records, if this should prove necessary as part of the investigation of the complaint.

32. It is for the complaints staff, possibly in discussion with the Chief Executive, to determine whether the person making a complaint is suitable to represent a patient. This decision will depend, in particular, on the need to respect the confidentiality of the patient, for example, the patient may have made it known that their information should not be disclosed to third parties. If it is decided that a person is not suitable to act as the patient's representative, they must be provided with an explanation in writing outlining the reasons for that decision.

What can be complained about?

33. The potential subject of a complaint is wide and not just related to medical care. A complaint may, for example, be about a decision taken by an NHS organisation that is likely to affect the person making the complaint. Each complaint must therefore be taken on its own merit and responded to appropriately.

34. However, the NHS complaints procedure primarily deals with concerns about patient care, or about issues related to or having an impact on patient care and the provision of services, or about matters related to the health of the population served by an NHS organisation where an individual is personally affected. Patients or their authorised representatives may raise issues or concerns about:

- NHS care provided:
 - by hospitals and health centres
 - by Family Health Services (including General Medical Practitioners (GPs); General Dental Practitioners, Opticians and Community Pharmacists)
 - by Community Services who provide health services such as community dentists, community nurses, physiotherapists, dieticians or health visitors etc
 - in private hospitals or care homes in which the patient is funded by the NHS
- NHS funded catering, domestic and environmental matters
- public health issues such as management of major incidents or outbreaks where they have been adversely affected

¹⁹including, for example, a child, young person or adult who is unable to give his/her consent.

- decisions NHS Boards make regarding what services are funded and provided locally where this has an impact on care or services provided or available to them
- the way in which NHS Boards organise healthcare services locally where this has an impact on care or services provided or available to them.

What the Procedure Doesn't Cover

35. Members of the public, including patients, may raise concerns with NHS organisations, which those organisations need to address, but which do not fall within the scope of the NHS Complaints Procedure. The organisation should ensure that there are other appropriate management processes in place to deal with these concerns, which might include:

- matters which are/have been subject to an NHS consultation process or where there are other appropriate avenues for comment, e.g. someone is unhappy with plans to site an NHS building in close proximity to their home
- complaints about the way a candidate perceives an NHS job interview to have been conducted.

36. The NHS Complaints Procedure is unable to look at concerns about:

- private care and treatment or services including private dental care or privately supplied spectacles
- services not provided or funded by the NHS, for example provision of private medical reports etc
- some aspects of care where social work services have responsibility – in these cases the person making the complaint should be advised of where to direct their complaint.

37. If any complaint received by a member or employee of a NHS Board appears to raise matters normally dealt with:

- under the disciplinary procedure
- by a professional regulatory body
- an independent inquiry into a serious incident under Section 76 of the National Health Service (Scotland) Act 1978
- an investigation of a criminal offence, including fraud
- a possible claim for negligence
- under Freedom of Information

they should immediately refer the matter to the person appointed by Board to deal with such matters - complaints staff will be able to advise on who this is. This reference may be made at any point when dealing with a complaint. In these circumstances, investigation of other aspects of the complaint will only be taken

forward if they do not, or will not, compromise or prejudice the matter under investigation.

38. Where it is decided to take action about an aspect covered by another procedure before a complaint investigation is completed, a full report of the investigation thus far should be made. This report should be made available to the person making the complaint, with where possible an indication of the expected timeframe for the other investigation process. The covering letter must balance the need to provide reassurance that their complaint has been dealt with seriously and satisfactorily, with the need to protect the right of staff to confidentiality. The guiding principle should be that the person making the complaint should receive the same consideration and information as if the matter had been dealt with under the complaints procedure. They therefore have a right to know what happened; why it happened; and what action has been taken to prevent it happening again. Any outstanding unresolved element of the complaint may recommence when the other investigation has concluded.

*Staff Grievances*²⁰

39. NHS organisations should have a procedure for handling staff concerns about the way in which they have been dealt with under the complaints procedure. Staff may also take their concerns to the Ombudsman. The Ombudsman would normally expect staff to have followed local procedures for resolving their complaint. However, the Ombudsman has the power to consider complaints that have not been put to the relevant NHS body and/or where the internal procedure has not been exhausted if, in the circumstances of the particular case, it is not reasonable to expect this.

When can a Complaint be made

40. Complaints are normally made at the time a patient becomes aware of an issue or a concern. Wherever possible they should be dealt with immediately to reduce the chance that the passage of time, with inevitable staff changes etc, could hamper resolution. However, it is not always possible for the patient to make a complaint immediately. In clinical complaints, for example, a complication or other issue may not become apparent to the patient for sometime after the procedure.

41. Given the difficulties that the passage of time can make to the resolution of a complaint the **recommended** timescale for accepting a complaint is:

- up to 6 months after the event which is the cause for the complaint, **or**
- up to 6 months from the patient becoming aware of a cause for complaint;
- **but**, normally, no longer than 12 months from the event.

However, NHS organisations must operate these guidelines flexibly and accept a complaint where it would have been unreasonable for the patient to make it earlier and where they believe it is still possible to investigate the facts. A decision not to

²⁰ including those of independent contractors' staff

extend these timescales should be agreed by the Chief Executive. A patient can appeal to the Scottish Public Services Ombudsman against a decision not to accept their complaint.

Joint Complaints

42. Where a complaint relates to the actions of two or more NHS bodies, for example, two NHS Boards, or a Family Health Service practitioner and a NHS Board, there should be agreement about who will take the lead in co-ordinating the complaint and full co-operation between the organisations to resolve the complaint. The person making the complaint must be informed about who will take the lead in dealing with the complaint.

43. Where a complaint covers more than one sector, for example where a patient receives health and social care services while living in the community, 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. The person making the complaint should be informed about which matters are being dealt with under which procedure.

44. Where an NHS Board is advised of a complaint is primarily about a regulated care home, the person making the complaint should be advised that this should first be raised with the care home. If this has been done or the person making the complaint considers that it would be inappropriate to do so, they should be referred to the Care Commission²¹. If the Care Commission investigate, they will liaise directly with the person making the complaint and any NHS provider named in the complaint.

Roles and Responsibilities

The NHS Board

45. NHS Boards should make arrangements to ensure that all staff who provide services on their behalf are aware of and are trained in the procedures to be followed when dealing with patient feedback and complaints.

The Chief Executive

46. The Chief Executive of an NHS Board is statutorily responsible for the quality of care delivered by his or her organisation, and should appoint a named member of their executive team to take responsibility for delivering the organisation's patient feedback and complaints processes and for ensuring that all necessary organisational learning takes place.

The Director with responsibility for patient feedback and complaints

47. The role of the Director with responsibility for patient feedback and complaints is, on behalf of the Chief Executive to whom he or she is accountable, to oversee the way in which the Board's operational divisions, units and independent contractors

²¹ <http://www.carecommission.com/>

deal with patient feedback and complaints. They should ensure that each of the Board's operating divisions or units appoint a complaints officer(s) of sufficient seniority to be able to deal with any issues raised by the NHS Complaints Procedure quickly and effectively without needing to refer, in all but the most exceptional circumstances, to more senior staff. Complaints officers should be readily accessible to patients, the public and staff. It is important that arrangements are made so that the role of the complaints officer is not interrupted by one individual's annual or sick leave.

The Complaints Officer

48. The Complaints Officer should work with staff responsible for other relevant policies to:

- develop ways of encouraging effective patient feedback, including for example telephone and internet-based systems
- manage the operation of the NHS Complaints Procedure within the statutory Directions, so that staff
 - have the training, support and help they need to deal effectively with comments, concerns and complaints, including those which are unreasonably demanding or persistent
 - can advise the person making the complaint on how it will be dealt with, including providing them with a copy of *Health Rights Information Scotland's* leaflet *Making a complaint about the NHS*, and about the role, availability and how to contact:
 - ❖ advice and support services
 - ❖ specialist services, for example those that provide information, translation, interpretation etc
 - know when to seek assistance and advice from senior staff or complaints staff
 - have access to advice and support on associated issues, for example patient consent; confidentiality; the operation of related legislation, such as the Data Protection Act, access to medical records, Freedom of Information, etc
 - have an understanding of how organisations such as the Royal College of Nursing (RCN), the Medical and Dental Defence Union of Scotland (MDDUS), etc can assist them.
- establish procedures to record the handling and consideration of each complaint
- establish procedures to ensure organisational learning from the operation of the Board's patient feedback and complaints process. The complaints officer should ensure that a complete record is kept of the handling and consideration of each complaint. These records will be particularly important if the complaint is referred to the Ombudsman. Complaints records should be kept separate from health records, subject only to the need to record

information which is strictly relevant to the patient's health in their health record.

