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Executive Summary

Outcome of Complaints Research for the Care Inspectorate

July 2013

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Executive Summary

GENERAL SUMMARY: THE OUTCOME OF COMPLAINTS IN CARE SERVICES

The main focus of this project is the outcome and impact of complaint investigations on individual complainants in care services and on the services complained against. The aim is to ensure that people receive high quality care and to support and encourage the development of better ways of delivering care services.

While there have been some studies of the process of investigating complaints, there has been little or no research of its impact on services. This project seeks to identify the difference a complaint investigation makes to outcomes for people using the service. The core of the research was a set of qualitative interviews with complainants and service providers. These interviews considered the impact of complaint investigations on individual complainants, on the service providers against which complaints were made and on the services about which complaints had been made.

The research has identified a number of important considerations for the development of better practice in the response to complaints throughout the care services system. It shows that good communication is key to good outcomes from complaints. Information sharing, sensitivity and engagement are fundamental to making progress in relation to both individual complaints and system-level learning. The role and potential of the Care Inspectorate in supporting this system and helping to lead developments is significant.

This research also shows that complainants want workable solutions and find the defensive attitudes of some service providers very difficult. Complaining is not a pleasurable activity; it is resource-hungry and stressful. Complaining is considered to be ‘worth it’ predominantly where change is successfully achieved. It is therefore crucial for complaints to be taken in the right spirit, using them as learning opportunities. The research shows that listening to complainants has a key role to play in both reducing consumer detriment and making service improvements. The Care Inspectorate shows up as having an important role in leveling the playing field for complainants, given the relative imbalance of power and information held by providers.

Improved service outcomes are considered fundamental to successful complaint resolution. Apology is not enough, and compensation is not a priority for complainants. The key desired outcomes are both ‘hard’ and tangible (such as updating care plans, following procedures and training staff), and ‘soft’ or intangible (such as providing services with empathy, respect, dignity and compassion). Both types of outcome are important in the provision of ‘person-centred care’.

However, it was clear from the research that factors such as leadership failure, financial inhibitors, organisational inflexibility and lack of trust led in many of the cases to service breakdowns. The desired culture of the organisation as both an open and a caring organisation had somehow been lost or found missing. Complainants valued the Care Inspectorate's power to investigate. However, in perhaps the most significant finding of this research, complainants were often left uncertain about the impact of the Inspectorate's recommendations in relation to actual service improvements. The research suggests that more could be done to link the complaint investigation and routine inspection functions of the Care Inspectorate, and to communicate more clearly with complainants over any changes and improvements made to services as a result of their complaint.

The following summary highlights some key findings from the research and is structured in four sections: the impact of upheld complaints on services; views of complainants about service providers; the Care Inspectorate as a valued third party; and views of service providers.

KEY FINDINGS 1: Impact of the outcome of upheld complaints on services

1. People's assessment of whether their complaint had been 'worth it' or not depended predominantly on their assessment of whether it had brought about changes and improvements in service delivery; the more this was the case, the more positive they felt. Having a complaint 'upheld' by the Care Inspectorate was the starting point for this assessment; greater clarity about the changes and improvements made to the service as a result would enable people to reach a 'finishing' point, where they feel able to finally close their complaint off.

2. Complainants perceived a range of outcomes and impacts from their contributions. A significant minority felt their complaint had achieved nothing. Others simply held an unconfirmed 'hope' that it had or would. Meanwhile, a small majority reported a rather vague level of confidence that their complaint had had a positive, although largely unspecifiable, effect.

3. For a large number of complainants there was a lack of closure at the end of the process; they did not know the outcome or if anything had changed following their complaint. This demonstrates the problems of asking complainants to identify impact, given they have limited access to information and must therefore rely on their own perceptions. By contrast, the Care Inspectorate collects data from inspections and other follow-up but currently does not aggregate this effectively.

4. It is important not to lose sight of hard outcomes, the actual changes to services. There is a large amount of inspection data within the Care Inspectorate but the inspectorate need to establish systems to collect and report systematically on

these outcomes. Softer outcomes, such as whether people are treated with dignity, respect and compassion, are connected with the culture of the organisation and can be harder to identify. New systems may need to be developed to take account of this.

5. For both hard and soft outcomes, inspection arrangements to check providers' responses to recommendations and requirements also need to be improved. The results also need to be reported back more effectively to complainants and the public.

KEY FINDINGS 2: Views of complainants about the service providers

1. The main drivers for people's complaints were perceptions of inadequate standards and/or insensitive practices. The research team was told of many long and harrowing experiences, often involving clearly vulnerable people. Complainants were often emphatic about how such experiences offended basic values of decency, respect and compassion.

