



**UNIVERSITY OF  
STIRLING**

# **Outcome of Complaints Research for the Care Inspectorate**

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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.

# Outcome of Complaints Research

## Introduction

The main focus of this project is the outcome and impact of complaint investigations on individual complainants in care, social work and child protection 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 and on the service providers against which complaints were 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. The role and potential of the Care Inspectorate in supporting this system and helping to lead developments is significant. 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.

This research also shows that complainants want workable solutions and find the defensive attitudes of 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, and to use them as learning opportunities. Voice emerges from the research as having 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 levelling 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 service provided 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 such factors as leadership failure, financial inhibitors, organisational inflexibility and lack of trust had led in many 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 Inspectorate's power to investigate. However, in perhaps the most significant finding of this research, complainants were often left uncertain about the impact of its 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 the changes and improvements made to services as a result of their complaint.

For providers, the Care Inspectorate was generally seen as thorough and dependable, even when being critical of services. Input from inspectors and investigators was seen as useful for service improvement, although sometimes more process-led than outcomes-led. Certain forward-thinking providers sought a relationship with the Care Inspectorate as 'improvement partner'.

## Reader's Guide

This research report provides insights from the literature and insights from the complainant interviews for each key area of interest which emerged from the findings. These insights highlight lessons for policy and practice. Section 1 of this report covers care, complaints and communication; section 2 considers learning and insight; section 3 analyses challenges of defining successful outcomes and impacts; section 4 concerns poor practice and training; and section 5 considers the role of the Care Inspectorate. Key issues from the provider interviews follow covering the value of complaints; the complaint investigation process; communication issues; and the nature and impact of decisions. The next section considers how to incorporate feedback and this is followed by innovative case studies to promote ideas for the development and improvement of the Care Inspectorate's role in managing and learning from complaints. Conclusions and areas for further research and enquiry are also given.

# Methodology

## Desk Research

Desk research was conducted to identify how other complaint handling organisations obtain feedback on complaint investigation quality and outcomes. Research focused on ombudsman organisations, since these perform an external complaint handling role that is similar in important respects to the complaint handling role fulfilled by the Care Inspectorate.<sup>1</sup> A request for information was also sent to members of the Ombudsman Association. Finally, a meeting was held with the Financial Ombudsman Service in order to discuss their sophisticated approach to the collection of feedback.

## Complainant Interviews

The sample for the complainant interviews was taken from a list of 106 people provided by the Care Inspectorate. This list comprised those complainants from the previous 12 months who had had their complaints at least partially upheld, and who had responded to an invitation letter from the Care Inspectorate to take part in the research.

The sample was contacted by the research team by letter to provide further information about the project and to request access to the decision letter in each case. Access to the decision letter was agreed by 34 of the 37 complainant interviewees. This added to the understanding of their individual cases and their perceptions of the investigation process carried out by the Care Inspectorate. Each complainant in the sample was then contacted by telephone to arrange an interview with one of the research team members.

Face-to-face interviews were conducted with 35 complainants. One interview was conducted by telephone and one by e-mail. The face-to-face method was chosen as a good way to ensure high response rates. It is also the most effective way to follow up on non-verbal cues during interviews. The interviews lasted for around 45 minutes to 1 hour. A range of pertinent topics were covered in the interviews. These included questions about the complaint process, the outcomes from people's complaints and the role of the Care Inspectorate.

Of the 37 complainants who were interviewed, seven respondents (19%) were male and thirty (81%) were female. Nine (24%) were under fifty years of age; eleven (29%) were in their fifties; seventeen (47%) were over 60. Many were quite well qualified, with twelve respondents (32%) having a professional or degree

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<sup>1</sup> It is recognised that the Care Inspectorate's regulatory function means that its role is significantly different to most ombudsmen. However, in relation to the quality of complaint investigations and their outcomes, similar issues are likely to be relevant for ombudsmen and the Care Inspectorate.

qualification, and a further twelve (32%) having a National Certificate or Diploma. Most were also confident about making a complaint: twenty seven respondents (73%) said they were 'very confident' about complaining to the service provider or to the Care Inspectorate. Only three respondents (8%) said that they were in any way unconfident about complaining, in each case in relation to complaints to the service provider.

The geographical coverage of the sample was broad, from the Highlands to the Borders and from the East coast to the West coast. Eleven respondents' complaints (29%) related to care home services, seven (19%) to the care of children, twelve (32%) to domestic support services and seven (19%) to housing support services. The larger number of respondents for care homes and domestic support services reflects the proportions in the original list provided by the Care Inspectorate. Seven respondents (19%) were service users; twenty four (65%) were friends, relatives or visitors; six (16%) were health professionals or professional visitors.

Transcripts from the in-depth interviews were subject to extensive and highly robust qualitative data analysis to extract the full range of insights from the data. This involved three complementary forms of analysis (i) by individual respondent ('summaries'); (ii) by question ('grid analysis'); and (iii) according to selected 'thematic codes'. In the first two stages, transcripts were read through to identify descriptive and inferential codes for classifying concepts and themes in participants' statements. The aim was to allow the language and concepts (i.e. the "voices") of respondents to emerge and to use this to guide the development of our coding schemes. Next, transcripts were re-read to code each statement according to the scheme developed through the first two stages. Finally, the coded statements were subjected to pattern analysis to identify common themes and relate them back to our theoretical framework. Insights from this phase of analysis were then used to design the feedback tools for complaint outcomes and quality assurance.

### **Service Provider Interviews**

The Care Inspectorate provided the research team with a list of all service providers that had been subject to a complaint investigation in the previous 12 months. From this long list, the team confidentially selected providers from a range of different service contexts to relate their experiences of the process and outcomes of complaint investigations. The sample was again contacted by letter to provide further information about the project. Eight interviews were completed. These interviews were generally shorter, of around 15-20 minutes duration, and were conducted by telephone. Telephone interviews were selected for this group due to the less detailed question schedule and the difficulty in arranging face-to-face appointments with busy care managers who often needed to be able to respond flexibly to the needs of service users rather than those of the researchers. The schedule included questions about the complaint investigation process, the outcomes from people's complaints and the role of the Care Inspectorate.

# Key Issues: Complainant Interviews

## 1. Care, Complaints and Communication

### 1.1 Complaints and Communication

#### A. Insights from the Literature

- There is a need for the service user to be the first and foremost consideration of the system and everyone who works in it (Francis, 2013: 7). Good communication is a key factor in ensuring this.
- Personal communication is particularly important. The Francis Report (2013: 14) found that “a very significant number of patients gave accounts of poor standards of communication”, including lack of information sharing, insensitivity, lack of engagement with families and friends and poor listening skills. In other words, users need to feel that providers are *receptive* (Simmons, 2011).
- For Nichols (1995: 247) this suggests that listening is more than a skill, it is also ‘an attitude of caring and concern’. Listening without blame, turning complaint processes into a positive experience and acting on the learning can help bring about practical improvements to services (George and Joseph 2009; Cowan and Anthony 2008; The Kings Fund 2009).
- The Nursing Times (2012) highlights that communication is vital when many agencies are working together to provide holistic care. This is particularly the case for vulnerable people, who may not be able to articulate their own needs and rely on family, friends or carers to be their voice.
- Written communication is also important. Simplification and consumer focus have been emphasised as central for the development of a responsive complaints handling process for each public service sector in Scotland (Sinclair 2008). Consumer Focus (2012) warns Social Care and Social Work Improvement Scotland to ensure their complaints procedure is checked by the Plain English Campaign and tested with service users, as they tend to use language that is too formal for consumers.

In general, communication features as an important focus for improvement in the public sector. The UK Customer Satisfaction Index (UKCSI), covering 13 service categories in the public and private sectors, is administered annually to 26 000 respondents. Key issues that consumers find annoying include an organisation not keeping its promises or commitments, staff attitude, and staff competence. For local

public services such as social care, the highest proportion of complaints is about staff attitude (44%) and staff competence (36%). These issues have a strong relationship with satisfaction with complaint handling.

Specific research about adult social care has been conducted by the Local Government Ombudsman (LGO; 2011). This included a quantitative survey with 604 complainants, two focus groups with providers and local authorities, one focus group with complainants and eighteen interviews with service users, relatives and advocates. The main issues giving rise to complaints were poor communications with users/relatives; poor standards and quality of care; staffing issues, including staffing levels and timekeeping; lack of continuity of care; food, nutrition and mealtimes; laundry in care homes; missing personal possessions in care homes; fees, financial issues and contracts; medication; physical environment of care homes; conduct and actions of local authorities, especially in relation to assessments for Direct Payments; and complaints about how concerns or complaints had been handled.

The Francis Report (2013: 72) acknowledges that ‘complaints, their source, their handling and their outcome provide an insight into the effectiveness of an organisation’s ability to uphold both the fundamental standards and the culture of caring’. The LGO (2011) research found great inconsistency between care providers in how they determine what to treat as a complaint, and what to treat as a lower level ‘concern’ or ‘comment’ instead. Some providers have introduced systems to capture concerns, comments and grumbles but these can be difficult to implement by staff. Some people were found to have “immense difficulty” making a complaint particularly where the provider or local authority was unresponsive.

Complaints, including everyday grumbles, gripes and expressions of dissatisfaction from service users, provide an important and often underutilised resource for communication (Simmons & Brennan, 2013). Francis (2013) concurs that any expression of concern made by the person should be treated as a complaint, and that complaints provide a source of information that has been undervalued as a source of accountability and to shape improvements. Greater consumer engagement between providers and users will not be without challenges, particularly in relation to more vulnerable and disadvantaged consumers, but does offer scope to strengthen those relationships and stimulate service improvement. There is considerable scope for care providers and local authorities to consult consumers on how to improve their complaints systems.

## **B. Insights from the Complainant Interviews**

Communication with the service provider was a huge issue for most complainants. Some reported that it was a challenge to decide to complain in the first place:

*'Q: How confident did you feel about your ability to communicate about service issues?*

*A: It takes courage'*

However, once they had made the decision to come forward, many also felt that it should be possible to find a workable solution in conjunction with the service provider. Where the experience was that this was not indeed possible, this became difficult for many complainants. For example, respondents stated that:

*'It was almost like sides; it wasn't like a partnership between my sister and the company. It was like sides. A complaint would be made and then it would be almost refuted or they'd give some excuse about it, so it didn't feel like my sister was actually part of that'*

*'I'd contacted the nursery with a view to possibly working along with them, but that will not be happening now'*

*'There's all sorts of things lacking and relatives can actually help care homes if they would listen... but I get the feeling they just want to keep us at arm's length.'*

Many people felt their concerns were not listened to, or rejected altogether:

*'You get fed up phoning the company, the care company. You're fed up phoning them. You get nothing. They never say sorry, it's never their fault, they never even, they don't take you on. You're properly, you're absolutely ignored.'*

*'I think that would have been one of the starting points, you know, if there's no communication, I think the three, I think there's ten C's to good relationships and I remember the three C's which is communication, cooperation and compromise, there has to be some link between the two sides and I felt I was a complete stranger.'*

A feature of many complainants' interviews was an expectation that their complaint would be received positively as a contribution from a loyal consumer to the collective pursuit of better practice. They could not understand why the provider would not want to engage with them on this basis.

*'When you're faced with incompetence, you try to improve people's practice by sharing with them, you know. But if the level of understanding and professionalism is not there, where do you go?'*

Complainants' communication with the Care Inspectorate appears to be much more positive and less 'loaded'. That this is so might be expected, given that the two parties are not in dispute. However, it is still an achievement for complainants to speak so highly of the communication received from investigators:

*'[The Investigator] kept me in touch the whole way through...She couldn't have been better frankly'*

However, there were some problems about how well people felt listened to, and some others around the language used in written communications:

*'First of all you fill in a form online or write to them. Then they phone you up and you can discuss further things but I sort of felt, I don't know how open they are? I know they listen but I think they always err on the side of 'oh, maybe it's not quite as bad as all that', I just have that sort of feeling...'*

*'I think the terminology, the wording is too jargoned. I think the jargon is a wee bit – well, most people want to know, was I right or was I wrong?'*

*'I didn't understand the partially upheld and things like that, there were, I think it would have been helpful if they had put a key or a note at the bottom to say 'this is what this means and this is what that means'. That report, I felt, was understood by the person who wrote it but giving it to a lay person they would be kind of unsure about some of the terminology and this is a problem in society which is that the jargon has to be addressed and that's, you know, that is a major issue'.*

In sum, while the contact and relational aspects of complainants' communications with the Care Inspectorate were good, the clarity of written communications and reports was sometimes found to be lacking.