Dealing with a Complaint

49. A complaint may be made in writing, by phone or in person²².

50. Where a complaint is made to a member of staff their first responsibility is to ensure that the patient's immediate health care needs are being met. They should then contact the organisation's complaints staff.

51. The complaints officer should involve the person making the complaint from the outset. They should establish that they wish the matter dealt with under the NHS Complaints Procedure by explaining the process to them. It is also important to ask them what they want to happen as a result of the complaint. Research carried out in developing this guidance²³ indicates that a common weakness of many local procedures was seeking to investigate and respond to a complaint without first establishing the outcome the person making the complaint would wish. If their expectations are entirely unrealistic, it is important to say so at once. They should be informed of this gently, but firmly²⁴.

52. Where a complaint is made on behalf of somebody else, the complaints officer should ensure that the person making the complaint can demonstrate that they have obtained the patient's consent to:

- make a complaint on their behalf
- members of staff examining the patient's health records, if this should prove necessary as part of the investigation of the complaint.

53. Where the person wishes to proceed, the complaints officer should agree the details of the complaint and confirm them in a letter of acknowledgement.

Acknowledging a complaint

54. Complaints should be acknowledged or an initial response issued in writing²⁵ within 3 working days of receipt. The acknowledgement letter should normally thank the complainant for raising the matter along the following lines:

- *"Thank you for bringing this matter to my attention. I understand that you are concerned about"*
- *"Further to our telephone conversation of I would like to thank you for bringing this matter relating to to my attention".*

²² where complaints are made by eg fax, e-mail, textphone/typetalk etc the correspondent should be advised that these methods may not guarantee confidentiality. A name and home address should always be obtained and the method of correspondence for the future agreed.

²³ <http://www.show.scot.nhs.uk/complaints/Persistent%20and%20Serial%20Complainers%20Report.pdf>

²⁴ <http://www.show.scot.nhs.uk/complaints/Appendices%20PC%20Report.pdf> Appendix 3'

²⁵ the term 'written' covers use of Braille, audio tape etc to meet the needs of the person making the complaint.

wherever appropriate, they should also express sympathy or concern over the incident, for example:

- *"I regret the discomfort experienced"*.
- *"I apologise for the anxiety this incident has caused to you and your family"*.

However, replies should be personalised to the individual and the examples quoted above should not be followed rigidly.

55. The letter should also:

- outline the proposed course of action to be taken or the investigations being conducted
- offer the opportunity to discuss issues either with a member of the complaints staff or, if appropriate, with a senior member of staff
- provide information about the availability of independent support and advice, or the possible use of conciliation where this may help and may be agreeable to both parties.

56. First class post – or, exceptionally, special/recorded delivery – should be used in correspondence with the person making a complaint and practitioners. All communications should be marked 'Private and Confidential' or 'Personal'.

The Investigation

57. It is important that a timely and effective response is provided in order to resolve a complaint, and to avoid escalation. An investigation of a complaint should therefore be completed, wherever possible, within 20²⁶ working days following the date of receipt of the complaint. Where it appears the 20 day target will not be met, the person making the complaint, and anyone named in the complaint, must be informed of the reason for the delay with an indication of when a response can be expected. The investigation should not, normally, be extended by more than a further 20 working days.

58. While it may be necessary to ask the person making the complaint to agree to the investigation being extended beyond 40 working days, for example because of difficulties caused by eg staff illness, they should be given a full explanation in writing of the progress of the investigation, the reason for the requested further extension, and an indication of when a final response can be expected. The letter should also indicate that the Ombudsman may be willing to review the case at this stage if they do not accept the reasons for the requested extension.

59. A complaint may best be resolved through face-to-face meetings²⁷ being arranged with members of staff and early consideration should be given to this approach. Equally, the complaints officer may decide, on a case by case basis that other action would be helpful, for example offering conciliation. However, a record

²⁶ For Family Health Services, see paragraph 73

²⁷ The person making the complaint should be informed that they can be accompanied by a friend or other supporter.

should be kept of all meetings and discussions and a letter issued setting out the agreements reached and any action to be taken.

60. It is important to ensure impartiality in an investigation. The investigating officer must approach the complaint with an open mind, being fair to all parties. The investigation must not be adversarial and must be conducted in a supportive, blame free atmosphere that demonstrates the principles of fairness and consistency. Anyone identified as the subject of a complaint should be provided with a full account of the reasons for the investigation and a proper opportunity to talk to the investigating officer who should ensure they are kept informed of progress. The person making the complaint and the person complained against should be informed of the support services that are available to them. The process is best described as listening, learning and improving.

61. Complaints officers should ensure that all information relevant to the investigation is recorded and kept in a case file. If, subsequently, the complaint is referred to the Ombudsman, this may result in a request for all relevant papers and other information to be provided in good time to the Ombudsman's office. Complaints records should be kept separate from health records, subject only to the need to record information which is strictly relevant to the patient's health in their health record

62. Where the complaint involves clinical issues, the draft findings and response must be shared with the relevant clinicians to ensure the **factual** accuracy of any clinical references.

Completing Local Resolution

63. The complaints process should be completed by the Chief Executive²⁸ reviewing the case to ensure that all necessary investigations and actions have been taken. If the Chief Executive is satisfied that the complaints process is complete, they should issue a letter to the person making the complaint. The letter should be clear and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address all the issues raised and show that each element has been fully and fairly investigated
- include an apology where things have gone wrong
- report action taken or proposed to prevent any recurrence
- highlight any area of disagreement and explain why no further action can be taken
- indicate that a named member of staff is available to clarify any aspect of the letter
- indicate that if they are not satisfied with the outcome of the local process, they may seek a review by the Scottish Public Services Ombudsman - details of how to contact the Ombudsman office should be included.

²⁸ or in Family Health Services the senior or executive or complaints partner.

64. There may be some circumstances where a Chief Executive decides that it is appropriate to nominate a senior officer to 'sign off' responses on their behalf. In such circumstances, corporate and clinical governance arrangements should be made to ensure that the Chief Executive can maintain an overview of the issues raised in complaints, the responses given and be assured that appropriate organisational learning has taken place.

65. Once the final response has been signed and issued, the complaints staff should file all correspondence, liaise with local senior managers to ensure that all necessary follow-up action is taken, for example sharing the outcome with those named in the complaint and providing any necessary staff support or counselling, and report to the Board's Clinical Governance Committee when this has been done. In the interests of patient confidentiality, it might not be appropriate to copy the response letter to all those involved in the investigation, but general feedback on the main conclusions and actions should be given. In more serious cases the Board may wish to consider a formal debrief for the staff involved in the complaint.

66. Arrangements should also be made for any outcomes to be monitored to ensure that they are actioned. It is good practice to keep the person who made a complaint and those named in the complaint informed of progress and the final outcome when all actions have been taken.

Learning from Complaints

67. It is good practice to collect data on complaints, even when they are not confirmed in writing, so that lessons can be learned which may help improve service delivery throughout the organisation. NHS Boards must therefore have in place area-wide procedures for collecting and disseminating the information, themes and good practice gained from patients' views, experiences and complaints and ensuring they are used to improve service quality. Local managers and Family Health Service practitioners should be encouraged to share this information and seek staff feedback and suggestions for further improvement.

Specific Issues for Family Health Service Practitioners

The independent contractor and the NHS complaints procedure

68. Most Family Health Service practitioners, such as GPs, dentists, opticians and community pharmacists, are not employed by the NHS. They are '*independent contractors*' who hold a contract with the NHS to provide a service to patients. They are responsible for their own actions in exercising their clinical duties and for the administrative and organisational aspects of running their practices. In general, they also directly employ the staff within their practices, and are, therefore, responsible for their actions too.

69. Family Health Service practitioners are obliged by the 'terms of service' in their contract to have in place and operate for the NHS services they provide a practice-based complaints procedure, which complies with Directions issued by the Scottish Executive. Failure to do so could result in disciplinary action.

70. The disciplinary process is entirely separate from the complaints process and the aims of the two are very different. The focus of the complaints process is to resolve issues between parties and to learn lessons for improvement to service delivery. The complaints process is not, and should not be, restricted in what it can deal with and, therefore, even matters that would not constitute a breach of the terms of service if proved, can be dealt with under the complaints procedure.