2. Most complainants wanted 'to make a difference' to the quality of services. However, the complainant's knowledge was not typically valued: they felt resented by providers and that they were pestering the organisation, with some providers becoming defensive or aggressive.

3. Speaking for the user population as a whole was important for many complainants; they tended to see themselves as more confident than some of their peers, who they perceived as having anxieties about complaining. They also felt it was important to voice concerns likely to impact on particularly vulnerable service users.

4. Many people felt that they had had no alternative but to pursue the complaint. The responsibility that others (often relatives) feel for taking up the complaint on behalf of someone else is often strong.

5. It is important to ensure that service providers welcome complaints and respond appropriately. This means being open, willing to learn from customers, prepared to investigate underlying problems and ready to make relevant changes to services. It was widely felt that service providers need training to respond more effectively to complaints, and to the issues they raise.

KEY FINDINGS 3: Care Inspectorate as a valued third party

1. Overall, the Care Inspectorate comes out well in this sample of complainants. Its role in supporting an effective complaints process is valued and the attitude and the approach of its complaint investigators receives plaudits from many complainants. Communication with Care Inspectorate investigators was also perceived as positive.

2. The Care Inspectorate plays a fundamentally important role for people who feel 'at the point of no return', having complained to the service provider several times without a satisfactory response. It is generally seen as an independent and authoritative third party in establishing what should be done.

3. Third party involvement can be effective in 'turning up the volume' on complaints. The role of the Care Inspectorate is of fundamental importance to people in giving them a sense of empowerment to proceed with their complaint.

4. The power to make unannounced visits to investigate complaints was highly valued by complainants. However, complainants were often negative about the powers available to the Care Inspectorate to ensure that the necessary changes and improvements were made.

5. The Care Inspectorate needs to ensure it is easy for people to complain to the organisation; service users could see a notice about it but often did not know how to make contact. Complainants also thought there should be less jargon in written communications and that the Care Inspectorate website needed to be redesigned.

KEY FINDINGS 4: Views of service providers

1. Service providers also value the role of the Care Inspectorate. They take regulatory recommendations and requirements seriously in reviewing their practice.

2. A more positive role was envisaged by some providers for the Care Inspectorate in relation to system-level improvement, particularly in the movement from process-led to outcome-led service developments. An opportunity exists to develop a more meaningful role as 'improvement partner' as well as regulator.

In light of the above findings, the following key recommendations and further recommendations emerge from this research.

Recommendations

A. Key recommendations (the most important points emerging from the research)

1. **Put in place a systematic follow-up of recommendations and requirements** which enables the outcomes of upheld complaints to be actively communicated to the individual complainants, as well as readily accessible to the public through the website. People would like to know that the effort involved in making a complaint to the Care Inspectorate had been worthwhile and resulted in a positive outcome.

2. Always keep people **informed of progress** with their complaint.

3. The Care Inspectorate should review its use of the enforcement powers it has and **make the case for stronger enforcement powers** where these are inadequate.

4. **Improve follow up communications with providers in relation to the decision letter** and recommendations. Some providers received a regular inspection soon after the investigation decision was communicated. However, some reported an ‘essence of tick-boxiness about that’, and that the outcomes from complaint investigations were not always explicitly considered. A majority of providers said that they did not receive follow up visits. This was to the chagrin of at least one provider, who said ‘we would welcome more active involvement to embed Care Inspectorate recommendations properly’.

5. **Encourage improved engagement between service providers and consumers** so that grumbles, gripes and grievances can be identified, and recorded, with an early opportunity to enhance practice.

6. As an important part of the improvement agenda, **promote training for service providers on effective responses to complaints.** This may involve collaboration with other organisations. Training must be genuinely valued by providers.

7. In partnership with other organisations, **help service providers to become more open, learning organisations**.

8. Explore the opportunity to **introduce a new system of mediation** at an early stage in the complaint management process.

B. Further recommendations (desirable for service improvement over time)

1. Consider the merits of providing **specialist investigators and inspectors** in different care contexts.

2. Promote the **ownership of the whole complaint process by one team**, simplifying the collection and aggregation of data about outcomes. Properly defined and aggregated data could help the Care Inspectorate make informed choices about inspection priorities. This would also assist the Care Inspectorate's choices about targets and methods for the improvement agenda.

3. Build on good practice and develop consistent high standards through **training for Care Inspectorate staff**.

4. **Information about the complaint handling role of the Care Inspectorate** should be crystal clear and accessible; it must be clear that the organisation is able to receive complaints without first making them known to the service provider.

5. **Remove jargon from decision letters**; use plain English that can be readily understood by consumers. A short summary of key terms such as upheld and partially upheld would be helpful.

6. Drawing from existing case studies, develop a three year programme of **innovative qualitative approaches to gathering feedback** in ways which engage service provider staff, complainants and the Care Inspectorate.