## **1.2 Communication Channels**

### **A. Insights from the Literature**

- Consumers want a variety of contact methods with telephone, in person and email the preferred methods. Managing expectations is very important; satisfaction with complaints which are resolved more slowly than expected score 48% lower than those closed in line with expectations (Institute of Customer Service 2012).

- Although supporting improvements to communication systems, Consumer Focus (2013) cautions against hasty solutions and it is important to ensure improvements meet consumer and organisational needs. At present consumers prefer phone calls when complaining and this is the cheapest way for organisations to solve first tier problems; 75% cheaper than in writing (Ofwat, 2010).
- The extent of post-complaint follow up is of particular interest to this study. A growing proportion of organisations contact consumers after their complaint is believed to be resolved; 27% in July 2012, up from 8% in January 2008. Satisfaction with complaint handling among consumers who received follow-up contact is 51% higher than those without contact. An effective system for monitoring the outcome of complaints is likely to strengthen service user satisfaction (Institute of Customer Service 2012).

It is vital that organisations provide an adequate complaints system, not only to reduce detriment for their customers, but in order to learn from them and make improvements (Cowan and Anthony, 2008; Friele and Sluijs, 2006; Kings Fund, 2009). Furthermore, empowering the consumer with rights, protection and access to a trustworthy, fair and user-friendly redress system is vital for organisations to maintain reputations and customer loyalty (DTI 2005).

In his taxonomy of vulnerability, Cartwright (2012) highlights that one area where people suffer is in terms of 'information vulnerability', i.e. lack of information or inability to understand it. Lack of awareness of the opportunities to complain provides a clear issue for the expression of voice (Wilcox, 1996; Lowndes *et al.*, 2001). It is important to understand whether people find their way easily to the complaints process or not, and some may be better informed than others (Simmons *et al.*, 2012). Moreover, remaining informed throughout the complaint process is likely to be important, especially where the process may extend into a long period of time to allow due process.

The BSI Inclusive Service Provision Standard, BS 18477 (BSI Group 2010) states that "consumer vulnerability is relative and dynamic, and a consumer's needs and abilities can change with time or circumstance, especially if the consumer is faced with a particularly urgent or complex issue". Hunt (2008) argues that the rise in vulnerable consumers due to the change in economic climate will see more individuals seeking face-to-face support when complaining, and personalised experiences via named advisors within redress organisations.

However, it has increasingly been argued that social media and the internet can help to empower consumers by providing access to information (Sawhney and Kotler, 2001; Wathieu *et al.*, 2002). In the private sector, Nielsonwire (2011) asserts that 90% of consumers trust recommendations from people they know and 70% of

consumers trust what they read in online feedback systems. Furthermore, Techtrader (2012) shows that complaints via social media have risen by 19% to 36% in just eight months. In the public sector, Leadbeater (2009: 126) has welcomed this opportunity for people to express their opinions, viewing it as a means for “collective self-expression and self-organisation which creates new options for us to become organized and to get things done together in new ways”. The relative importance of these forms of engagement in relation to complaints is also considered in this research.

## **B. Insights from the Complainant Interviews**

Eleven complainants (29%) complained in a personal capacity and twenty six (71%) on behalf of someone else. Similar findings are common in consumer research on care services. At least three explanations may be offered for this. First, service users may have a lower capacity for the stress involved in making a complaint, due to their condition. Second, their vulnerability may lead to anxiety about possible reprisals as a result of making a complaint about the people and organisations upon which they depend for their care. Third, some service user complainants may see themselves as more confident about complaining than some of their peers. These explanations are certainly supported in some of the things our respondents told us:

*“Some people can’t talk. Some people can’t walk at all. Some people are deaf and blind. Now they can’t talk and say anything like that. I can stick up for anybody who wants to hear me. I’ll tell the whole world about what they’re like in that office... I’m not going to sit shy and say nothing when I’ve got a bit of mouth.”*

*“I feel that there are lots of people who aren’t in the same boat as me who don’t have maybe the ability or the education or the experience to be vocal”*

A related phenomenon is that of speaking for the user population as a whole. Of the respondents who answered the question, twenty one (68%) felt they were speaking for service users as a whole rather than the ten (32%) who were speaking for a particular individual. Speaking for others was important for many complainants.

*“If I’ve shaken the carpet and made a bit of dust, then I hope it’s for the benefit of all, not just for one individual”*

People complaining on behalf of someone else also commonly saw their complaint as a way to give voice to vulnerable people and groups:

*“I always say that any complaint I made to [the care home] was for all the poor old souls that didn’t have anybody, that didn’t have a voice, because if they were doing that to my mum, they were doing that to other old people as well”*

*“People are a bit scared of making formal complaints because of the possible knock on effects...They’re usually very vulnerable if they’re in a care home. So they have to have somebody that’ll complain for them if things aren’t right”*

Speaking for others goes beyond the facilitation of ‘voice for the voiceless’, however. There is also a sense of wanting to achieve shared outcomes. Hence, it should not be assumed that complainants will see the outcome of their complaint as being a good one if they benefit from an improved service as a result while others do not.

*“I thought if I complained and things would change, it would change for everybody, not just my mum. It would change across the board”*

It is not clear whether this is always fully acknowledged in complaint handling. Underpinning this issue are questions about whether in fact complainants are seeking to add weight to their complaint by presenting their own particular problems as universal ones, or whether providers are seeking to lessen the intensity of scrutiny on them by presenting universal problems as particular to an individual complainant. The extent to which it is reasonable for Care Inspectorate investigators to examine such questions is unclear. However, these are clearly matters of concern for complainants.

Our data shows that the large majority of complainants had made their initial complaint to the service provider: twenty six (71%), compared with eight (21%) who had made their initial complaint to the Care Inspectorate, and three (8%) who had complained to both at the same time. There was a perception amongst some respondents that the Care Inspectorate would not deal with a complaint until the complaints procedure with the service provider had been exhausted. For example, one respondent observed that:

*“We felt that if we went straight to the Care Commission without having gone through the complaints procedure in the home they would direct us back to the home”*

As this perception is incorrect, and the Care Inspectorate is in fact willing and able to receive complaints directly, there may be some work to be done to ensure that all complainants are aware of this. Indeed, visibility in general presents an important issue. As one respondent put it:

*‘People don’t know about the Care Inspectorate, it’s hidden away. Once you do get to the Care Inspectorate, their services are 110%, but it’s getting there. When I found the Care Inspectorate they couldn’t do enough’*

Overall, the Care Inspectorate comes out well in the complainant interviews. Its role in supporting an effective complaints process is clear and the attitude and approach of its complaint investigators receives plaudits from many complainants. On balance,

it seems that a majority of respondents have an overall sense that their complaint investigation has led or will lead to changes and improvements in services. Yet there is sufficient lingering doubt about this for further action to be widely perceived as necessary - in terms of follow up activity and feedback - if people are to achieve full and final closure of their complaint.

The end point of the complaint process is resolution. For many complainants the Care Inspectorate did a thorough and professional job with the investigation. There was occasional criticism over the time things took:

*'There didn't seem to be much urgency...'*

*'I never got the feeling that there was a lot of urgency when I was talking to them'*

However, more generally people seemed patient and supportive of the inspectors' work and keen to see due process followed:

*'It doesn't matter how long it takes so long as you're getting something concrete at the end of it'*

*"I didn't care whether it was a week or six months, these things take as long as they take".*

*'Maybe that's the time they need to thoroughly investigate it... It's better taking more time'*

The Care Inspectorate investigations were therefore generally seen as authoritative and comprehensive.

The Care Inspectorate provides one of a number of routes by which people might express their views. As part of this research we sought to see if there were any other mechanisms that people valued equally or more highly. These other mechanisms included internet groups, user/relative meetings, local authorities, elected representatives and the police. There were mixed views about these mechanisms.

Internet groups and user/relative meetings were not seen as particularly effective in bringing about change although, where they were absent, the idea of them was often popular:

*'I would like to see a relative forum in care homes, somewhere that people could maybe meet every six months, because I've heard people in the lift complain about the home.'*

*'The manager now has residents' meetings, which is great. I'd question how valuable they are but it's a forum, which is good'*

*'Anything that they said would happen in the relative's group just never happened, just never.'*

*'I wouldn't use online forums because nowadays you've got to watch what you say, because if you put the wrong thing down the next thing is you are in the courts'*

Local authorities varied in their perceived level of responsiveness. Some were considered to have almost abandoned their role, while others seemed more supportive and interested:

*'I must say that the council are very hands off – 'we don't want to know – we have no control over how the home is run''*

*'I phoned the council, I phoned social workers, I spoke to the doctor, I spoke to everybody I knew I could go to to try and get something done but I think you are just up against a brick wall'*

*'When I'd voiced it, the Social Services started jumping around. Now whether they were feeling guilty because they hadn't noticed or hadn't done anything about it I don't know...'*

*'What difference has the complaint made? My mum's back 'in house', as they call it, with [x] Council. It's first class care from [x] Council with no worries whatsoever'*

Elected representatives had been contacted on some occasions, again with varying levels of success. Some did not support the idea of approaching them at all, or thought they might have more pressing priorities. However, a number of respondents saw this as being 'the next step' that they would take if they were not happy with the outcome of the Care Inspectorate's investigations:

*'God almighty, I wouldn't contact an MP for anything'*

*'I went to my MSP, but at that time he had issues in his private life that came out into the media and he resigned...'*

*'My MSP recommended that I contact the Care Inspectorate. I said 'I have', but she said 'Do it again', and it worked.'*

The press was also a mechanism often considered but generally rejected by complainants due to the desire not to drag themselves or relatives into the gaze of local publicity:

*'I have thought about going to the press but it's been so hard and my daughter keeps saying to me, you've got to move on, you know?'*

Meanwhile, disappointment with the outcome from Care Inspectorate investigations or a subsequent lack of perceived improvements has led a number of complainants to consider taking what they perceive to be 'tougher' legal routes:

*'Next time I will take legal action'*

*'If I were in a situation like that again I think I'd just go straight to the Police to be honest... I would advise anyone if you're really concerned just go straight to the Police because the Police have to investigate don't they?'*

### **1.3 Voice and the Costs of Complaining**

#### **A. Insights from the Literature**

- Complaining can be a resource-hungry and stressful activity, particularly where the process becomes extended over a considerable period of time. There are a number of potential costs that might be associated with embarking on the complaints process.
- Measurable costs of time and money are relatively easy to identify. Less measurable costs - in terms of the energy required to pursue a complaint, the emotional costs of doing so, and the effects on people's health and wellbeing - are also present and need to be acknowledged.
- The UKCSI found that just over 24% of consumers who have a problem are "silent sufferers" who do not make a complaint, with local public services having a higher than average proportion in this category. People are more likely to complain than exit if they are sufficiently convinced that voice will be effective. Yet around one third of public service consumers feel they 'would not be listened to' (Simmons et al, 2012).

The above aspects need to be considered in relation to the outcomes achieved through the complaints process, so that the costs can be weighed against the benefits of complaining. People are generally instinctively able to assess the costs and benefits to them of different activities, and retrospectively to answer to themselves whether their complaint was 'worth it'. Prospectively, however, it is not always possible to foresee the costs, nor to be certain of what benefits may accrue.

This represents a risk for some care service users, whose levels of key resources may already be lower than other members of the population.

It is worth noting that in this study, where only those complainants whose complaints were upheld were interviewed, it may be more likely that the benefits of a 'successful' outcome provide a balance for the various costs incurred than in those where the complaint is not upheld. To establish whether or not this is the case would require further research with a wider group of complainants.

## **B. Insights from the Complainant Interviews**

At the outset, we should note that when we discussed the costs of complaining with respondents, it was clear that measurable costs such as time and financial expense were of secondary importance. These were rarely calculated and largely dismissed by respondents as significant.