71. Family Health Services are also very personal services. The majority of an individual's contact with the NHS is with Family Health Services and their relationship with their GP may, literally, last a lifetime. The vast majority of Family Health Service contacts are already 'patient-focused' but, when things go wrong, this special relationship can make complaints resolution more difficult. Patients may not want to raise a concern directly with the practitioner and, sometimes, issues can lead to a breakdown in the professional relationship. To recognise the special relationship patients have with Family Health Services, a complaint can be made either to the practice or to the NHS Board who will agree a way forward with the person making the complaint.

What can be complained about?

72. The NHS complaints procedure is intended to deal with complaints made about the NHS services provided by the practice. It does not deal with complaints about non-NHS services for example, privately supplied spectacles, private dental treatment, etc. If it is unclear whether a service is an NHS service, the NHS Board should be asked to help establish the facts without being drawn into the investigation of the complaint.

Handling complaints

73. Practices should adopt a positive approach to patient feedback and the investigation of complaints by:

- ensuring that the complaints process is 'owned' by the practice
- designating a named person to be responsible for managing the procedure
- publicising the procedure and ensure that it is clear to patients, carers etc how to lodge a complaint and to whom it should be addressed
- ensuring that complaints are acknowledged or an initial response issued in writing within 3 working days
- ensuring that the person nominated to investigate the complaint makes all necessary inquiries, including, where appropriate, interviewing the person making the complaint, the practitioner(s) and practice staff
- ensuring that a full response is provided within 10 working days of receipt of the complaint. Where it appears the 10 day target cannot be met, the person making the complaint must be informed of the reason for the delay with an indication of when a response can be expected. Normally, this should be within 20 working days of the date of receipt of the complaint²⁹

²⁹ See also paragraph 58

- providing information about the role and how to contact independent advice and support and the Scottish Public Services Ombudsman.

The NHS Board

74. NHS Boards should provide access for people wishing to complain about a Family Health Service to a named individual who can explain how the NHS complaints procedure works and the options open to them. Normally, the most effective resolution route is for the person wishing to make a complaint to deal with the practice.

75. Provided the NHS Board is not involved in any way in the complaint itself, it may also offer its impartial advice and support in making the process of resolution easier for both parties. This might be appropriate where, for example:

- the person making a complaint wants no direct contact with the practice, and the Board consider it appropriate for them to act as a 'post box' for correspondence
- the person making a complaint is prepared to deal with the practice, but would be more comfortable if a Board representative attended meetings between the parties
- a practice is relatively inexperienced in handling complaints or the complaint is particularly complex. However, wherever possible and appropriate the practice should be encouraged to engage directly with a complainant.

76. The Board should agree the extent and scope of its role with both parties at the outset. This will vary from case to case depending on the source of, and the reason for, the request. It should, for example, be made clear that the Board cannot assume responsibility for either the circumstances leading to the complaint or for the resolution of the complaint – these continue to rest with the practice, who also remain responsible for:

- investigating the issues raised
- providing information and co-operating in the resolution of the complaint
- the factual accuracy of information provided during the investigation
- ensuring a response is provided to the person making the complaint.

Failure to operate a complaints procedure

77. Where it appears that a practice is not operating a complaints procedure, the NHS Board should arrange for the facts to be established and appropriate action taken. This may involve reminding the practitioner of their terms of service requirement to operate a practice complaints procedure and offering support where appropriate. If a practice procedure does not meet the requirements of the statutory Directions, the Board may need to consider whether disciplinary action for breach of terms of service would be appropriate.

Role of the Ombudsman

78. The Scottish Public Services Ombudsman Act 2002 established a 'one-stop shop' ombudsman service, headed by the Scottish Public Services Ombudsman³⁰, to deal with complaints formerly handled by the Scottish Parliamentary Ombudsman, the Scottish Health Service Ombudsman, the Scottish Local Government Ombudsman and the Housing Association Ombudsman for Scotland. The new Ombudsman also took over the Mental Welfare Commission's³¹ function of investigating complaints relating to mental health.

79. The Ombudsman can in principle investigate complaints from aggrieved persons that have sustained injustice or hardship as a result of maladministration or service failure³² on the part of an authority within the Ombudsman's jurisdiction. Such authorities (referred to as "listed authorities") include all NHS bodies and family health service providers in Scotland.

80. The Ombudsman's office can generally consider complaints only when they have been fully considered under a listed authority's internal complaint procedures - although this requirement can be waived in exceptional circumstances. Complaints should generally be made to the Ombudsman within 12 months of the events giving rise to them, or within 12 months of the complainant becoming aware that there were grounds for complaint, although there is scope to waive this requirement if there are special circumstances.

81. The Scottish Public Services Ombudsman Act 2002 requires listed authorities, such as NHS Boards and family health service providers, to take reasonable steps to publicise -

- the right conferred by the Act to make a complaint to the Ombudsman
- the time limit for doing so
- how to contact the Ombudsman.

The Ombudsman's contact details are:

The Scottish Public Service Ombudsman
Freepost EH641
EDINBURGH
EH3 0BR
Telephone 0870 011 5378
Email enquiries@scottishombudsman.org.uk
Website, which includes a complaints form, www.scottishombudsman.org.uk

³⁰ The circular '*A modern complaints system: the new Scottish Public Services Ombudsman*' provides further information about the legislation governing the Ombudsman's work at:

<http://www.scotland.gov.uk/library5/government/amcs-00.asp>

³¹ <http://www.mwscot.org.uk/>

³² *Maladministration* is generally taken to mean a failure in administrative procedures or processes, and *service failure*, as defined in statute, as "any failure in a service provided by the authority, or any failure of the authority to provide a service which it was the function of the authority to provide".

Monitoring Of Complaints

Informing the Board

82. NHS Boards are required to make arrangements to monitor how they, or those providing care on their behalf deal with the complaints they receive. Monitoring should be undertaken with due regard to the principles of equality and diversity in terms of the person making the complaint, the person complained against and the content of the complaint. In so doing Boards should identify areas for action in relation both to service improvement and their responsibilities to deliver a service that is *Fair for All*. The Board should receive a quarterly report which identifies:

- trends in complaints
- the effectiveness of local complaints handling
- the lessons learned and shared and the result in terms of service improvement.

This data should be regularly supplemented by surveys of patient views on the way in which their feedback is acted upon.

83. An increase in the number of complaints should not in itself be a reason for thinking the service is deteriorating. It could mean that the organisation's patient feedback arrangements are becoming more responsive. The important point is to ensure that complaints (and comments, concerns and compliments) are handled sympathetically, effectively and quickly and that lessons are learned and result in service improvement.

Annual Reports

84. NHS Boards must publish in their Annual Reports a report on patient feedback and complaints handling which explains some of the statistics, expands on lessons learned and the action plans developed. Care must be taken in compiling these reports to avoid any possible breaches of patient confidentiality.

National Monitoring

85. The Information and Statistic Division (ISD) will continue to collect statistics on the number and type of complaints made to NHS Boards and Family Health Service practitioners.

**PART 4: INFORMATION THAT MAY BE USEFUL IN DEALING
WITH COMPLAINTS**

Part 4: Information that may be useful in dealing with comments, concerns and complaints

This section provides information on related policies, procedures, legislation etc which may impact on the handling of a complaint. It is intended to be a guide to some of the issues on which NHS Boards should have local policies. It is not meant to be all-embracing or to cover every contingency, and the general advice it offers is purely advisory. NHS Boards remain responsible for ensuring the appropriateness of their actions and for their interpretation of related legislation. They are encouraged, within the scope of the Directions, to develop local initiatives and training in a way that ensures the management and operation of the procedure meets local circumstances.

1. ADVICE AND SUPPORT

1.1 It is important that individuals are able to navigate and be provided with information on local NHS systems. When things go wrong, as they inevitably do within a large organisation such as the NHS, people sometimes need support to help them understand and use the NHS Complaints Procedure. People who are normally confident and articulate may feel less able to cope because of illness, anxiety, or lack of knowledge and may feel intimidated by professional attitudes that seem paternalistic or authoritarian.

1.2 NHS Boards should have in place arrangements to:

- ensure patients (or their representatives) have access to information and advice about local healthcare services
- provide information, advice and support to patients to identify and explore options about making a complaint when they are dissatisfied with aspects of the treatment or care provided to them by or on behalf of the NHS Board
- provide information, advice and support to patients and carers to assist them cope with the direct and indirect effects of illness or disability, helping to reduce anxiety and stress.