*'Certainly no financial cost. Well maybe the odd phone call, but that's nothing'*

*'It took time for us to do this, of course. But there were no second thoughts about it. It was never a consideration'*

Overwhelmingly, the key costs for complainants were identified as the emotional and energy costs associated with making a complaint. This added to the already high emotional impact on many respondents of either being or seeing a close friend or relative in care. Hence, people told us how:

*'It was very, very emotionally draining, very'*

*'We have been through the wringer. Right through the mill. Every possible emotion'*

*"Emotionally it has been exhausting, it has been exhausting, it's felt like a job as well as paying them"*

The Care Inspectorate's investigations are often key in helping people to manage the emotional burden of making a complaint. Where complaints are upheld, it can also provoke quite an intense emotional release for some complainants:

*'It was great satisfaction to know that somebody had listened and that our complaints were justified'*

*'I was so relieved to know somebody was listening to me'*

*'I feel vindicated for having made it and taken this step'*

*'It was really good to have the evidence that what I was concerned about was, you know, upheld'*

However, people's overall opinion of whether their complaint had been 'worth it' or not did seem to depend predominantly on their assessment of whether they had been successful in achieving changes and improvements in the delivery of services. The more this was the case, the more positive they felt:

*'Once I'd made the complaint and got the thing en route it was a great comfort to have. Knowing that it was being investigated, you know, and that things might improve'*

*'Q: Do you think your complaint was worth the effort?*

*A: If I had to give you a one word answer, no... I would say no because nothing's been done because of it'*

The main exception to this came where, even if there was no conclusive evidence of positive change, 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. For many, there is no alternative; they would feel bad about themselves if they did not take action:

*'Probably everybody down there will hate me for what I've done, but I just felt I had to'*

*'I think I couldn't bear to live with myself if I stayed silent'*

## **2. Learning and Insight**

### **A. Insights from the Literature**

- The key outcome for service users is to use the learning from complaints to drive service improvement. Outcomes provide an insight into the effectiveness of an organisation's ability to uphold both the fundamental standards and the 'culture of caring'. Openness links learning from complaint experiences to continuous professional development, from the board to frontline staff (Kings Fund, 2009).
- Sinclair (2008) highlights that the information from complaints provides vital feedback and learning for service providers and for scrutiny bodies to inform improvement. This builds on the Crerar Review which proposed that complaint outcomes should be closely linked to service improvement with opportunities for greater sharing of information (Scottish Government 2007).

- The Francis Report (2013) highlights the need for more effective learning from complaints and dissemination of the lessons. Complaints and feedback are important sources to inform a learning organisation, provided they are discussed and addressed adequately (Scottish Health Council 2009; Scottish Executive Health Department 2002).
- Hence, the Scottish Public Services Ombudsman (2011) believes ‘the right complaints culture can pay dividends: restoring trust between the service user and provider, improving public services, and cutting costs to the public purse’. Creating an open, sharing and learning culture could reduce the recurring complaints that strain resources, improve employee morale and enhance the provision of more sustainable services.

Margaret Mitchell, MSP, said regarding the Apologies (Scotland) Bill (2012), that people simply want public services “to acknowledge the problem or bad outcome and to ensure the same thing doesn’t happen to anyone else”. Implementation of improvements is a vital part of the complaints system. Ninety-four per cent of complainants questioned during a study by Friele and Sluijs (2006, p.106) said they didn’t want the incident to occur again and that “something must change”.

Complaints can be valuable in identifying the need for service and care enhancement (Siyambalapitiya et al., 2007; Anderson et al., 2001). Complaints identify blind spots and hold the potential to unlock innovation and improvement. There is an opportunity to identify the root cause of service users’ concerns, and incorporate innovation at the heart of management policy. Research shows that powerful knowledge is generated by the users of public services. This helps broaden and deepen discussion, and demonstrates strength in a diversity of ideas (Simmons & Brennan, 2013). However, while individual complaints are investigated and there may be redress, this does not always lead to service improvements (Hsieh et al, 2005), as overall organisational policies and practices remain unaltered.

How an organisation manages and learns from complaints can have a significant impact on its effectiveness and on consumer perceptions. Eraut (2000) suggests that some of the most desirable attributes for this kind of organisational learning include:

- locating and using relevant knowledge from outside organisational boundaries
- enhancing understandings and capabilities at both collective and individual levels
- learning from both positive and negative experiences
- a blame-free culture which provides mutual support.

In this way, we argue that a learning culture embraces complaints, using them to help measure quality of service and make improvements (cf. Siyambalapitiya et al. 2007). Notions that complaints can provide an important source of performance

information and opportunities for innovation are inherent in Barlow & Moller's (1996) classic assertion that 'a complaint is a gift'. In this sense, complaints can provide the 'spark' to ignite other important actions and reactions in public services.

The above places an emphasis on listening as requiring the listener to understand, interpret, and evaluate what they hear, and to provide evidence of their comprehension of what complainants are saying. In this way, it would seem advantageous for providers to make greater efforts to listen carefully and understand how people want to be treated. Such understanding can then be utilised to review matters at the institutional level, in terms of both the more 'transactional' issues of everyday policy and practice, and the more 'transformational' issues of organisational values and attitudes (Simmons, 2011).

Consumer Focus (2013) is currently studying potential methods, using technology, to improve access to redress for consumers, capture data on complaints and problems, collate and categorise them and highlight patterns – in order to focus on organisational solutions. Similarly, the Patients' Association has been working with staff and complainants at Mid-Staffordshire NHS Foundation Trust to enable complainants to have their voices heard and to translate that voice into genuine improvements in care. They have four key strategies: (1) Patient Champions and a Complaints Support Service to make the process of complaining as positive as possible; (2) Peer Review Panels to improve the independence, rigour and validity of complaints investigations through quarterly reviews of complaints handling; (3) Reflective Digital Stories of patient care using narrative as well as data to bring the complaints to life; and (4) a Complaints Survey which will be given to all complainants (The Patients Association 2013). Progress in all areas is reported on their website with critical commentary readily accessible.

The LGO (2011) study of complaints about adult social care suggests some key mechanisms for disseminating learning from complaints within provider organisations. In particular, creating openness and linking learning from complaint experiences to continuous professional development. Opportunities for reflection are important (including analysis at senior management or board level). These include staff meetings; staff supervision; management meetings; informal opportunities to voice and discuss complaints; training and induction and service user forums. There is a need for a robust data collection system, which collates, analyses patterns and which can then be reviewed at senior management level (Parry and Hewage 2009). This would allow public service organisations to identify and resolve any complaint patterns that may be developing (Gulland, 2011). However, as we discuss below, more might also be done at the service 'system' level to transfer knowledge and learning from complaints. The role of regulators and ombudsmen in doing this is another issue worthy of consideration (Simmons & Brennan, 2013).

## **B. Insights from the Complainant Interviews**

There was a widespread sense of hope and expectation that complaints would lead to positive changes and improvements in the care services provided. This was both in terms of service recovery where the service had been perceived to have failed, and in terms of service development where it was perceived that standards should be higher. Hence, complainants told us how:

*'I was hoping they would get themselves together, to start looking after the people and caring properly'*

*'I wanted to see higher standards in operation. Higher standards in monitoring.'*

Key to this was an extensive underlying desire to see the development of a more compassionate caring approach:

*'We wanted a better standard of care and more recognition of her personal needs...Just consideration of all these sorts of things, you know her dignity and all the rest of it'*

On occasions, the means for achieving these changes and improvements were also suggested:

*'It should lead to better training but whether it will or not I don't know.'*

A very common feature of making a complaint from the complainants' perspective was a notion that they were trying to make a valid and valuable contribution to better practice. This was neatly stated by one respondent, who when asked about the costs of complaining, countered this question with another:

*'What is a cost and what is an investment?'*

If it is accepted that 'a complaint is a gift', this places the onus on the receiver to invest wisely the endowment of knowledge that it represents (Simmons & Brennan, 2013). However, there was little evidence in complainants' responses of feeling that their knowledge had been valued by service providers:

*'Q: Do you feel your knowledge about the position was valued by the provider or not?'*

*A: No, it...it was resented'*

*'I think they just thought I was a pest'*

This rejection of complainants' perspectives establishes a clear need for third party intervention, such as that of the Care Inspectorate, particularly given the power differentials and information asymmetries often involved between service providers and complainants.

Some complainants felt that there was a definite resentment by service providers of scrutiny by service users' relatives or representatives. This led to a sense of 'opacity' in the level of information and communication provided:

*"I felt they were stirring things and trying to cover their own mistakes, which just led to an even worse situation".*

A number of respondents indicated that care staff were often covertly supportive of their complaints.

*'One of the carers, two weeks ago, was sitting there crying because the way the company was treating them and their clients. She was sitting there crying.'*

*'One day a member of staff pulled us over – me and my dad – and said, you know, "You've done the right thing. It's terrible the way that they get treated in here".'*

In this sense, complaints become almost a proxy for whistleblowing. This suggests that the current whistleblowing mechanism in care services might benefit from further activity to promote awareness and confidence amongst care staff in coming forward. As one respondent observed:

*'Some staff were delighted that somebody had complained. They had noticed the decline in service but were pretty helpless to do anything about it themselves'*

### **3. Challenges of defining successful outcomes and impacts**

#### **3.1 Defining successful outcomes**

##### **A. Insights from the Literature**

- The key outcome for service users is to use the learning from complaints to drive service improvement. Implementation of service improvements should be communicated to the complainant and the public (Francis 2013).
- The LGO (2011) research suggests that fifty-two per cent of care providers had changed the way their service operates as a result of complaints, with thirty-seven per cent changing the standard of service provided. Services that were part of a larger group were more likely to change the way their organisation operates and to improve the standard of service.

- However, Department for Education research (McKenna and Day 2012) underlines some of the challenges of defining a successful outcome. The need for clarity about the desired outcome from the outset emerges as fundamental to satisfaction with the result in some cases. The research identifies the need for ongoing communication during the complaints process; agreement on the point of closure; and restoring positive relationships at the end of the process as resentment continued in some cases (with mediation or support suggested where relationships have been put under great strain).

Complaints are based on judgments that users form about public services. Simmons (2011) shows that one aspect of this concerns outcomes for the tangible ‘attributes’ of the service, such as whether or not floors are kept clean. This is the relatively straightforward level at which many understandings of ‘customer satisfaction’ tend to be focused.

A second key aspect concerns the outcomes that the service produces for consumers, such as ‘helping me stay healthy’ or ‘helping me to feel more self-confident’ (Simmons, 2011). This mirrors recent research on “SHANARRI” outcomes for children and young people: <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/well-being>). These recommend that people should be:

<b>Safe...</b>	protected from abuse, neglect or harm
<b>Healthy...</b>	experiencing the highest standards of physical and mental health, and supported to make healthy, safe choices
<b>Achieving...</b>	receiving support and guidance in their learning – boosting their skills, confidence and self-esteem
<b>Nurtured...</b>	having a nurturing and stimulating place to live and grow
<b>Active...</b>	having opportunities to take part in a wide range of activities – helping them to build a fulfilling and happy future
<b>Respected...</b>	to be given a voice and involved in the decisions that affect their wellbeing
<b>Responsible...</b>	taking an active role within their schools and communities
<b>Included...</b>	getting help and guidance to overcome social, educational, physical and economic inequalities; accepted as full members of the communities in which they live and learn

However, rarely are such outcomes explored with consumers in any systematic way. This undermines levels of understanding and risks leaving implicit what consumers want and expect.

As Simmons (2011) points out, thinking about the outcomes of the service helps to build bridges to a third aspect of the way in which consumers make judgments about public services. This involves users’ values - what they want in life or see as a better

way of living (Laaksonen, 1994). Values therefore summarize some of the more abstract end results that people hold dear. When users sense that the values underpinning the service are not compatible with their own, this can also lead them to reflect on the situation and attempt to promote service improvements through complaints.

## **B. Insights from the Complainant Interviews**

There were two main categories of outcome desired by complainants. First, hard outcomes (or tangible aspects of service provision), such as updating care plans, following procedures and training staff. Second, soft outcomes (or intangible aspects of service provision), such as providing services with empathy, respect, dignity and compassion. Both types of outcome are important in the provision of 'person-centred care'. Each features strongly in people's responses when asked about the outcomes they were looking for from their complaints:

*'We wanted procedures put in place that would change things'*

*'I just wanted them to do what they should be doing. I wasn't looking for anything wonderful, just good, basic care'*

*'I wanted a better standard of care and more recognition of my mother's personal needs'*

However, in addition to considerations of changes and improvements in the delivery of care services, we asked complainants about other personal outcomes that might be important to them such as receiving an apology or financial redress. The perceived sentiment behind an apology was important in determining its value. This confirmed that being taken seriously and receiving recognition and acknowledgement were fundamental.

*'An apology would have been...it would have showed that they took the complaint seriously and they cared...You know what I mean, 'What you're saying is right, I'm really sorry'. That would have been worth loads'*

*'I don't think I did receive the apology from the service provider...That would have meant that there's a human side there rather than just an organisation which is doing the, you know, the run of the mill type work, yeah, is that what you call it, the sort of humanistic element would have been there and that would have been appreciated'.*

However, in general it was clear that receiving an apology was of secondary importance in relation to service improvements:

*'If it's a spontaneous really genuinely meant apology then it's very valuable, but I wouldn't have thought it would have been. Anyway, we needed an improvement not an apology'*

A number of respondents had little expectation of an apology, as they felt that this would somehow require providers to incriminate themselves. As one respondent put it:

*'I didn't expect an apology, because that's them accepting guilt'*

For others, the thought of any further communication with the provider was distressing, even the receipt of an apology:

*'I wasn't looking for an apology – I really didn't want to have any contact with them at all'*

One thing that was clear from the research was that financial compensation was not a factor for complainants. Despite the cost of care services, people were generally dismissive of the very idea of financial issues as a consideration.

*'No. That wasn't a driver at all. No, no. Not at all'*

*'Absolutely not, nothing like that'*

*'Never thought about it'*

Even on the rare occasions this had entered people's minds, it seems they had quickly dismissed it as being of a different order of importance:

*"At the beginning I was wanting compensation for the way they had treated him. I wasn't looking for anything big... Just more or less: 'look, you got that money from us every month to look after [x], I want something back in return'. And then I sat down and I thought about it; I thought, no, I don't want it. I don't have much but I don't want it. I just want to make sure that the home doesn't get away with it any longer the way that they're running it".*

## **3.2 Moving Towards 'Person-Centred' and 'Compassionate' Care**

### **A. Insights from the Literature**

Values of 'person-centred' and 'compassionate' care are key themes in the current health and social care agenda. Brooker (2003) argues that person-centred care exemplifies that people are valued, and helps to find a realistic way in which patients

and families can be involved in service design. She summarises such care as involving:

- valuing people with care needs and those who care for them
- treating people with care needs as individuals
- looking at the world from the perspective of the person with care needs
- a positive social environment in which the person with care needs can experience relative wellbeing (Brooker, 2003: 216).

The UK government's Health and Social Care Act (2012) aims to empower people by giving them choice in their own care – “no decision about me, without me” and in co-creating health and social care services, locally and at national level. The Scottish Government (2013) echoes this in its 20:20 vision of Quality:

*“Person-Centred’ - Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making’.*

Similarly, Dewar et al (2009: 39) suggest a number of touchpoints to promote compassion, including help for care providers to emotionally engage with patients and families and understand their experience at a deep level. This may help to uncover aspects of compassionate caring practice that are not easy to define.

The Francis Report (2013) has raised significant concerns about a lack of compassion or care, which can invoke strong emotions with service users and family members. However, Meyer (2009) defends the actions of service providers. Indeed, she says they are taught these defence systems to distance themselves and therefore maintain professional integrity when dealing with highly charged emotions. She adds that the pressures of constant change within organisations; added paperwork, less staff, and tick-box culture leaves little time for providers to deliver person-centred care.

People can become so emotionally involved when complaining that their normal behaviour changes in response to the injustice they perceive (Schoefer and Ennew 2005; Chebat and Slusarczyk 2005; Aurier and Siadou-Martin 2007). Complaints and complaint investigations hold great potential for sharing these experiences with service providers, but this requires outcomes to be generated that consider the level of human values rather than focusing solely on the level of tangible service attributes.

## **B. Insights from the Complainant Interviews**

Value-based aspects of the culture of care shone through in people's responses about the outcomes they were looking for from their complaints. Person-centred care

was a consistent and powerful theme in the interviews with complainants. This represents one of people's key concerns.

*'I do feel that there's no person-centred approach and that is missing'*

*'What is needed is empathy, respect, dignity, compassion. Because you've got to have compassion for the people that are there, and an understanding of where they've been. Or where they're at'*

*'We wanted them to treat people with a wee bit of dignity and respect and show some compassion'*

*'All I wanted them to do was just to care for the person rather than seeing them as a number'*

In this way, many people lamented about the lack of person-centred care. Hence, respondents pointedly remarked on perception that providers were *'only interested in pounds and pence'*, and *'balance sheet-driven, not care-driven'*. The motivations of private care companies were subject to particular disapproval in this respect.

People told us how their values were offended by this attitude and approach, and how their experiences were difficult to endure:

*'I'm pretty intolerant of people not taking ownership. If you take the money, well, with it comes the responsibility'*

*'Somebody's got to get up off their backside and work for their money and gie us back our dignity, because we shouldnae be sitting here complaining about this. This is, this is bearing on neglect.'*

*'Everybody should get help...you're not in there to die cruelly, you're in there to get love while you die'*

*'There's no treasuring of the people'*

From the perspective of the Care Inspectorate, there is a similar risk that any impersonality in investigations may compound complainants' feelings of a lack of compassion. One complainant told us that:

*'I found the whole complaint system extremely stressful and highly complicated when a few people meeting round a table could have sorted things out... I do not think your department or whoever is in charge realises that the offspring of the elderly are themselves elderly and suffering illnesses. I would never again put myself through the hardship and interminable emails, letters and convoluted phraseology again'*

While this was not a widely-reported experience in the complainant interviews we conducted, it serves as a reminder of the need to balance the 'human' and administrative aspects of investigations.

In either case, one-off or long-term issue, the drivers for people's complaints concerned their perception 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.

*'The room was filthy, it hadn't been cleaned, it hadn't been hoovered, there were stains on the floor - and I just thought it was dreadful situation for her to be in, you know, a vulnerable person'*

*'Well, if there's something which I just really shake my head at, it's the compassion thing. We need more compassion, more dignity, more respect'*

Many complainants felt that these values should be ubiquitous in the provision of care. The following comments were typical of this:

*'Why should anybody have to tell a nursing home that they have to care?'*

*'If you are incompetent, you are going to affect nothing. You're going to get a salary and sleep nights, but you're going to wreak havoc on the people around, the people that need care'*

*'They shouldn't put people into those sorts of homes if they're not prepared to work with older people'*

*'I just feel as if that letter from the Care Inspectorate is telling them to do what they should be doing anyway'*

The level of frustration is compounded where there is no choice about the service provider. Some people were able to move their relatives away from providers with whom they had experienced a problem, although they still felt the need to pursue their complaint on principle and to avoid the same problems happening to others.

*'It was really to make sure that anybody else wouldn't go through what [x] went through. Because that's cruelty. In my eyes, that was cruelty'*

However, for most complainants there was no choice. Twenty five of the thirty two respondents who answered the question (78%) told us that they had no choice about who provided them with the service. This led to some to feel quite desperate about the situation:

*'Emotionally it's reprehensible to think your mother is somewhere that's awful'*

*'When I found out there was no other option, it was terrible. Terrible for me to look at it and say, 'This is all we've got. This is it, and I'm going to have to put you back there'*

Even where there sometimes appears to be choice, consolidation in the sector can mean that the same provider company ends up running all the care services in a locality. As one respondent identified:

*'They're expanding and taking over. Although it looks like you've got lots and lots of choice, they're all getting to be owned by [company x].'*

## **4. Poor Practice and Training**

### **A. Insights from the Literature**

- The Francis Report (2013) examined 'conditions of appalling care' at the Mid Staffordshire NHS Foundation Trust. Effective complaints handling, professional leadership, clearly understood standards, accredited training, evidence-based compliance, openness, transparency and accountability were all identified as essential for good quality care services.
- The LGO (2011) study summarised poor practice in complaints handling as failure to 'take on' the complaint; poor communications with complainant; complainant experiencing negative repercussions as a result of complaining; failure to investigate/weak investigation; shunting of responsibility/lack of liaison with more than one organisation involved; lack of timescale/delays; lack of follow up/implementation of agreed actions resulting from complaint.
- Citizens Advice (2011) recommends that organisations need to improve complaint handling systems and training for employees to help them recognise vulnerable consumers and their individual needs. It also highlights that ease of use and access to advice, information and communication systems, such as websites that are accessible, are of utmost importance to reduce potential detriment.

When it comes to communication, having a range of methods available to consumers can be a good thing (Simmons et al, 2012). However, no matter what method is used, one of the most important communication skills is listening. Hence, as Simmons (2011) points out, even public service organisations with ostensibly elaborate involvement processes often remain remarkably impervious to the input from these processes. In itself, therefore, institutional design is not enough. Institutional effort must also be invested in ensuring that the message gets through.

A listening culture requires a degree of congruence between the values and norms that are institutionalised in care organisations and those held by service users (Simmons, 2009; 2011). The institutional structures of public service organisations preserve particular cultural values and norms, give them authority, and provide a context for social interaction (Brett, 2000). Such cultural values and norms are important in the way that they inform organisational systems and practices, and it is important to understand these issues. If the values and norms institutionalised in public service providers are compatible with those internalised in service users, there may be 'cultural congruence'; if they are incompatible, there may be 'culture clashes' (Simmons et al, 2012).

Key barriers to changes and improvements include: leadership failures, financial inhibitors, poor service design, poor coordination, organisational inflexibility, and lack of trust (Simmons & Brennan, 2013). The current study examines the extent to which such factors represent barriers to the way in which complaints might lead to positive changes and improvements.

However, spaces for complaining and voice are influenced by power as well as culture (Skelcher et al, 2005; Barnes et al, 2003). Empowerment, as a concept, has different characterisations within behavioural and social sciences. According to Zimmerman and Warschausky (1998: 6), an empowered consumer "would be expected to feel a sense of control, understand their socio-political environment, and become active in efforts to exert control". Simmons et al (2012) capture this in terms of 'having a say and making a difference'. They show that where public service consumers do not feel they have the ability to do this, they may approach 'authoritative' bodies (such as the Care Inspectorate or elected representatives) as a way to overcome perceived power differentials and information asymmetries between them and service providers. This research seeks to find the extent to which this applies to the role of the Care Inspectorate in relation to care services in Scotland, and the value people attach to this.

## **B. Insights from the Complainant Interviews**

Many complainants saw the opportunity to complain as a chance to 'have a say and make a difference' (cf. Simmons et al, 2012), especially where a choice of provider was not available. This was evident in comments such as:

*'The more that people actually complain the better. Otherwise nothing's going to get done about it and we have no other alternative'*

As described above, complaining directly to the service provider often resulted in standoff between the two parties. The role of the Care Inspectorate is therefore of fundamental importance to people in giving them a sense of empowerment to proceed with their complaint:

*"[The manager] wasn't wanting to take on board the complaint and come to grips with it and it made one feel a bit powerless. Whereas, you know, the Care Inspectorate gave you a sense that you were more in charge of it".*

*'I thought right, you know, we're going to be listened to now'*

This is linked to the second issue, about how service providers might be encouraged to be more open, learning organisations, even in the face of potential conflict. This could include a re-evaluation of the mechanisms of making a formal complaint, which might include an opportunity for the complainant to say what they do like about the service as well as what they do not.

*'We wanted them to be more open and, you know, to do what they'd say they'd do'*

People commonly gave us a picture of the service in which things were not bad in every respect. However, levels of commitment and morale were often perceived to be inconsistent:

*'They're all nice girls to speak to, but their caring wasn't right. It was a case you had to push them to do anything'.*

*'I wanted them just to care more about their job, to want to be there instead of having to be there'*

*'The managers, although they're very pleasant, they just listen and don't give any feedback, you know'*

*'Some staff were very, very good. Others couldn't care less. They were just there for the money.'*

*'There's one good SCO up there, I've got to be honest with you, she's good, she's a good practitioner. She likes her job, she has an empathy and she knows what makes people click. But, the other people that are in there, they don't have a level of professionalism and the team work's not there and the hierarchical structure is not there. So, she's constantly battling. There's another one or two girls that are in, that are not bad, but they definitely need instruction. So, there is a potential for having a really good team.'*

This sense of balance is often missing in complaints, which tend to emphasise only the negative. This may serve to create a more adversarial relationship than may be necessary during the complaints process. Hence, the following comments are typical of the experiences commonly reported by respondents:

*'They just want to keep us at arm's length'*

*'Every time I asked to discuss something they closed rank'*

*'Every time we complained they were just so defensive'*

*'It went from defensive to aggressive actually'*

Vulnerable people perceived a number of barriers to complaining that resulted from the attitude and approach of others to the complaint. A key barrier was fear:

*'I think people find it very difficult to complain, I do. They are scared about the impact that has. There is that, 'will they be nice to my mother, father, or whoever it is?''*

*'People are afraid to complain, they're afraid to ... How can you complain when your carer is handing you a sheet of paper saying "could you write down and then I'm going to take it away". That's morally wrong isn't it?'*

However, for some people their own pride was sometimes also a barrier. This could drive the behaviours of 'silent suffering' noted by the Institute of Customer Service (2012). One service user complainant put it like this:

*'Nobody wants care. When you say that to people, they gasp. "What do you mean, nobody wants care?"...'*

This complainant's experience was that people could not comprehend the idea that care consumers might feel a need to maintain their dignity and sense of self, and not be labelled as dependent through verbalising their needs in complaints. In this sense, an attitude from others in the care system that people should be 'grateful recipients' is pervasive and often difficult for consumers to challenge.