1.3 As patients should have access to a complaints support and advice service provided independently of NHS organisations, Boards should develop a strategic partnership with a consortium of the Citizens Advice Bureaux in their area. To assist this, Citizens Advice Scotland has been funded to work with Boards to support the development of these partnerships. The Scottish Health Council will monitor Board's support and advice services to ensure that they meet local need. A draft framework for a local advice and support services will issue shortly for final comment.

2. ADVOCACY

2.1 Advocacy services are an important way of enabling people to make informed choices about, and to remain in control of, their own health care. Advocacy helps people have access to information they need, to understand the options open to them, and to make their views and wishes known. In these ways it provides support to people in reaching decisions about their care and treatment. Advocacy in NHS Scotland therefore has two main themes:

- protecting vulnerable people; and
- supporting them in making their wishes and needs known.

2.2 Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives, and for their friends. Concerned individuals do it for people who are particularly vulnerable or undervalued. In the NHS, advocacy has been mainly available for vulnerable groups, such as people with mental health problems, learning disabilities, and older people (including those with dementia).

2.3 NHS Boards, working with Local Authorities and other partner organisations, are required³³ to provide access to independent advocacy services to all users of NHS services who need it. Further information on advocacy services can be obtained from the:

Advocacy Safeguards Agency

1-2 St Andrew Square,

Edinburgh

EH2 2BD

Tel: 0131 524 9380

Fax: 0131 524 9381

or

Scottish Independent Advocacy Alliance

138 Slateford Road

Edinburgh EH14 1LR

Phone: 0131 455 8183

Fax: 0131 455 8184

³³ NHS Circular HDL (2001)8

COMMISSIONED SERVICES

3.1 Some aspects of patient care are provided by an independent provider under contract to an NHS Board, for example nursing home care, hospital 'hotel' services, etc. Such contracts should include a provision requiring the service provider to comply with the requirements of the NHS complaints procedure.

3.2 Where a complaint is received by an NHS Board that relates to a service procured from an independent provider, the Board is responsible for ensuring that the complaint is adequately answered. If this proves difficult, the NHS Board may have to use their contract's quality monitoring provisions to ensure resolution.

3.3 Complaints about care provided on the Board's behalf in nursing or care homes may also be referred to and investigated by the Care Commission who will liaise directly with any NHS provider named in the complaint.

4. CONCILIATION

4.1 Conciliation is a **voluntary process** which seeks to resolve difficulties and which may help the resolution of a complaint at local level. It is a process of examining and reviewing a complaint with outside assistance. Conciliation is often useful in resolving difficulties arising from a breakdown of a relationship, for example between a clinician and a patient. NHS Boards must make suitably trained, competent and accredited conciliators available where this assistance is requested. Either party may request conciliation, but both parties must agree to the process being used.

4.2 The aim of conciliation is to enable both parties to address the issues in a non-confrontational manner with the aim of reaching an agreement. The function of the conciliator is to assist the process, **not to impose a solution**. Any resolution of the complaint must come from the parties concerned. The conciliator seeks to clarify the issues and to help in exploring the options. Essentially, the conciliator works to ensure that good communication takes place between the parties.

4.3 Confidentiality is vital in the conciliation process. The conciliator should encourage the participants to explore the issues involved in the complaint in an open manner. The content of the conciliation process remains confidential and neither the conciliator nor the participants should provide information from the process to any other person. The conciliator should advise when conciliation has ceased and whether a resolution was reached. No further details should be provided.

4.4 Where conciliation fails and the complainant wishes to pursue the complaint, the process should continue in the normal way with a final response letter being sent from the relevant NHS body. However, as the conciliation process is confidential, neither party can use anything said during that process to support their case.

5. CONFIDENTIALITY OF PATIENT INFORMATION

5.1 The requirement to maintain confidentiality is absolute during the complaints procedure. Staff in NHS Boards and Family Health Services practices should be aware of the requirements of the Data Protection Act 1998, the contents of 'Protecting and Using Patient Information - a Manual for Caldicott Guardians' (SEHD, 1999), and of HDL (2003)37 on 'The Use of Personal Health Information' and any relevant provisions in their local staff code of conduct.

Obtaining Express Consent to Use Information in Health Records

5.2 Where a patient makes a complaint that relates to a clinical matter, they should be informed that information from their health records may need to be disclosed to those handling the complaint, but this information will only be shared on a need-to-know basis. All complaints leaflets must contain this information and a leaflet should always be sent to the patient when acknowledging receipt of the complaint. If the patient objects to this, they should be advised that refusal to allow information sharing could affect the handling of the complaint.

Deceased Patients

5.3 In the case of a deceased patient, the 1990 Access to Health Records Act applies and the patient's personal health information can be disclosed to the patient's representative and 'any person who may have a claim arising out of the patient's death'. However, doctors are also bound by GMC guidance, which warns that

'you still have an obligation to keep personal information confidential after a patient dies. The extent to which confidential information may be disclosed after a patient's death will depend on the circumstances. These include the nature of the information, whether that information is already public knowledge or can be anonymised, and the intended use to which the information will be put. You should also consider whether the disclosure of information may cause distress to, or be of benefit to, the patient's partner or family' (see also Access to Health Records Act)

5.4 The NHS complaints procedure may also be used to investigate a complaint about any aspect of an application to obtain access to the health records of deceased persons under the **Access to Health Records Act 1990**. This does not affect the patient's representative's right to take the matter to a court if they remain dissatisfied with the outcome of an investigation.

5.5 Access to records compiled before November 1991 is at the discretion of the record holder, having regard to the fact that such records were not compiled in the expectation that they would be disclosed to the patient.

5.6 For records compiled after November 1991 it remains the responsibility of the record holder to decide whether access should be granted. Decisions to withhold information should be taken by the Chief Executive³⁴.

5.7 Care must be taken in reporting the outcome of a complaints investigation about access to health records to ensure that the complainant does not obtain information to which he/she would not be entitled under the Access to Health Records Act 1990. This is particularly important in the following circumstances:

- where access was denied on the grounds that it might cause serious damage to the physical or mental health of the patient's representative or another individual
- where the information relates to, or was provided by a third party who could be identified from the information and who has not consented to its disclosure.

Third Party Information

5.8 Third party information must not be disclosed unless the person who has provided that information, or about whom information is held, has expressly consented to its disclosure. This also applies where the information would enable the third person to be identified as the source of the information.

5.9 The duty of confidentiality applies equally to third parties who have given information or who are referred to in the patient's records, unless they are health professionals who either contributed to the record or were involved in the care of the patient. The Data Protection Act 1998 sets out only 2 circumstances in which information relating to a third person can be disclosed:

- where the other individual has consented to the disclosure of this information, or
- where it is reasonable in all the circumstances, e.g. an overriding public interest³⁵, to comply without the consent of the third person.

Even if these circumstances apply, only that information which is relevant to the complaint should be considered for disclosure, and then only to those within the NHS who have a demonstrable need to know in connection with the complaint investigation.

³⁴ or in Family Health Services the Senior or Executive or Complaints Partner

³⁵ The GMC describes an overriding public interest as '*where the benefits to an individual or to society outweigh the public and the patient/ individual's interest in keeping the information confidential*'.

Use of anonymised information

5.10 Where anonymised information about patients and/or third parties would suffice, identifiable information must be omitted. Anonymisation does not of itself remove the legal duty of confidence, but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/third party identity, it may be passed on where justified by the complaint investigation.

6. CONSENT

6.1 Where someone (including MPs, MSPs and local Councillors) other than the patient or their authorised agent wishes to make a complaint, they should be advised that they must be able to demonstrate that they have obtained the patient's consent to:

- make a complaint on their behalf;
- members of staff examining the patient's health records, if this should prove necessary as part of the investigation of the complaint.

Exceptions are if that individual is a child or is deemed by a clinician as incapable of acting on their own behalf: for example where the individual has been rendered unconscious by an accident; or their judgment is impaired by a learning disability, psychiatric illness, dementia or brain injury; serious communication problems or where the individual has died.

Children and Young People

6.2 All NHS organisations should have and operate clear policies in relation to obtaining consent where the patient who is the subject of a complaint is a child. These procedures should reflect any guidance or advice that may be issued by the Commissioner for Children and Young People in Scotland. The principles in that guidance will be equally relevant to the local operation of the NHS complaints procedure.

6.3 Generally, a person with parental responsibility can pursue a complaint on behalf of a child where the NHS organisation judges that the child does not have sufficient understanding of what is involved. While in these circumstances, the child's consent is not required, it is considered good practice to explain the process to the child and inform them that information from their health records may need to be disclosed to those investigating the complaint^{36 37}.