Many of the key barriers to complaints and voice discussed in the literature review were evident in the findings from the complainant interviews. One barrier identified was *leadership failure*. For example, the quality of management was seen as an important factor. Hence, complainants told us that:

*'The manager was more interested in keeping the staff happy...the staff did what they wanted'*

*'Even though the Care Inspectorate have been brought in and all the rest of it I don't think anything is going to change long-term with that service. If you haven't got management right at the top then it's going to be a bad service you get'.*

*'When you have a culture of nobody caring, it probably also means that the staff aren't cared for, in which case they don't care'.*

Another barrier identified was a lack of resources to pay for the required level of care. Such *financial inhibitors* were widely perceived to have real effects, for example in everyday staffing levels and difficulties in staff retention due to low rates of pay for care staff. Even so, there was still a sense that these resources could be more effectively managed:

*'They kept saying they were short of staff, 'we're short of staff'. Yes in some ways they were but in other ways they weren't... Even if there were four on they'd all go outside and have a cigarette and sit outside, so they had plenty of time in my eyes'*

*'There were a lot of temporary staff coming and going'*

Another barrier picked up by certain complainants, especially other professionals, was *poor coordination*. Hence, it was expected that the learning from suggested improvements would be disseminated through the hierarchies of care companies and therefore more widely applied:

*'We wanted them to acknowledge that they were lacking and we wanted procedures put in place that would change things and I think we also wanted it to go further up the chain of command in [private care provider group] and for them, you know, to say we are going to change things and for them to be more open and to change, you know'*

This was compounded by a sense of *organisational inflexibility* that complainants translated as either incompetence or intransigence:

*'They were either incapable of taking it seriously, or they were under instructions...'*

*'Aye, nobody listens. Everybody does exactly the same as your daeing, make notes. Then you go awa', four days later we get a letter saying we cannae help you, thank you, that's a.'*

Relationships established between care providers and certain complainants often did little to engender good faith between them. This *lack of trust* was evident in a number of cases. For example, respondents told us how:

*"We just felt there was an undercurrent, they knew they were in the wrong but they were hoping to get away with it".*

*'I knew [the provider company] would just lie to them, because we've had this before; they just lie, they just flannel you. And I thought, 'No, to support what I'm saying, what I'm alleging, I need to give them evidence'. So I did, I had a*

*big dossier like that, to support everything that I was claiming, and I cross referenced everything'*

Training emerges from the complainant interviews as a particularly important focus for improvement and the achievement of better outcomes:

*'I just wanted them to start following their policies and procedures and make sure their staff are properly trained'*

*'We wanted better professional standards, better professional training, better...a more professional approach to the whole thing'*

*'We wanted them to discipline their staff. Retrain them'*

However, as one respondent astutely observed, this needed to be linked to effective recruitment practices:

*'For people who have the right qualities training will do the rest, but basically if people are mismatched in their job, all the training in the world will not make them effective'*

*'Preferably you would want to put a whole new staff team in there altogether, somebody with a bit of drive and determination'*

## **5. Role of the Care Inspectorate**

### **A. Insights from the Literature**

- Social Care and Social Work Improvement Service (SCSWIS), also known as the Care Inspectorate, regulates and inspects care services and carries out social work and child protection inspections with the aim to ensure that people receive high quality care and that their rights are promoted and protected.
- The Care Inspectorate scrutinises around 14,500 care services including child minders, nurseries, care homes and care at home services. They inspect social work and child protection services provided by the 32 Scottish local authorities. They also investigate complaints against care services registered with the Care Inspectorate. In 2011/12 (the year of study), the Care Inspectorate completed investigations into 1562 complaints by the end of the year with seventy per cent (1094) upheld or partially upheld. In the current year, 2012/13, the Care Inspectorate completed investigations into 1796 complaints by the end of the year with sixty five per cent (1172) upheld or partially upheld (source: provisional information, complaints extract 4 April 2013, Care Inspectorate).

- The impact of complaint investigations by professional and regulatory agencies on the organisations they oversee is an under researched area. However, a small amount of work has been carried out on the impact that ombudsmen have on the practices and policies of bodies they investigate and this may offer a useful starting point for researching this dimension of the Care Inspectorate's impact.

Ombudsmen have recently become interested in their impact and the Parliamentary and Health Service Ombudsman has commissioned research in this area. This research selected 21 upheld complaints and interviewed the public officials most closely involved in the implementation of the recommendations. The research concluded that in 17 cases PHSO recommendations had either been effective in driving change or acting as a catalyst for change, while in 4 cases recommendations had a limited impact (IFF Research 2010). It suggests factors which make the positive impact of recommendations more likely such as timeliness of investigations and a cooperative approach by ombudsman staff in which they are seen as an 'improvement partner'.

Academic work on the impact of ombudsmen is extremely limited. Hertogh (2001) conducted a study in the Netherlands comparing the impact of courts and the national ombudsman. The study involved qualitative interviews with 30 key informants in two administrative agencies, in addition to observation at several meetings at which responses to court and ombudsman decisions were discussed. The findings showed that ombudsman investigations were more likely to have a policy impact compared with court decisions and Hertogh theorised that this was due to these organisations 'control styles'. He concluded that a cooperative style of control, epitomised by the approach of the ombudsman, was more likely to be effective in improving administrative practices than the coercive style of control epitomised by the courts.

There is desire from organisations to improve collaboration and communication to benefit service users. A working group have created Care Homes Connect, which gathers information from all sources including residents, relatives and carers, in order to collectively make improvements (NHS Institute for Innovation and Improvement 2013). Hunt (2008) has suggested that there could be stronger collaboration and co-operation between advice, redress and information providers. In one example of good practice here, the Financial Ombudsman Service (2012) uses 3-way phone calls to allow their specially trained advisors, the consumer and their advice worker to speak together, to ensure inclusive access and improve communication.

In terms of approaches to studying impact, Gill (2011), building on Halliday's (2004) work on the impact of judicial review and Hertogh (2001), has suggested six factors

which are relevant to assessing the impact of complaint investigations on administrative practices:

1. The number of decisions reviewed by the complaint investigation agency
2. The nature, clarity and consistency of decisions taken by the complaint investigation agency
3. The quality, quantity and timeliness of feedback provided by the complaint investigation agency to bodies subject to investigation
4. The attitudes and aptitudes of officials in bodies subject to investigation
5. The relative strength of competing influences on bodies subject to investigation
6. The style of control, authority and powers of the complaint investigation agency

These factors, suitably adapted to the context of the Care Inspectorate's investigations, might form a useful basis for understanding bodies subject to the Care Inspectorate's oversight.

## **B. Insights from the Complainant Interviews**

Eight respondents (21%) reported that they had complained about a one-off problem, and twenty nine (79%) about a longer-term issue. This supports the findings from earlier research (Simmons et al, 2012), that people use different channels for different types of issue; i.e. that a majority of one-off problems will be taken up and resolved with service providers directly without recourse to bodies such as the Care Inspectorate. However, if a one-off problem is considered to be serious enough, the complainant may still decide to take this to the Care Inspectorate. For example, there were complainants who reported that:

*"They broke the law. There was a high level of incompetence and they endangered another person"*

*'All the staff were sitting having coffee in the conservatory, nobody was answering the door...eventually the doorbell was answered by another resident. Anything could have happened'*

Longer-term issues tend to be different. Sometimes they have been taken up unsuccessfully by complainants with service providers in the past. At other times, the complainant has taken a view that the provider is either unwilling or unable to make the changes they perceive to be necessary.

*'They were saying things like, 'if you've got a problem you should say it to the nurse on duty not save it up for a meeting' and I thought 'well we do but nothing's ever done about it''*

*'I'd actually drawn this matter to their attention about four times and they did not address it satisfactorily and it kept on happening'*

*'We were at the point of no return, we kept, you know, approaching the home and they were telling us they had strategies in place and they just weren't happening, you know?'*

In this way, the Care Inspectorate plays a fundamentally important role for people who feel 'at the point of no return'. It is generally seen as an independent and authoritative third party in establishing what should be done.

*'I think for most people you view the Care Inspectorate as sort of the regulator and someone that will do something about it and we felt going there was the final option and it was serious and that the home would take that on board as being very serious so really that was it there was nowhere else to go for us really'*

*'I don't think we would have had the same result if we'd just gone to the Social Services or just to the care home itself, they would have been quite defensive and - maybe not Social Services, they're more independent - but the overall management of the care home I think would probably have tried to hush it up. Whereas this is a legally binding thing that they have to do.'*

The role of the Care Inspectorate in supporting all of the above - an effective complaints process, a better attitude and approach, and changes and improvements in services – is widely seen by complainants as being of great significance. The overall balance of complainants' responses was clearly positive about this. First, there was a sense that the Care Inspectorate's status as an independent party was important. As one respondent put it:

*'You don't want to drag people's name through the mud when in fact your experience might be unique, and you're looking for almost like a kind of independent arbiter to say is this just all in our mind or is there something substantive that's gone wrong?'*

This value of independence was supported by a widespread perception of objectivity in the approach taken by the Care Inspectorate's complaint investigators:

*'The Care Commission went in, they did an unannounced visit which was fab'*

*'They'd gone in unannounced, which I'd known because I was there on the day they went in, and they'd gone into different rooms. They had a free rein'*

For a number of complainants, this released some of the burden of pressure they had been feeling to maintain their own ongoing scrutiny of the service:

*'It's not up to me if it's resolved now, because the Care Commission has to make sure it's resolved'*

*'They're now being watched as to what's going on so they won't get away with what they did before'*

Nevertheless, some respondents were unsure if investigations and inspections could get to the root of the problem if the underlying issue was 'cultural' rather than 'technical'. Hence, as one respondent observed:

*'It was a cultural thing with this place, which I think is probably a bit more difficult to pin down, isn't it?'*

One respondent went further, suggesting that the Care Inspectorate could improve its practice by taking into account the wider implications of concerns raised in complaints:

*'I think they need to just give a bit more thought to the extent of complaints. Looking a bit deeper, you know, thinking about the keys and triggers that should raise concerns and ramifications of that being widespread practice'*

Whether complaint investigators were able to get access to the necessary evidence was also a concern for one respondent. However, if complainants were negative about anything, it was about the level of authority that the Care Inspectorate was able to exert over changes and improvements in service delivery. Some were unsure about what was possible:

*'One thing that's not clear about the Care Inspectorate, even if you look at the website or whatever it is, is precisely the powers they have'*

*'We know they've got the power to inspect, but we don't know what they've got the power to do'*

Certain other respondents went further. Based on their own observations rather than alternative evidence, they seriously questioned whether the Care Inspectorate currently had the ability to deliver the outcomes they had hoped for:

*'I think that their remit needs to be improved... The remit is so limited that they are only offering guidelines. There has to be an added area where they can enforce, and that is what I would be looking for'*

*'I don't think they've got enough teeth. I think the legislation possibly prevents them ... the legislation ties them up in knots. And I think that perhaps the legislation should be changed.'*

*'I think they could come down harder on the provider... more enforcement on them. More powers to them, that's what they need'*

*'I don't know how much [the providers] take on board. That's why I think the Care Commission needs the teeth to really go in there'*

Just occasionally, complainants went as far as to suggest that the Care Inspectorate was unwilling rather than unable to tackle their complaint. This might be put down to an unwarranted level of trust in providers, or a 'cosy' personal connection ('regulator capture'):

*'It can be quite cosy in that they all tend to know each other because a lot of inspectors have been nurses'*

*'Their intentions are good. But they dinnae want to rock the boat'*

All this led to a certain degree of exasperation with what some complainants saw as either insufficient or ineffective sanctions for providers' non-performance:

*'What really gets me is the wording of the complaints when they're upheld, in my view, it's not strong enough, it's like a wee slap on the wrist'*

*'The inspector told me "don't worry, they're definitely being monitored", but I just feel as if they've had a slap on the wrist'*

*'What's the good of having a Care Commission and they'll just go in and say things aren't right and then just leave it be?'*

A large majority of complainants were concerned about follow up to make sure that the recommendations and requirements from investigations were actually put into practice.

*'The Inspectorate, they publish two lines and if you want to read the full complaint you have to email them and about a month later you get it through so you're not really being given that much information so for me I would like, you know, maybe a few months after the complaints been upheld to say what happened as a result of the complaint being upheld'.*

*'I felt angry at the response. Angry at the time delay. Angry at the fact that I'd been sent a letter. I mean, I know it is a form of communication, but I just felt it was very, very formal and that was it, that's it all finished now. We've done our investigation, so. That was it'*

*'I got a nice, however many pages, report done and it achieved nothing. It was an absolute waste of my time... Talking about it, producing reports and doing absolutely nothing is counterproductive'*

For large numbers of complainants this meant that there was a lack of closure at the end of the process. Hence, complainants stated that:

*'It went into a miasma of whatever'*

*'They could be getting off scot-free, we just don't know'*

*'I don't know, that's the difficulty, I really don't know. I have to hope and pray that it's getting monitored now but...'*

*'I just feel as if I don't have closure'*

*'There's no closure, that last letter's inadequate'*

This lack of closure is an important finding from the research. While everybody was able to say what they hoped their complaint would achieve, very few were able to say with any sense of clarity or certainty what it had actually achieved.