³⁶Code of Practice on Confidentiality of Personal Health Information, NHS Circular No 1990 (GEN) 22

³⁷UKCC Code

6.4 Where an NHS organisation judges that a child has sufficient maturity and understanding³⁸, they can either pursue the complaint themselves or consent to it being pursued on their behalf by a parent or third party of their choice. It is also good practice to obtain the child's written consent to information from their health records being released.

Adults who cannot give consent

6.5 Where a patient is unable to give consent, or where the patient has died, the NHS organisation can agree to investigate a complaint made on their behalf by a third party. However, before doing so they should satisfy themselves that the third party has:

- no conflict of interest, and
- a legitimate interest in the patient's welfare, for example if they are a Welfare Attorney acting on behalf of an individual covered by the Adults with Incapacity Act³⁹.

CONTINUING CARE

7.1 The review procedure for continuing care is not part of the NHS complaints procedure⁴⁰. Where someone has had their case considered by a continuing care review procedure they can use the NHS complaints procedure to complain about, for example, the original decision on discharge, or the continuing care review process.

7.2 Alternatively, they may choose to complain directly to the Ombudsman, who has discretion to decide whether, in the circumstances of the particular case, to waive the normal requirement that, before there is an investigation by the Ombudsman, the NHS complaints procedure should have been invoked and exhausted. As with all complaints, the Ombudsman will need to be convinced that there are clear grounds for an investigation related to hardship or injustice.

8. CRIMINAL INVESTIGATION and INDEPENDENT INQUIRIES

8.1 As the complaints procedure cannot deal with matters subject to a criminal investigation or an independent inquiry into a serious incident, consideration of those parts of a complaint affected by that investigation must be suspended until the other investigation is concluded. The Chief Executive should immediately advise the complainant of this in writing.

³⁸The Age of Legal Capacity (Scotland) Act and Data Protection Act 1998

³⁹ <http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2000/20000004.htm>

⁴⁰ See MEL(1996)22

8.2 Where such an investigation is initiated before the NHS complaints procedure has been completed, a full report of the investigation to that point should be made available to the complainant under cover of a letter from the Chief Executive indicating that this information may need to be passed to the criminal/independent investigation and how any other aspect of their complaint not affected by these investigations will be dealt with under the complaints procedure.

8.3 When the independent inquiry or criminal investigation has concluded, consideration of any outstanding part of the original complaint on which action was suspended can recommence.

9. DATA PROTECTION ACT 1998

9.1 Patients may use the NHS complaints procedure for complaints arising from rights given by the Act, and if this route is chosen, complaints staff will take the matter forward in conjunction with the Data Protection Officer or Data Controller within the NHS Boards or Family Health Services practice, ie the person who makes decisions on what information is stored and how it is processed. Where a patient remains unhappy with the outcome of local resolution they should be advised to contact the UK Information Commissioner⁴¹.

9.2 Under the Data Protection Act 1998, patients or their representatives may also make a request to the Information Commissioner for an assessment about any aspect of their own health records, or any other aspect related to the processing and storage of their personal health information. This is an assessment of how well the organisation has complied with the Act in processing their data.

9.3 The Data Protection Act 1998 lists a number of categories of personal information⁴² which are exempt from access by the patient:

- UK human fertilisation and embryology information
- Information contained in adoption and parental order records and reports
- Information provided by reporters for the purposes of a children's hearing

and prohibits access to information⁴³ where:

- it might cause serious damage to the physical or mental health of the patient or another individual, including a health professional

⁴¹ <http://www.informationcommissioner.gov.uk>

⁴² SI 2000 No 419 'The Data Protection (Miscellaneous Subject Access Exemptions) Order

⁴³ SI 2000 No 413 The Data Protection (Subject Access Modification) (Health) Order 2000

- someone acting on behalf of a patient has requested access to the patient's data, but the patient has given the information on the condition that it would not be disclosed, eg in the case of a young person requesting contraception
- where information relates to or was provided by a third party who could be identified from the information and who has not consented to its disclosure.

9.3 Care must be taken to ensure that in reporting the outcome of an investigation into a complaint about access to health records that the patient does not obtain information to which he/she is not entitled under the Data Protection Act 1998.

10. 'OUT-OF-HOURS' CARE

10.1 The Family Health Service contract defines the practitioner's 'terms of service' and when the doctor will be held responsible for the treatment given to his or her patients. A doctor is responsible for his or her own acts and omissions, and also for those of any doctor acting as his or her deputy. However, if that deputy is a doctor whose name is on a medical list of an NHS Board – not necessarily the same Board as the doctor who has employed him or her - then he or she (the employing doctor) is responsible for their actions.

10.2 Under the new General Medical Services contract a GP may opt out of out-of-hours care. Where this has happened, the NHS Board is responsible for the provision of out-of-hours care and will have responsibility for handling complaints about that service.

10.3 A doctor may decide not to opt out of the provision of out-of-hours services. They can also transfer his or her out-of-hours obligations to a deputising doctor who is on a medical list, but they retain responsibility for dealing with any complaints that arise from that service.

NHS 24 involvement in out-of-hours complaints

10.4 NHS 24 is a national provider of information to patients about health and health care. It operates 24 hours a day, 365 days a year and provides an initial assessment service for all calls to GP services after hours, at weekends and on public holidays. Where NHS 24 receives a complaint about:

- its own service it will deal these under its own local procedure
- its services and services provided by a local service, it will co-ordinate a response to the complaint with the local service;
- a service provided entirely by a local out-of-hours service, it will acknowledge the complaint and explain that it is being transferred to the local service for a reply.

11 DISCIPLINARY ACTION AND INVESTIGATION BY A PROFESSIONAL ORGANISATION

Disciplinary Action

11.1 The NHS Complaints process requires a **clear separation of complaints from discipline**. The latter is essentially concerned with an individual's contract of employment/Terms of Service, while complaints can take in wider issues - eg an individual's demeanour.

11.2 Where a decision is made to embark upon a disciplinary investigation, action under the complaints procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the complaints procedure.

11.3 The Chief Executive must advise the complainant in writing that a disciplinary investigation is under way; that they may be asked to take part in that process; and that:

- issues affected by the disciplinary investigation cannot be taken forward until the disciplinary investigation is complete
- how issues not affected by the disciplinary investigation will be taken forward as part of the complaints procedure.

In drafting these letters, care must be taken to ensure that the complainant is not left feeling that their grievance has only been partly dealt with.

11.4 If a complainant asks to be informed of the outcome of the disciplinary investigation, the NHS Board's response must balance the need to reassure the complainant that their grievance has been dealt with seriously and satisfactorily, with the need to protect the right of confidentiality of its staff. The guiding principle should be that the complainant should receive the same consideration and information as if the matter had been dealt with under the complaints procedure. They therefore have a right to know what happened; why it happened; and what action has been taken to prevent it happening again. They can also be told, in general terms, that disciplinary action may be imposed as a result of the complaint.

Investigation By A Professional Body

11.5 A similar approach should be adopted in a case referred to a statutory professional or regulatory body, for example the NMC for nurses, midwives and health visitors. The Chief Executive must:

- inform the complainant in writing of the referral to the regulatory body;
- explain that the NHS Board now has no control over what happens or over how long the process will take;
- give as full a response as possible on the matter indicating that this information may need to be passed to the regulatory body;
- indicate how any other aspect of their complaint not covered by the reference to the regulatory body will be investigated under the complaints procedure.

12. FATAL ACCIDENT INQUIRIES/PROCURATOR FISCAL CASES

12.1 All NHS organisations and Family Health Services Practitioners must report to the Procurator Fiscal any death where a complaint has been received about the medical treatment given to the patient⁴⁴.

12.2 Where a complaint is about an incident which may result in a Fatal Accident Inquiry (FAI) being held, the Chief Executive⁴⁵ should consider whether it would be appropriate to proceed with investigating a complaint before the FAI is held and, if necessary, seek advice from the Procurator Fiscal's Office. It may be more appropriate to recommence the complaints procedure after the completion of the FAI to consider any matters not dealt with by it.

13. GRIEVANCE PROCEDURES

13.1 The NHS complaints procedure does not address the concerns of staff. There are separate procedures for handling staff grievances. NHS Circular GEN(1993)10 and associated guidance sets out the rights and responsibilities of staff when raising issues of concern about health care matters. Local procedures will also cover more general grievances.

13.2 NHS Staff may complain about the way they have been dealt with under the complaints procedure and, provided they have exhausted the local grievance procedure, may take the matter up with the Ombudsman.