*'I have no idea about the outcome from my complaints'*

*'I don't know if it's still ongoing. I suspect it is. So is it wasting my time if the companies are still continuing like that?'*

*'What's the difference of all that effort, all that anguish?'*

People perceived a range of outcomes and impacts from their contributions. This varied from the sense in a significant minority that their complaint had achieved nothing, or simply brought an unconfirmed 'hope' that it had or would, to a rather vague level of confidence in the majority that it had had a positive, although largely unspecifiable, effect.

The importance of the above observations should not be underestimated; this was one of the key findings from the research. People's assessment of the overall impact of their complaints on the service was by far the most important consideration in their calculation of whether the complaint had been 'worth it' or not. Having a complaint 'upheld' by the Care Inspectorate was a starting point for this; 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 things off.

## Key Issues: Provider Interviews

The Care Inspectorate provided the research team with a list of all service providers that had been subject to a complaint investigation in the previous 12 months. From this long list, the team confidentially selected providers from a range of different service contexts to relate their experiences of the process and outcomes of complaint investigations. First, we asked them about the value they place on complaints as a source of information. Second, we asked them whether the Care Inspectorate was fair in the way it conducted its complaint investigations, whether it was thorough, and how long it took to communicate its decisions. Next, we asked whether the Care Inspectorate gave advance notice of its investigation visits, whether its investigators kept providers properly informed throughout the process, and whether follow up visits were made to see how improvements were going. Finally, we asked about the nature and impact of its decision letters, and about any changes that providers had made, or had been unable to make.

### Value of Complaints

Providers generally welcome complaints in principle: ‘there is definitely a place for complaints – if the service is not running well you need complaints’. Typically, they see complaints as a ‘really valuable source of information – it could be small things, you can pinpoint them and do something about them’. Another provider recognised that formal complaints were just one source of hearing ‘local concerns’, and that they needed to get better at ‘recognising and reacting to grumbles and gripes’, despite the resource issues that might be involved. However, they also found being involved in a complaint investigation difficult at times. A lone childminder found it difficult to respond to complaints and investigations ‘when you work on your own’. Other providers felt that ‘sometimes the level of expectation [from consumers] is too high – people expect a gold service (e.g. one-to-one care), but they are not paying for this’. A minority felt that complaints could be resolved more easily at the local level: ‘some complaints should come to us first, it is premature to go to the Care Inspectorate’. However, because of the emotions involved, some providers felt it was difficult for complainants to see the provider side; the Care Inspectorate was therefore often seen as valuable in promoting more ‘open communication’.

### The Complaint Investigation Process

Most providers felt that the complaint investigation process was fair – only in one specific case was this not the provider’s experience. In the large majority of cases providers were either already familiar with Care Inspectorate processes and had built an effective working relationship with Care Inspectorate staff, or the experience was that the investigator gave all interested parties the opportunity to speak and have their views taken into consideration. A small number of providers identified a degree of inconsistency in the approach taken by inspectors. Where they had an existing

working relationship, they claimed to be able to establish a shared vision for what should be done more easily. Where investigators were coming cold to the organisation, a small number of providers felt they tended to be more process-driven and 'pedantic'.

A good, open relationship built on trust was considered to be very helpful and valuable. However, one provider felt that this could work as a disadvantage for them in terms of the fairness of the process:

*'[Care Inspectorate investigators] don't know what they don't know. Cheap companies with no training can just tick boxes and say they have processes in place and that is accepted, whereas we are candid and too honest and we end up with problems as a result.'*

This may be true in some complex cases. However, the large majority of providers felt that the investigators were quite thorough in their complaint investigations. Most felt that the investigators 'always looked for the paper trail' and went through 'lots of paperwork and documentation', even where this required the provider to locate files in their archives. Most also felt that the investigators 'spoke to the people they needed to speak to', complementing the analysis of documentation with interviews with staff and service users. Only in one case did the provider feel that their own personal evidence was not taken into account, although another felt that the Care Inspectorate inspector 'did not take into account wider problems in the sector' in reaching their decision. There was, however, no sense that the investigators were 'too thorough'. Typically people commented that it was important to 'get underneath things'; one provider said 'I don't think it could ever be too thorough, would always want to do the best we can', another that 'it is not too thorough - it is good to evidence if there is a problem or not as an important learning tool'.

In general, providers were also satisfied with the length of time that investigations took. Most providers said that the length of time varied according to the nature of the complaint, with some resolved very quickly and others taking longer. However, in much the same way as complainants, almost all felt that this was reasonable and appropriate in following due process.

## **Communication Issues**

There was varied experience about whether visits from investigators were announced or unannounced. Some providers had experienced both of these situations. The extent to which this was perceived as a problem varied between different services. For example, nurseries and care homes felt that unannounced visits created operational difficulties in delivering care while staff were required to help locate paperwork and/or give testimony. A home care service provider also raised the issue that 'some users are quite stressed if they have to respond suddenly to an unannounced visit in their home' and that "bogus caller" stress is an issue

here'. There may be some practical solutions to these problems, such as informing home care clients but not providers about home visits, or bringing agency staff as cover. Problems in care homes and nurseries might also be avoided if the investigator simply observes what is going on during an unannounced visit and then comes back at a more suitable time for further discussion/investigation. In principle, however, there appears to be strong support for unannounced visits. As one provider put it, 'we should not be painting the toilets' in preparation for Care Inspectorate visits: *'The Care Inspectorate should just turn up...they should understand that things would not look perfect all the time'*. Another put it more simply: *'That's your regulator - if they appear, they appear. If people knew they were coming, some companies would rely on that'*.

The large majority of providers were quite satisfied with how they were kept informed during the investigation process. In general they felt that they were kept in the loop and informed of any delays. One told us that 'you always know what is going on'. Only in one case did the provider feel they had been kept in the dark. Another mentioned that it was sometimes difficult to get answers when phoning in, as they were put through to a different person each time. E-mail contact appeared to be more reliable; one respondent told us 'they always get back to e-mails'.

In terms of follow up communications after the decision letter and recommendations, the picture is much more patchy. While some providers did receive a regular inspection soon after the investigation decision was communicated, there was sometime an 'essence of tick-boxiness about that', and the resulting recommendations/action plans were not always an explicit feature of the inspection. 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'*.

### **Nature and Impact of Decisions**

Providers were unanimous that the decision letters issued following a complaint investigation are clear and straightforward to follow, and that 'investigators are good at explaining'. Letters were therefore generally seen as a good summary of what had happened and what needed to be done. Almost all providers responded positively to these communications – even if just in terms of being 'glad it was over and I could move on'. Providers see working with the Care Inspectorate staff as a good part of the learning process. As one respondent put it, 'if there's a complaint been upheld it is part of the learning curve – you accept it, you put something in place'. Another observed positively that '[the Care Inspectorate] give you plenty to work on, it's like a consultancy'.

The actual changes that were brought about as a result of investigations were quite clear in providers' minds. There was usually discussion at management level about

how to incorporate decisions into operations. Most providers spoke of how they had changed procedures, systems, practices and paperwork:

*'I am more careful about my daily diaries'*

*'We changed our practice – all pre-care plans for each child are now completed before they start'*

*'We changed our internal procedures, we now set up visits on a computerised system'*

*'We have put in additional changes to financial procedures – more records are being kept'*

*'Documentation is the big area – and occasionally more input into staff training'*

However, while important, there was a sense from at least one respondent that this did not go far enough, and that *'some actions end up being quite tokenistic'* rather than contributing to a *'strand of continuous improvement'*. This provider was concerned about the extent to which things were *'process-driven rather than outcomes-focused'* – a point that appears to be confirmed by some of the comments above. It is also evident in anecdotal events, such as a home-care provider being pulled up for not having risk-assessed a remote control falling down the side of a client's chair.

Importantly, more than one provider felt that the Care Inspectorate needed to *'catch up'* – with both what was actually happening (in terms of what has been termed the *'don't know squared'* problem above), and in terms of engaging fully with moves to promote more flexible and tailored care rather than more standardisation and compliance. Another provider captured this balance between flexibility and standardisation as *'a need for loose tightness'*. Such notions begin to engage with ideas of value-shift and cultural change that seem to lie, implicitly or explicitly, at the heart of the pursuit of future service improvement.

Overall, however, there was unanimous support for the role of Care Inspectorate from providers. The Inspectorate is generally seen as capable, approachable, and reliable. If it did not exist, it would probably have to be invented; as one respondent told us:

*'If there was no Care Inspectorate there would be problems. We need what they do - the Care Inspectorate is an essential part of the landscape'*

These views represent the tip of the iceberg in terms of the very valuable feedback that might be acquired from service providers. For example, further exploration is

required of the notions of partnership inherent in both the above contributions and the literature supporting a role for organisations such as the Care Inspectorate as an 'improvement partner'. We believe further qualitative research with providers would be very valuable in moving this agenda forward positively (we raise this again later in the report in suggestions for further research and enquiry).

# Incorporating Feedback

## A. Insights from the Literature

- Much of the literature on how other complaint handling organisations obtain feedback on complaint investigation quality and outcomes is focused on ombudsman organisations. Ombudsmen perform an external complaint handling role that is similar in important respects to the complaint handling role fulfilled by the Care Inspectorate.<sup>2</sup>
- Some ombudsman organisations seek feedback predominantly from complainants (e.g. Local Government Ombudsman), while others seek feedback from both complainants and the organisations they investigate (e.g. Legal Ombudsman). No ombudsmen routinely collect information about the outcome of their complaint investigations, although most measure customer satisfaction with complaint outcomes.
- Ombudsman organisations tend to collect both qualitative and quantitative feedback – using quantitative methods for routine collection of feedback and qualitative methods for less frequent, more in-depth investigations of customer feedback. The vast majority of ombudsman schemes use independent research consultancies to collect feedback on their behalf.
- Generally, feedback is collected under the banner of ‘customer’ or ‘stakeholder’ satisfaction. This focuses almost exclusively on satisfaction with various aspects of the complaint investigation process – from the first contact made by a complainant to the final decision being issued by the ombudsman organisation – rather than collecting data on changes brought about by the complaint investigation.
- Most ombudsmen collect feedback after a decision has been taken and a case is closed, so that questions can be asked about the whole customer journey.

Our desk research provided some useful information about how other complaint handling organisations obtain feedback on complaint investigation quality and outcomes. We also asked members of the Ombudsman Association for information. Finally, a meeting was held with the Financial Ombudsman Service in order to discuss their sophisticated approach to the collection of feedback.

There is variation in the frequency with which organisations collect feedback: some organisations conduct a quarterly customer survey whose results are reported

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<sup>2</sup> It is recognised that the Care Inspectorate’s regulatory function means that its role is significantly different to most ombudsmen. However, in relation to the quality of complaint investigations and their outcomes, similar issues are likely to be relevant for ombudsmen and the Care Inspectorate.

annually; others conduct research every few years; others still collect feedback on an ongoing basis; and some vary their approach to collecting feedback depending on organisational need, some years conducting a survey and other years commissioning qualitative research.

Although ombudsman organisations collect feedback in ways that suit their particular structures and concerns, there is a broad degree of congruence in terms of the areas about which feedback is sought. These generally relate to overall satisfaction; customer service; complaint handling/investigation; communication; timeliness; and suggestions for improvement.

There are various approaches to sampling. Some ombudsmen ask for feedback on all cases decided within a given period. Others seek feedback on a sample of cases (either drawn randomly or strategically). The sampling choice often depends on the number of cases in the total population and the aim of collecting feedback. The choice of method also generally depends on the purpose: some organisations use telephone surveys, while others use postal or online surveys. Online surveys are the simplest to administer and analyse; yet equality and diversity issues mean that a postal survey may be preferable. Meanwhile, telephone surveys allow for probing and greater depth of response than either form of text-based survey.

Information from customer satisfaction surveys is used as part of organisations' attempts to assure and improve the quality of the service they provide. The closest ombudsmen organisations have come to considering complaint outcomes *per se* is a qualitative research project commissioned by the Parliamentary and Health Services Ombudsman looking at the impact of their complaint investigations on organisational practices (PHSO/IFF 2010).

Generally, the focus in this report is on survey approaches to feedback collection rather than in-depth qualitative approaches. This is because qualitative approaches are more expensive and unlikely to be suitable for the *routine* collection of feedback. However, we draw attention here to certain pitfalls in the conduct of feedback surveys. First, it should be noted that some methods of feedback collection may not be suitable for in-house feedback collection e.g. telephone surveys would be difficult to carry out if conducted by members of Care Inspectorate staff. It should also be noted that the analysis of quantitative data requires specialist skills that may not be available in-house. Second, routine collection of feedback from provider organisations may be inappropriate given that they are more likely to be repeat players. There is a danger of survey fatigue if organisations are asked to respond too regularly and, therefore, it may be appropriate for feedback to be collected less frequently from organisations than from complainants.

## **B. Insights from the Primary Research**

In relation to obtaining feedback on outcomes, the primary research provides a steer on how this can be incorporated. As a result, we have designed a feedback tool that attempts to capture the full learning from this project. This draft feedback tool draws on the analysis in this report to identify the key issues about which complainants might be expected to raise concerns. After a short section identifying the background of the individual complaint 'Your Complaint and Care Services', the feedback tool has sections asking about 'The Complaint Process', 'Approach and Attitude', 'Changes and Improvements' and 'Overall Satisfaction'. A decision is yet to be made about the inclusion of 'Equalities Monitoring Information'. The latter section was not included in the pilot.

The tool was piloted with a sample of 106 complainants identified by the Care Inspectorate. Twenty two responses were received (after a chasing e-mail/letter after two weeks), giving a response rate of just over 20%. This is in line with expectations for a postal survey. Results from the pilot show that the tool was well received. However, it is to be recognised that the 80% who failed to respond may have had different views, or have found the form more difficult to complete. A more extensive pilot might therefore be advisable prior to a full launch.

We asked people to complete the form and then tell us if any questions were difficult to understand, whether anything was missing that ought to be included, whether the form was too long or if there were any questions we should cut out. Respondents were clear that all the items should be included. They told us that all the questions seemed relevant, and that it was not too long. One respondent observed it was 'a perfect length'. Another appreciated 'having room to make a comment'. Respondents also found generally that the form was clearly worded and easy to understand. The large majority of respondents observed that the form covered most of the key issues, that it was 'fairly comprehensive' and 'covers all situations/choices'. However, some minor suggestions were received and these have shaped the final feedback tool.

## **C. Further Questions**

In addition to questions about the format and content of the feedback tool, there are a number of other design and methodological considerations for the Care Inspectorate to consider:

- Should feedback be collected from both organisations and complainants?
- Should feedback be quantitative or qualitative or both?
- Should feedback be collected in house or independently? (And what resources are available for either option?)
- Are quantitative analysis skills available in house?
- Should feedback be collected before or after a final decision or both?
- If collected after, how soon should feedback be requested?

- Should feedback be collected quarterly, annually or over a longer time frame?
- Should feedback be sought from organisations and, if so, over what time frame?
- Should feedback be sought on all cases or only a sample of cases?
- Should feedback be collected over the telephone, online or by post?
- Should feedback be collected anonymously or be tied to cases?
- How will feedback be used?

Further discussions are recommended about these considerations, both within the Care Inspectorate and with other stakeholders.

# Conclusions

## Summary

This research has identified a number of important considerations for the development of better practice in the response to complaints throughout the care services system. The role and potential of the Care Inspectorate in supporting this system and helping to lead developments is significant. We identify a number of key areas for further consideration that arise from this study:

- Good communication
- Ensuring opportunities for voice
- Learning from complaints
- Desired outcomes and positive relationships
- Developing the service culture and values
- Power and empowerment

## Good communication

This report 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. It is important for complaint handlers to listen without blame and turn complaints processes into a positive experience. These are valuable goals, helping to both uphold fundamental standards *and* develop the culture of caring. All actors within the service system have responsibilities here. The Care Inspectorate can help to ensure coherence and consistency in promoting and enacting this approach. This may extend away from an overly technical and administrative interpretation of its role, to one of 'improvement partner' with service users and providers. There is evidence in this report of some good progress in these respects; however, the research shows that there is also scope to take this agenda further.

## Ensuring opportunities for voice

Complainants want to find workable solutions and find the defensive attitudes of service providers very difficult. The availability of a variety of channels for user voice is valuable in allowing voice to emerge. It is well known that a significant proportion of users are 'silent sufferers' who do not think they are going to be listened to, while others may speak to frontline staff but not have their views properly recorded to be taken into account by service managers. This is of particular concern where vulnerable consumers are involved. Voice has a key role to play in reducing consumer detriment and making service improvements. The Care Inspectorate's role amongst the various channels for voice is highly valued by the large majority of complainants in this study, standing in an important place between dealing with the

service provider directly (with all the power and information asymmetries this presents to the consumer), and taking legal action.

### **Learning from complaints**

Complaining is not a pleasurable activity for complainants. 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 spirit in which they are largely intended, and to use the learning opportunities they endow to drive service improvement. This requires the right complaints culture throughout the service system so that blindspots can be identified that help to unlock innovation and improvement. The Care Inspectorate has another important role to play in encouraging greater openness and commitment from service providers to the 'learning organisation' agenda, whilst also ensuring the system-level transfer of knowledge within the care services sector to promote continuous improvements in practice.

### **Desired outcomes and positive relationships**

Service outcomes are fundamental to the successful resolution of complaints. At the outset, there is a need for greater clarity of desired outcomes and agreement on the point of closure. Apology is not enough, and compensation is not a priority consideration 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 service provided with empathy, respect, dignity and compassion). Both types of outcome are important in the provision of 'person-centred care'. Complainants in the research wanted to see both 'higher standards in operation' and for providers to 'start caring properly'. The Care Inspectorate can develop its role in more fully exploring complainants' desired outcomes early in the process. As a respected third party, it can also play an important part in helping to restore positive relationships between complainants and service providers where these have broken down. The addition of mediation services may further extend these capabilities (see below).

### **Developing the service culture and values**

Dealing with cultural issues means addressing the values that people hold dear. It should be noted that in interviews providers shared many of the same values as complainants. However, it was clear that such factors as leadership failure, financial inhibitors, organisational inflexibility and lack of trust had led to service breakdowns in many of the cases we examined. The desired culture of the organisation as an open, caring learning organisation had somehow been lost or found missing. It was recognised by complainants that these are more difficult considerations for the Care Inspectorate to investigate. Nevertheless, it was commonly perceived that a bridge needed to be more securely built between service attributes and processes, and

service outcomes and their consequences. Positively, this point was also raised by some providers, who saw great value in the Care Inspectorate 'catching up' with a new focus on outcomes rather than process. For the Care Inspectorate, an examination may be valuable of its style of control and the attitudes and aptitudes required to deliver on this broader agenda.

### **Power and empowerment**

Power is an important underpinning theme in this research. The Care Inspectorate also has a very important role to play in levelling the playing field for complainants in the face of power and information asymmetries. Complainants valued the Inspectorate's power to investigate, but were often left uncertain about its power to act and secure service improvements. The impact of its recommendations where complaints were upheld was therefore highly uncertain for the large majority of complainants. While providers reported compliance with Care Inspectorate recommendations as essential regulatory requirements, it seems that this is not always followed up consistently through the regular inspection process. The value of locating inspection and complaint investigation in the same organisation is clear where vulnerable consumers are involved and prompt regulatory action is required. The feedback from this research is that these advantages could be even more effectively achieved.

# Recommendations

The recommendations emerging from this research are outlined in the Executive Summary. We repeat them here, annotating each of the 'key' recommendations with a short summary of the related key findings. This adds context to the most important action points emerging from the research. Our 'further' recommendations are repeated without additional annotation.

## A. Key Recommendations

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.

Perhaps the biggest issue in this research was that of resolution; in particular a widely-perceived lack of closure due to a lack of feedback about the outcome of a complaint. Currently, the complainant receives the Care Inspectorate report with recommendations/ requirements and associated timescales but the Care Inspectorate does not contact complainants to say what has been complied with (or not).

Complainants would be interested to know the outcome and what had changed following their complaint. Continued contact with complainants after the decision letter would provide greater clarity about the changes and improvements made to the service. Moreover, there does not appear to be a mechanism for the complainant to tell the Care Inspectorate if there has been no change as a result of their complaint – apart from complaining again.

In terms of costs and benefits, considerations such as financial redress were universally seen by complainants as being of secondary importance. Similarly, measurable costs of time and money were of secondary concern. However, emotional costs were almost universally considered to be heavy, even when the complaint was upheld. What many of the complainants seemed to want from complaining was that they/their relative be treated with a more humane approach and with dignity. The redress put forward by the Care Inspectorate was about adhering to Care Standards. The Care Inspectorate may wish to review this to ensure the delivery of outcomes that more closely meet consumer expectations.

It should be noted that a growing proportion of organisations across the public and private sectors are following up on complaint outcomes: 27 per cent now

do so routinely, up from 8 per cent in four years. When organisations take the time to contact complainants for feedback, satisfaction with complaint handling is increased by more than 51 per cent.

2. Always **keep people informed of progress** with their complaint whilst the investigation is ongoing.

The Care Inspectorate was largely considered to deliver an effective service by our complainant sample in this respect. This recommendation is made to ensure that the commitment to doing so remains high. This feature of the Care Inspectorate's service is very highly valued by complainants and would be a source of considerable dissatisfaction if it were to be reduced in priority.

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.

The system of unannounced visits by investigators to providers was almost universally supported by complainants. Providers also saw good reason for this, but raised concerns about service disruption at short notice. If resources allowed, perhaps agency staff could be employed to help cover staff commitments during the course of investigations. Following investigations, complainants had widespread expectations that the Care Inspectorate would continue to keep a close watch over providers to ensure improved performance. Where this is unrealistic within given resource constraints many organisations apply a 'traffic light' system, with more regular follow up inspections for those marked as 'red' and fewer for those marked as 'green'. Some complainants felt that the powers and range of sanctions available to the Care Inspectorate needed to be extended.

The particular vulnerability of care service users was identified by complainants as requiring careful consideration. This was recognised by the Sinclair Report (2008) in relation to the linking of complaint investigation and regular inspection.

4. **Improve follow up communications with service 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’.

Complaints identify blind spots and hold the potential to unlock innovation and improvement. There is an opportunity to identify the root cause of service users’ concerns and incorporate innovation at the heart of management policy. With consumers, service providers and third parties working together, they will broaden and deepen discussion and develop new solutions to better meet consumer needs.

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.

As almost a quarter of consumers who have a problem are “silent sufferers”, the Care Inspectorate may wish to encourage service providers to adopt a more proactive approach to inviting complaints and promoting earlier, more cost-effective early resolution. Telephone, in person and email remain the preferred methods of contact.

The Care Inspectorate may seek to develop a stronger consumer focus in the service providers’ approach to complaints and encourage them to respond effectively to comments, concerns and grumbles, in addition to formal complaints. For example, the Care Inspectorate did not seem to comment in their Reports on how the provider had handled the complaint – looking at why the complainant had decided to progress the complaint/why they were dissatisfied with the response (if any) from the provider in relation to their complaint. ‘Expressing your views’ is one of the Care Standards and includes dealing with complaints.

However, where these methods fail the Care Inspectorate is widely seen as a more desirable means of ‘upscaling’ a complaint than the available alternatives. For example, some people see approaching elected members as a possible next step but those who had done this reported mixed experiences. The press was seen as too intrusive, and the police as excessive (especially where moral imperatives of compassionate care were considered to be of equal or greater importance compared to legal imperatives).

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.

The findings from the complainant interviews show that complaints in care services tend to be about matters which offend core values of decency, respect and compassion. In turn this tends to provoke emotional commitments to complaints, whether the complaints are made by people on behalf of themselves or others. This requires complaint handling in care services and by the Care Inspectorate to be conducted both with sensitivity and consideration for due process.

Service providers need training to respond more effectively to complaints and feedback. This would provide a positive opportunity to use training to create a culture which is open, listening and responsive, and where organisations want to learn from complaints. Training in the area of compassionate care is also important as part of the improvement of services. This training needs to be embedded in organisations and valued by staff at all levels. More senior staff would benefit from complaint investigation training to enable them to learn from complaints and use them as a spur for improvement.

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

Many complaints involved multiple agencies, so the service user may be satisfied with the Care Inspectorate outcomes, but still dissatisfied with others, like social work services. It is important to find ways to encourage better relationships between complainants and providers as a way to find workable solutions without recourse to the Care Inspectorate. This may involve support in developing skills in recognising and rewarding loyalty, rather than placing pejorative labels of 'persistent complainers' or 'the usual suspects' on complainants.

Support may also be provided for developing and extending anonymous systems of whistle blowing for users, relatives and staff. As the Prescribed Body for whistleblowing in the care services sector in Scotland (BIS, 2013), the Care Inspectorate may wish to consider how the process for whistleblowing is best promoted and facilitated with care staff who may otherwise feel unable to speak out against their employer.