⁴⁴ For further guidance on handling deaths in hospital, refer to NHS MEL 1999(75)

⁴⁵ Or in Family Health Services the Senior or Executive or Complaints Partner

14. NEGLIGENCE CLAIMS

14.1 If a complaint reveals a *prima facie* case of negligence, or the likelihood of legal action, the complaints officer should inform, and seek advice from, those responsible for dealing with risk/claims management. Complaints staff should not infer that the person making the complaint has decided to take formal legal action, even if their initial communication is via a solicitor's letter. Reacting to a complaint in a hostile or defensive manner is more likely to encourage the person making the complaint to seek a remedy through the courts.

14.2 In the early part of the complaints process it may not be clear whether the complainant simply wants an explanation and apology, with assurances that any failures in service will be rectified for the future, or whether they are in fact seeking information with litigation in mind. It is important that at this stage all complainants are treated with an open and sympathetic approach. Even *prima facie* evidence of negligence should not delay a full explanation of events and, if appropriate an apology: an apology is not an admission of liability.

14.3 However, if the complainant indicates an intention to instigate or instigates legal action, **the complaints procedure should be immediately suspended**. The Chief Executive⁴⁶ should advise the person making the complaint and any person(s) named in the complaint of this decision in writing.

14.4 All papers relating to the complaint should be passed to the person appointed to deal with such matters - complaints staff will be able to advise on who this is.

15. PRIVATE PAY BEDS IN NHS HOSPITALS

15.1 The NHS complaints procedure covers any complaint made about an NHS Board's staff or facilities relating to care in private pay beds, but it does not cover private medical care provided by NHS staff outside their NHS contract.

16. PUBLICITY

16.1 NHS Boards must ensure that their patient feedback and complaints procedures are well publicised locally. This means that patients and visitors should be aware of:

- The right to complain

⁴⁶ Or in Family Health Services the Senior or Executive or Complaints Partner

- Advice about how to access the complaints procedure, and the types of help available from:
 - frontline staff
 - complaints staff
 - advocacy and advice and support services.

16.2 All NHS organisations should also ensure that patients and their families have access to Health Rights Information Scotland's (HRIS) leaflet *Making a complaint about the NHS*. The HRIS information is available in accessible formats, as follows:

- leaflets in large (14 point) print in English
- easy-read leaflets with illustrations
- audio format in English
- CD-rom with British Sign Language
- Leaflets and audio formats in ethnic minority languages
- Accessible web-based information

This and any other necessary local information to enable access should be provided free of charge to any person who makes a request for it.

17. TRAINING

17.1 Training, initially through induction, is key to making the NHS complaints procedure work effectively. NHS Boards have a responsibility to ensure that their staff are competent and confident in dealing with expressions of concern or complaint. The improvement of these skills throughout the NHS Board must be a high priority of the Chief Executive and the NHS Board. Good practice suggests that NHS Board's key players in the complaints process benefit from regular informal discussion of matters of common interests for example local complaints data and the publication of the Ombudsman's Report.

18 UNREASONABLY DEMANDING OR PERSISTENT COMPLAINTS

18.1 NHS staff should be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further which can reasonably be done to assist them or to rectify a real or perceived problem. Where this is the case and further communications would place inappropriate demands on NHS staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonably demanding or persistent complainant.

18.2 NHS Boards and Family Health Service providers should ensure that, as part of their local complaints process, they have a policy for considering whether a person making a complaint is being unreasonably demanding or persistent.

18.3 Classifying a person making a complaint as unreasonably demanding or persistent should only occur in exceptional circumstances when it can be shown that:

- the complaints procedure has been correctly implemented
- all reasonable measures have been taken to resolve the complaint
- no material element of the complaint has been overlooked or inadequately addressed

and a full written case has been submitted to and approved by the Chief Executive⁴⁷ and Chair of the NHS Board.

18.4 Before agreeing to classify a correspondent as unreasonably demanding or persistent, consideration should be given to dealing with future correspondence in one or more of the following ways:

- by drawing up a signed "agreement" with the correspondent (and if appropriate involving any relevant practitioner in a 2-way agreement) which sets out a code of behaviour for the parties involved if the complaint is to continue being processed. If these terms are contravened, consideration would then be given to implementing other action as indicated in this section.
- declining contact with the correspondent either in person, by telephone, by fax, by letter or any combination of these, provided that one form of contact is maintained
- temporarily suspending all contact with the correspondent or investigation of a complaint whilst seeking legal advice or guidance from other relevant agencies.

18.5 Where a decision is taken to classify a correspondent as an unreasonably demanding or persistent complainant, the Chief Executive⁴⁸ must notify the person in writing of the reasons why they have been so classified and the action which will be taken with future correspondence or calls. The letter should provide a summary of the organisation's position on their complaint, indicating that:

- they have responded fully to the points raised and, as there is nothing more to add, continuing contact on the matter will serve no useful purpose
- that further correspondence will simply be acknowledged unless it raises a new matter of substance.

⁴⁷ Or in Family Health Services the Senior or Executive or Complaints Partner

⁴⁸ Or in Family Health Services the Senior or Executive or Complaints Partner

In extreme cases the correspondent might also be advised that the organisation reserves the right to pass future correspondence to their solicitors.

18.6 This notification letter may be copied for the information of others involved in the process, eg conciliator, MSP, etc. A record must be kept of the reasons why a complainant has been classified as unreasonably demanding or persistent.

Note: it is an important when considering classifying an individual from an equality group as an unreasonably demanding or persistent complainant to make appropriate checks to ensure that the decision is in no way based on institutional discrimination or on a lack of knowledge of the specific needs of that individual.

Reviewing or Withdrawing Unreasonably Demanding or Persistent Status

18.7 The local procedure should also set out arrangements for reviewing or removing the designation of 'unreasonably demanding or persistent complainant' from an individual at a later date if, for example, they subsequently demonstrate a more reasonable approach. Staff who previously have used their judgement in recommending 'vexatious or habitual' status should similarly be prepared to use it in recommending that this status be withdrawn where appropriate. Once again, the Chief Executive⁴⁹ and Chairman should make any such decision. Subject to their approval, the normal contact arrangements under the NHS complaints procedure should then be resumed. This change of status should be copied to anyone whom previously was informed of the decision to classify the correspondent as unreasonably demanding or persistent.

⁴⁹ Or in Family Health Services the Senior or Executive or Complaints Partner

PART 5: THE STATUTORY DIRECTIONS⁵⁰

⁵⁰ Issued under HDL(2005)15

Note: These directions use the terminology of the 1978 Act, so NHS Boards are referred to as 'Health Boards' and NHS National Services Scotland as the 'Agency'

NATIONAL HEALTH SERVICE (SCOTLAND) ACT 1978

DIRECTIONS TO HEALTH BOARDS, SPECIAL HEALTH BOARDS AND THE AGENCY ON COMPLAINTS PROCEDURES

The Scottish Ministers, in exercise of the powers conferred on them by sections 2(5), 10(7), 105(6) and (7) of the National Health Service (Scotland) Act 1978⁽⁵¹⁾ and of all other powers enabling them in that behalf, hereby give the following directions:-

PART 1

COMMENCEMENT AND INTERPRETATION

Commencement

1. These Directions shall come into force on 1st April 2005.

Interpretation

2. In these Directions –

“the Act” means the National Health Service (Scotland) Act 1978;

“area professional committee” means an –

- (a) area medical committee;
- (b) area dental committee;
- (c) area nursing and midwifery committee;
- (d) area pharmaceutical committee; or
- (e) area optical committee.

“arrangements” means, unless the context otherwise requires, arrangements that are required to be made by these Directions;

“complaints officer” means the person appointed under direction 5;

“complainant” means -

(a) in Part 2 of these Directions, a person who either makes a complaint about any matter connected with exercise by an NHS body of its functions or the provision of services by a primary care provider;

(b) in Part 3 of these Directions, a person who makes a complaint about any matter connected with the exercise by an NHS body of its functions; and

⁽⁵¹⁾ 1978 c.29; section 2(5) was amended by the National Health Service and Community Care Act 1990 (c.19), Schedule 9, paragraph 19(1) and is to be read with section 1 of the Hospital Complaints Procedure Act 1985 (c.42); section 105(7) was amended by the Health Services Act 1980 (c.53), Schedule 6, paragraph 5 and Schedule 7, the Health and Social Services and Social Security Adjudications Act 1983 (c.41), Schedule 9, paragraph 24 and the Health Act 1999 (c.8), Schedule 4, paragraph 60. The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c.46).

(c) In Part 4 of these Directions, a person who makes a complaint about any matter connected with the provision of services by a primary care provider;

“disciplinary proceedings” means –

(a) any procedure for disciplining employees adopted by any NHS body;

(b) the investigation of matters relating to primary care services under the National Health Service (Services Committees and Tribunal) (Scotland) Regulations 1992⁽⁵²⁾

“HBPMS contractor” means a person or body which is providing primary medical services under arrangements made with a Health Board in accordance with section 2C(2) of the Act⁽⁵³⁾, other than in accordance with a general medical services contract or section 17C arrangements, and “HBPMS contract” shall be construed accordingly;

“NHS body” means a Health Board, Special Health Board and the Agency;

“person who is subject to the complaint” means any person or persons who –

(a) are identified in the complaint as the subject of the complaint;

(b) where the complainant does not identify a named person against whom the complaint is brought, a person who, in the opinion of the complaints officer is best able to deal with the matters that are the subject of the complaint; or

(c) in the case of a complaint about the provision of services by a primary care provider, the primary care provider;

“practice based complaints procedure” means a complaints procedure for dealing with complaints about the provision of services by a primary care provider established –

(a) in accordance with Part 6 of Schedule 5 to the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004⁽⁵⁴⁾;

(b) in accordance with Part 6 of Schedule 1 to the National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004⁽⁵⁵⁾;

(c) by a HBPMS contractor in accordance with a terms of their contract for the provision of primary medical services giving effect to direction 3(6) of these Directions;

(d) in accordance with paragraph 31A to C of Schedule 1 to the National Health Service (General Dental Services) (Scotland) Regulations 1996⁽⁵⁶⁾;

(e) by a person or persons providing personal dental services in accordance with a pilot scheme;

(f) in accordance with paragraph 8A to C of Schedule 1 to the National Health Service (General Ophthalmic Services) (Scotland) Regulations 1986⁽⁵⁷⁾;

(g) in accordance with paragraph 9A to 9B of Schedule 1 to the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995⁽⁵⁸⁾;

“primary care provider” means –

(a) a person who provides primary medical services in accordance with a general medical services contract;

⁽⁵²⁾ S.I. 1992/ 434.

⁽⁵³⁾ Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004, section 1(2).

⁽⁵⁴⁾ S.S.I. 2004/115.

⁽⁵⁵⁾ S.S.I. 2004/116.

⁽⁵⁶⁾ S.I. 1996/177; relevant amending instruments are S.I. 1996/841 and 2060 and S.S.I. 1999/51.

⁽⁵⁷⁾ S.I. 1986/965; relevant amending instruments are S.I. 1996/843 and 1999/725 and S.S.I. 1999/55.

⁽⁵⁸⁾ S.I. 1995/414; relevant amending instruments are S.I. 1996/840 and S.S.I. 1999/57.

(b) a person or persons who provides or provide primary medical services in accordance with section 17C arrangements;

(c) a HBPMS contractor;

(d) a dental practitioner who provides general dental services in accordance with arrangements made under section 25 of the Act;

(e) a person or persons who provide personal dental services in accordance with a pilot scheme;

(f) an ophthalmic optician or medical practitioner who provides general ophthalmic services in accordance with arrangements made under section 26 of the Act;

(g) a person who provides pharmaceutical services in accordance with arrangements made under section 27 of the Act;

“primary care services” means services provided by a primary care provider;

“Scottish Public Services Ombudsman” mean the individual appointed in accordance with section 1(1) of, and Schedule 1 to, the Scottish Public Services Ombudsman Act 2002⁽⁵⁹⁾; and

“in writing” includes, except in direction 12 and 19, transmission by electronic means.

PART 2

GENERAL

Requirement to make arrangements

3.—(1) Each NHS body shall make arrangements in accordance with this Part of these Directions

(2) Each NHS body shall make arrangements in accordance with Part 3 of these Directions for dealing with complaints made about any matter connected with the exercise of its functions.

(3) In paragraph (2), “any matter connected with the exercise of its functions” includes in particular -

(a) any matter connected with the provision of services at a hospital which that NHS body manage, including services provided for a patient other than on the hospital premises and including in particular the provision of transport for a patient to and from the hospital and the provision of pathology services; and

(b) the exercise of its functions by any other person under a contract or other arrangement with it, but does not include any matter connected with the provision of services by a primary care provider.

(4) Each Health Board shall also make arrangements in accordance with Part 4 of these Directions for dealing with complaints made about any matter connected with the provision of services by a primary care provider with whom it has made a contract or arrangements for the provision of primary care services.

(5) Each NHS body shall make arrangements in accordance with Part 5 of these Directions for monitoring the effectiveness of and for publishing the arrangements made for dealing with complaints.

(6) Where a Health Board makes an HBPMS contract with a HBPMS contractor, the Health Board shall ensure that the HBPMS contract contains terms which require the HBPMS contractor to have in place arrangements for the handling and consideration of complaints about any matter connected with its provision of services which have the effect of Part 6 of Schedule 1 to the National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004.

Arrangements in writing

4. The arrangements shall be in writing and a copy of the arrangements shall be given free of charge to anyone who requests them.

⁽⁵⁹⁾ 2002 asp 11.

The Complaints Officer

5.—(1) Each NHS body shall appoint a complaints officer to manage the operation of the procedures for dealing with complaints under the arrangements and in, particular, to -

- (a) perform the functions of the complaints officer under these Directions; and
- (b) perform such other functions relating to the investigation of complaints as the NHS body may require.

(2) The functions of the complaints officer under paragraph (1) may be performed personally or by a person authorised by the NHS body to act on the complaints officer's behalf.

Matters excluded from consideration under the arrangements

6. The following complaints are excluded from the scope of arrangements required under these Directions: -

- (a) a complaint made by an NHS body which relates to any matter connected with the exercise by another NHS body of its functions;
- (b) a complaint made by a primary care provider which relates either to any matter connected with the exercise by an NHS body of its functions or to the contract or arrangements under which it provides primary care services;
- (c) a complaint made by an employee of an NHS body about any matter relating to the employee's contract of employment;
- (d) a complaint made by an HBPMS contractor about any matter relating to arrangements made by a Health Board with that HBPMS contractor;
- (e) a complaint which is being or has been investigated by the Scottish Public Services Ombudsman;
- (f) a complaint arising out of an alleged failure to comply with a request for information under the Freedom of Information (Scotland) Act 2002⁽⁶⁰⁾;
- (g) a complaint about which the complainant has stated in writing that the complainant intends to take legal proceedings; and
- (h) a complaint about which an NHS body is taking or proposing to take disciplinary proceedings in relation to the substance of the complaint against the person who is the subject of the complaint.

Objectives of the arrangements

7. Arrangements shall be such to ensure that the complainants are treated courteously and sympathetically by any person dealing with complaints.

PART 3

DEALING WITH COMPLAINTS ABOUT NHS BODIES

Requirement to deal with complaints

8. Subject to direction 6, a complaint shall be dealt with in accordance with the arrangements required by this Part if it is made –

- (a) in writing to a the complaints officer or any member of staff of the NHS body which is the subject of the complaint;
- (b) within the period specified in direction 9; and
- (c) by a person specified in direction 10.

⁽⁶⁰⁾ 2002 asp 13.

Requirement to make arrangements

- 9.—(1) Subject to paragraph (2) the period for making a complaint is –
- (a) 6 months from the date on which the matter which is the subject of the complaint occurred; or
 - (b) 6 months from the date on which the matter which is the subject of the complaint comes to the complainant's notice, provided that the complaint is made no later than 12 months after the date on which the matter which is the subject of the complaint occurred.
- (2) Where the complaint is not made during the period specified in paragraph (1) it shall be referred to the complaints officer and if the complaints officer is of the opinion that—
- (a) having regard to all the circumstances of the case, it would have been unreasonable for the complainant to make the complaint within that period; and
 - (b) notwithstanding the time has elapsed since the date on which the matter which is the subject of the complaint occurred, it is still possible to investigate the complaint properly,
- the complaint shall be treated as though it had been received during the period specified in paragraph (1).