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

Complaints processes are adversarial by nature and can lead to a polarisation of positions. Restoring positive relationships at the end of the process was found to be important in reducing the scope for continuing resentment. Where relationships have been strained, it may be helpful to offer mediation or support services.

Complainants and providers both want to have their concerns listened to and acted upon. Mediation is increasingly used alongside and within complaints processes as it can produce outcomes which are both meaningful and cost-effective. Mediation is non-adversarial and aims to resolve matters to the mutual satisfaction of both parties. However, mediation is not a replacement for putting matters right and there can also be a robust investigation in order to prevent a re-occurrence of events or learn lessons. Mediation can work alongside these actions to bring much-needed closure and also be a valuable learning experience for the parties to a complaint.

## **B. Further Recommendations**

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.

## Further research and enquiry

There are opportunities for further research with consumers, providers and internally in the Care Inspectorate. We propose the following areas for consideration:

### **Consumer research**

A qualitative study with consumers whose complaints were not upheld. This would provide insight to learn why this group of people made complaints; the outcomes they hoped to achieve; their experience of the process; and whether they would recommend the organisation.

With the permission of complainants, consider filming them and using the clips as powerful material for training and to be viewed by colleagues at a senior level in the Care Inspectorate.

### **Service providers**

A study to achieve a deeper level of knowledge of service providers: to learn about their values; their ways of working; the extent to which they are focused on person-centred care; the barriers experienced in responding effectively to complaints; their views of taking an outcome-led approach to complaint management, service improvement and innovation; their relationship with the Care Inspectorate and how they would like this to develop; the nature of improvement partnership.

### **Care Inspectorate**

A pilot study within the Care Inspectorate to bring together its knowledge (from inspections and other sources) of impact and outcomes (hard and soft) on services following upheld complaints.

A study to capture the views of complaint investigators and inspectors. Focus groups with groups of complaint investigators, groups of inspectors and mixed groups of both investigators and inspectors would provide an insight into the values, attitudes and aptitudes of participants. They would provide an opportunity to explore the culture of the organisation and compatibility with the culture of service providers and expectations of complainants. Qualitative interviews would enable further exploration of key areas of interest and the opportunity to comment in a trusted environment. The study would enable learning about how the Care Inspectorate can lead positive change in the sector.

## Innovative approaches with complaints

Four case studies are presented which draw from earlier research by the team for the National Endowment for Science, Technology and the Arts (Nesta). These illustrate innovative approaches to using the knowledge and experience of complainants and service providers to develop services. They allow a deeper appreciation of the issues and the opportunity to get ‘under the skin’ of complaints and uncover blind spots causing problems for service users. While it is appreciated that these approaches are more expensive to implement, the Care Inspectorate could develop a rolling programme of innovative approaches to supplement the information gathered through the more routine feedback tool. In addition there is a short section on mediation as this may be of interest to the Care Inspectorate.

### Case Study 1: Experienced Based Design

Bolton health board introduced an initiative, Alzheimer100 to gain an ‘insiders’ view of service standards. People with Dementia, along with their carers and service providers were invited to record their experiences and challenges using video, photographs, journals and weblogs. Similarly, cancer patients recorded their experiences when visiting clinics from diagnosis to treatment within Luton and Dunstable Health Board, Cancer Clinic. In both situations, these service users created powerfully, emotive stories which were shared at workshops with service professionals, service users, design teams and managers. This **encouraged ownership and co-creation of services which more effectively met the needs of the people using the services.**

Many innovations arose from the learning outcomes for each project, For example, for Alzheimer100, a Dementia signposting service was developed to direct people to services; a mentoring programme was developed for carers and a ‘Wandering Garden’ was designed to allow safe nature walks. For the cancer clinic, the EBD technique helped to capture emotions and ideas for practical solutions to improve the user experience. The service provider can now point to more than 40 real improvements in their head and neck cancer services as a direct result of the EBD work. Feedback from a cancer patient “The thing that’s amazed me about this whole experience is how much can actually be achieved with little or no money – simply because we’re working as equals alongside staff, sharing ideas and finding common sense solutions.”

Sources:

Bolton:

[https://www.institute.nhs.uk/images/documents/Quality\\_and\\_value/EBD/Alzheimers%20100%20case%20study%20Dec%2009.pdf](https://www.institute.nhs.uk/images/documents/Quality_and_value/EBD/Alzheimers%20100%20case%20study%20Dec%2009.pdf)

Luton and Dunstable:

[https://www.institute.nhs.uk/images/documents/Quality\\_and\\_value/EBD/L%26D%20web%20case%20Dec%2009%20v2.pdf](https://www.institute.nhs.uk/images/documents/Quality_and_value/EBD/L%26D%20web%20case%20Dec%2009%20v2.pdf)

Co-creation, person-centred care and empowering service users to provide true insights into care provision are at the heart of this innovative approach. The sharing of this knowledge motivates professionals, organisations and carers to fully understand the needs of service users and has led to transformational, but not always costly, changes.

### Case Study 2: Patient Opinion

Patient Opinion is an independent social enterprise which allows service users to report experiences, good and bad, to the website. Its success has led to the UK government setting aside funds to allow patient opinion to include social care alongside health care. It has also recently been adopted by the Scottish Government (2013) having donated £150,000, which is encouraging all health boards to join.

Service users can read and share stories about care, both good and bad which are then passed to the relevant health board or care sector, who can respond, along with other service users. It empowers people with information and providing a forum for sharing experiences.

#### *Forum Theatre*

Patient Opinion took a complaint from the website and brought the complainants into the room with staff and other members of the public for a forum theatre workshop to consider the patient experiences and outcomes. As a result **52 people made 'promises' about how they would amend their behaviour.** This enabled input from the complainants, Patient Opinion and all workshop participants.

Source: <https://www.patientopinion.org.uk>

The focus is on **empowerment through information and voice for service users** but some organisations pay Patient Opinion to monitor complaints/feedback, to facilitate individual department feedback to service users and to collate information to inform learning from the experiences.

### Case study 3: 'You Said: We Did'

A corporate-down approach to complaints to turn Richmond Council into a 'listening council'. All complaints were collated, analysed and used for learning, including those not upheld. Patterns are identified, solutions sought and these are then fed into service planning.

Staff keep 'learning logs'. Lucy Knight, Complaints Advisor Research and Performance, feels that the Council's 'learning logs' really add value. "They make you stop and think about things from the consumer's point of view. They also **encourage innovation by allowing staff to suggest ways to improve services.** The Council's complaints panel is an excellent way to spread the learning so that something learnt by one service can be implemented by others".

A Complaints Mandate was created with six customer priorities:

1. respond quickly – for example, not all responses need to be by letter
2. get it right first time – for example, be responsive not defensive
3. be efficient – for example, act quickly to build a positive relationship
4. be more flexible, putting the customer first – for example, meet face to face
5. learn lessons from complaints – for example, use a 'learning log'
6. ensure quality through our complaints panel – review by senior officers

These measures have changed the strategy and culture of the Council and have been embedded organisation wide. There is a 'You said, we did' section on the website updating public on responses to complaints:

'Richmond Council is a large and complex organisation that provides services to thousands of people. We know we get some things right but we also make mistakes. We know this because you tell us. Receiving praise and criticism is a good thing as it tells us what we're doing well and where we could improve. If we have made mistakes or could have done something better, we want you to tell us so we have the opportunity to resolve the problem and stop it happening again. We want to know when we have not got things right; we want to involve our customers by listening and responding; above all, we want to use the information you give us to help us improve our services. We will always listen to your feedback and suggestions and, where possible, take positive action'.

Source: Centre for Public Scrutiny, 2011.

[http://www.richmond.gov.uk/home/council\\_government\\_and\\_democracy/council/councilprocedures/complaints\\_procedure/you\\_said\\_we\\_did.htm](http://www.richmond.gov.uk/home/council_government_and_democracy/council/councilprocedures/complaints_procedure/you_said_we_did.htm)

#### **Case Study 4: Experts by Experience**

Partnerships were formed between carers, users of health and social care services (termed Experts by Experience), with the Care Quality Commission (CQC) and Choice Support: a social care charity. This provides an 'insiders' view of service standards. Service users report experiences back to the charity and the CQC. This empowers and supports disadvantaged and disabled people by co-creating service provision to more closely match quality expectations. CQC must act upon reports to ensure recommendations have been acted upon and standards are met. One of the

Experts by Experience, Laura Minett, said “Service users’ voices have the power to be heard by this country’s regulator of health and social care.”

The focus is on **co-creation and person-centred care, empowering service users to provide true insights into care provision**. Professionals, organisations, service users, carers and everyone involved in care provision can share knowledge and understanding. This can lead to insightful learning from complaints and feedback.

Source: <http://www.cqc.org.uk/public/sharing-your-experience/involving-people-who-use-services#tab-1>

In addition to the case studies, complaint handling organisations are showing increasing interest in mediation or mediative approaches. A brief consideration of this area will add further material which may assist with the review of the management of complaints.

### ***Mediation***

Mediation is increasingly used alongside and within complaints processes as it can produce outcomes which are both meaningful and cost-effective. Complainants and providers both want to have their concerns listened to and acted upon. Complaints processes are adversarial by nature and can lead to a polarisation of positions. Mediation is non-adversarial and aims to resolve matters to the mutual satisfaction of both parties. It can also help to maintain and restore relationships.

Mediation can be defined as a process where disputing parties seek to resolve their differences in a mutually acceptable way with the assistance of a trained internal or external mediator. Mediation is both voluntary and confidential. The mediator helps both parties to be heard, to hear each other’s perspectives and to decide how they want to resolve their dispute.

The mediator achieves these outcomes by providing a process which encourages parties to communicate, move forward and actively seek solutions. However, the mediator does not offer advice or impose solutions and make no attempt to judge the situation. The settlement agreement can be made binding if the parties wish.

Principles of mediation include that there are two sides to every story and that the parties to a dispute are the best people to resolve it. Also, it is important that the third party facilitating the process is independent and impartial and has no vested interest in a particular outcome. Mediation may not be appropriate if power imbalances cannot be overcome, there is challenging behaviour, a legal point needs clarification or a precedent is needed.

The Scottish Legal Complaints Commission (SLCC), a second tier complaint handler, has included mediation as a formal stage in their complaints handling process (<http://www.scottishlegalcomplaints.com/making-a-complaint/complaints->

[process.aspx](#)). They use a panel of independent mediators. The SLCC fourth Annual Report (1 July 2011 - 30 June 2012) reports that 289 eligible service complaints were dealt with and closed by the SLCC during the report period, with 56 of these being resolved at mediation (<http://www.scottishlegalcomplaints.com/resources/annual-report-accounts.aspx>).

However, few complaint handling organisations have a separate mediation stage using external mediators. Others, such as Ombudsman Services, take a mediation approach to complaints handling, with their complaint handlers using 'shuttle negotiation' to try and resolve complaints at an early stage (<http://www.ombudsman-services.org/our-processes.html>). The Scottish Public Services Ombudsman also has a staged approach to complaint handling, with an Early Resolution stage (including mediation-like approaches) followed by an Investigation Stage with either a Decision or Investigation Report (<http://www.spsso.org.uk/our-complaints-process>).

The Patient Rights (Scotland) Act 2011 (Section 3.11) requires NHS Boards to consider and make provision for alternative dispute resolution, such as mediation or conciliation. Details can be found in the revised '*Can I help You?*' guidance on the handling and learning from feedback comments, concerns and complaints about NHS health care services ([http://www.sehd.scot.nhs.uk/mels/CEL2012\\_08.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2012_08.pdf)). During 2011-12 five NHS Boards participated in a six month mediation pilot conducted in conjunction with the Scottish Mediation Network. There were few referrals during that time and an review of the the pilot found the learning was limited (<http://www.knowledge.scot.nhs.uk/ncpas/mediation-via-scottish-mediation-network.aspx>). However, it was recognised that mediation had a role to play in resolving some complaints within the NHS and the Scottish Government agreed the subsequent provision of central funding to allow the Scottish Mediation Network to maintain the pool of mediators selected for the pilot.

It must be said that mediation is not a replacement for putting matters right and there can also be a robust investigation in order to prevent a re-occurrence of events or learn lessons. Mediation can work alongside these actions to bring much-needed closure and also be a valuable learning experience for the parties to a complaint. Therefore, considering whether to mediate (using internal or external mediators) could be an approach taken either when a complaint first comes to the Care Inspectorate (including whether to refer it back to the provider to for them to try and resolve through mediation), or at the end of the process when relationships might need to be re-established.

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