Person who may make a complaint

- 10.—(1) A complaint may be made by –
- (a) a patient or former patient; or
 - (b) any person who is affected or likely to be affected by the action, omission or decision of the NHS body which is the subject of the complaint.
- (2) A complaint may be made by a person on behalf of a person mentioned in paragraph (1)–
- (a) with the consent of the person mentioned in paragraph (1);
 - (b) where the person mentioned in paragraph (1) is a child –
 - (i) by either parent or in the absence of both parents, the guardian or other adult person who has care of the child;
 - (ii) by a person duly authorised by the local authority, where the child is in the care of that local authority under the Children (Scotland) Act 1995⁽⁶¹⁾;
 - (iii) by a person duly authorised by a voluntary organisation by which the child is being accommodated under the provisions of that Act;
 - (c) where the person is incapable of making a complaint, by a relative or other adult person who has an interest in their welfare.
- (3) Where a person mentioned in paragraph (1) has died a complaint may be made by a relative or other adult person who had an interest in their welfare or, where the person was as described in paragraph (2)(a)(ii) or (ii), by the authority or voluntary organisation.

Acknowledgement of complaint

- 11.—(1) The complaints officer must send to the complainant a written acknowledgement of the complaint within 3 working days of the date on which the complaint was made.
- (2) The complaints officer shall send a written copy of the complaint to any person who is subject to the complaint.

Investigation and report

- 12.—(1) A complaint may be investigated by the complaints officer in any manner which appears appropriate for resolving the complaint and may include in particular offering the complainant a meeting with senior staff or the use of a process of conciliation.
- (2) Subject to paragraph (3), the Chief Executive of the NHS body shall inform the complainant and any person who is subject to the complaint in writing of the result of the investigation.

⁽⁶¹⁾ 1995 c.36.

(3) Where for good reason the Chief Executive of the NHS body is not able to inform the complainant and any person who is subject to the complaint in writing of the result, it may be done by a person acting on the Chief Executive's behalf.

(4) The result of the investigation must be sent to the complainant within 20 working days beginning on the date on which the complaint was made or, where that is not possible, as soon as reasonably practicable.

PART 4

DEALING WITH COMPLAINTS ABOUT PRIMARY CARE PROVIDERS

Requirement to provide conciliation services

13. Subject to direction 6, every Health Board shall provide conciliation services in accordance with this Part if a request is made, orally or in writing to the complaints officer, by a person specified in direction 14, and any of the circumstances set out in direction 15 apply.

Persons who may request conciliation services under

14.—(1) A request for conciliation services under this Part may be made by –

- (a) a patient or former patient of a primary care provider; or
- (b) a primary care provider.

(2) A request may be made by a person on behalf of a person mentioned in paragraph (1)(a) –

- (a) with the consent of the person mentioned in paragraph (1)(a);
- (b) where the person mentioned in paragraph (1)(a) is a child –
 - (i) by either parent or in the absence of both parents, the guardian or other adult person who has care of the child;
 - (ii) by a person duly authorised by the local authority, where the child is in the care of that local authority under the Children (Scotland) Act 1995; or
 - (iii) by a person duly authorised by a voluntary organisation by which the child is being accommodated under the provisions of that Act;
- (c) where the person is incapable of making a complaint, by a relative or other adult person who has an interest in their welfare.

(3) Where a person mentioned in paragraph (1)(a) has died a request may be made by a relative or other adult person who had an interest in their welfare or, where the person was as described in paragraph (2)(a)(ii) or (iii), by the authority or voluntary organisation.

Circumstances under which conciliation is to be provided

15. The circumstances referred to in direction 13 are that –

- (a) a person wishes to make a complaint about the provision of services by a primary care provider and, in the opinion of the Health Board, it would be unreasonable in the circumstances of the case to expect the person to make the complaint directly to the primary care provider about whom the person wishes to complain;
- (b) a complaint about the provision of services by a primary care provider is in the course of investigation under the provider's practice based complaints procedure; or
- (c) the investigation of a complaint about the provision of services by a primary care provider under the provider's practice based complaints procedure has been completed and the complainant is dissatisfied with the result of that investigation,

and in each case that both the complainant and the person subject to the complaint have agreed that conciliation services should be provided.

Requirement to provide conciliation services

16. Where a Health Board is required to provide conciliation services in accordance with direction 13, the complaints officer of the Health Board shall, as soon as practicable, refer the matter to the conciliator .

Appointment of conciliators

17.—(1) Each Health Board shall appoint one or more persons, to be known as conciliators, for a period to be agreed between the Health Board and any conciliator of not more than one year (without prejudice to any re-appointment), to conduct the process of conciliation upon referral of the matter in accordance with direction 16.

(2) A person who is or has been a medical practitioner, dental practitioner, ophthalmic optician, registered pharmacist, a registered nurse or registered midwife shall not be eligible to be appointed as a conciliator.

(3) Each Health Board shall, after consultation with any relevant area professional committee, establish and maintain a list of persons from among whom a conciliator may nominate a person to assist them, as necessary, in the process of conciliation in relation to any matter.

(4) A person nominated under paragraph (3), to be called a professional adviser, shall be a member of the same profession as the person who performed the primary care service with which the subject matter of complaint is connected.

Conciliation procedure

18. The conciliator may adopt such procedures as they determine are appropriate for conducting the conciliation process.

Conclusion of conciliation

19. On conclusion of the conciliation process the conciliator shall notify the results of the process in writing to the complainant, the person who is the subject of the complaint and to the Health Board.

Reports on conciliation

20.—(1) Each Health Board shall require the conciliator to submit to it, at such intervals as it shall determine, a report on all matters referred to them under direction 16 during the period covered by the report.

(2) In relation to any matter reported on in accordance with paragraph (1) the report –

- (a) shall include a statement of the result of the conciliation process; and
- (b) shall not identify the patient, any person who made the request for conciliation services on behalf of the patient or the person subject to the complaint.

PART 5

MONITORING AND PUBLICITY

Monitoring

21.—(1) Each NHS body shall prepare reports at annual intervals for the purposes of –

- (a) monitoring the arrangements made for dealing with complaints;
- (b) considering the volume of complaints; and
- (c) monitoring the remedial action taken following the investigation of complaints.

(2) Each NHS body shall publish a report in its annual report detailing its dealings with complaints under these Directions which shall be sent to –

- (a) the Scottish Ministers; and
- (b) in the case of an NHS body other than NHS Quality Improvement Scotland, NHS Quality Improvement Scotland⁽⁶²⁾

Publicity

22.—(1) Each NHS body shall take such steps as are necessary to ensure that the persons listed in paragraph (2) are informed of the arrangements, the name of the complaints officer and the address where the complaints officer can be contacted.

(2) The persons referred to in paragraph (1) are –

- (a) patients and their carers;
- (b) staff of the NHS body;
- (c) in the case of a Health Board, primary care providers with whom they have made contracts or arrangements for the provision of services;
- (d) persons exercising functions of the NHS body under a contract or other arrangement with it.

PART 6

TRANSITIONAL PROVISION AND REVOCATIONS

Transitional provision in respect of former complaints directions

23.—(1) Where before 1st April 2005, a complaint has been made in accordance with any former complaints directions, it must be investigated, or in an appropriate case continue to be investigated, in accordance with those provisions.

(2) In this direction, “former complaints directions” means any of the directions in relation to complaints given under section 2(5) of the Act which are revoked by direction 25.

(3) Where, in accordance with the former complaints directions, the person who made the complaint has made a request to a NHS body for a review by a panel, that panel must be appointed, conducts its investigation and make a report in accordance with the former complaints directions.

HBPMS contracts entered into before the coming into force of Direction 3(6)

24.—(1) Where a Health Board has entered into an HBPMS contract before the coming into force of these Directions which does not comply with the requirement in direction 3(6), the Health Board shall enter into negotiations with the HBPMS contractor with a view to agreeing variations to the HBPMS contract to make it compatible with these Directions.

(2) Where a Health Board has power under an HBPMS contract to impose a variation of the HBPMS contract it shall where necessary (and in particular where the negotiations envisaged under paragraph (1) have failed) exercise that power so as to ensure that the HBPMS contract is compatible with these Directions.

(3) Until such time as such a variation to an HBPMS contract may be agreed or imposed the Health Board shall make arrangements in accordance with Part 3 of these Directions for dealing with complaints about the provision of primary medical services by the HBPMS contractor.

Revocations

25. The following directions made under section 2(5) of the Act are revoked: -

⁽⁶²⁾ NHS Quality Improvement Scotland is a Special Health Board established by S.S.I. 2002/534.

- (a) the Directions to NHS Trusts, Health Boards and Special Health Boards on Hospital Complaints Procedures, made on 20th March 1996;
- (b) the Miscellaneous Directions to Health Boards for Dealing with Complaints, made on 22nd March 1996; and
- (c) the Directions to Health Boards on Dealing with Complaints about Family Health Service Practitioners, made on 30th March 1998.

Andrew MacLeod
A member of staff of the Scottish Ministers

St Andrew's House,
Edinburgh
31 March 2005