Healthcare Improvement Scotland

scottish health council

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Voice In A Tough Place

Healthcare Complaints in Scottish Prisons

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Foreword

In 2014 the Scottish Health Council identified, in our *Listening and Learning report*[1], that more needed to be done:

"…to truly understand the challenges that exist in ensuring equity of the management of feedback, comments, concerns and complaints for prisoners."

Health inequalities are endemic amongst the prison population. In 2010 the Chief Medical Officer for Scotland reported that "almost every health problem and risk is over-represented in the prison population…" and that "70% of prisoners report a drug problem on admission to prison. Over 50% report a mental health problem"[2]. Seeking to reduce these inequalities was one driver for the transfer of responsibility for healthcare in prisons from the Scottish Prison Service to NHSScotland in 2011, though there has not yet been a full assessment of the impact this has made.

The Royal College of Nursing Scotland has called for more to be done to improve equity in health and care outcomes for people in prison in a recent report[3].

Prisons and NHS services, working together, have an opportunity to help address the health needs of prisoners. There are undoubtedly some challenges involved in delivering healthcare in the prison environment, where people's liberty has been restricted and there are a range of other considerations that do not apply to patients in the community. Having an appropriate system for prisoners to give feedback or make a complaint about their healthcare is an important factor in ensuring that prisoners rights as 'patients' and people using healthcare services are recognised.

This report shows examples where this has been achieved, and where staff from different bodies have worked together to improve systems and services based on learning from prisoners' views and experiences. It also identifies areas for further consideration.

As the report involved a relatively small sample, and looked at only three of the nine NHS Boards which have prisons within their areas, it cannot be assumed that the experiences it records would be shared across Scotland. However, it raises many interesting points that merit further consideration and also identifies some practice that the Scottish Health Council considers worth sharing.

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1 http://www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx#.V4i4YNIrJhE

2 Annual report of the Chief Medical Officer 2010: http://www.gov.scot/Publications/2011/12/14120931/5

3 Five years on: RCN Scotland review of the transfer of prison healthcare from the SPS to NHS Scotland, November 2016

Whilst prisoner healthcare is now the responsibility of integration authorities and NHS Boards, the impact and potential benefits of health and social care integration are not explored in this report. The Scottish Prison Service should work closely with all its partners across the public sector to ensure that services appropriate to prisoners' needs are developed in light of experience in other settings. The integration of health and social care presents an opportunity for this joint working to take place; particularly in terms of supporting an ageing population.

The Scottish Health Council, working closely with partners, is currently progressing the Our Voice[4] framework which is based on a vision where people who use health and care services will be enabled to engage purposefully with health and social care providers to continuously improve and transform services. In commissioning this report, we considered that it was essential to listen carefully to the voices of prisoners to inform the findings, as well as listening to relevant staff and statutory bodies.

This report will only be useful if people are aware of it, and if we learn from and act on its findings. The Scottish Health Council is grateful to everyone who contributed to this report and hopes that people will find it to be useful and informative.

Pam Whittle CBE
Chair of Scottish Health Council

[4] https://ourvoice.scot/about/

1. Introduction

This report sets out findings and considerations designed to help NHSScotland improve how it listens to what prisoners say about their experiences of healthcare. These findings and considerations have been informed by:

- Visits to three of Scotland's NHS Boards to hear about how they gather and listen to feedback, comments, concerns and complaints from prisoners about healthcare and how they learn from this to improve the services they provide. NHS representatives were interviewed in both the prison environment and Health Board offices. The research also included discussions with prisoners.

- Views gathered from other key stakeholders about their knowledge of the prison healthcare system and the handling of complaints. This included colleagues in the Scottish Public Services Ombudsman's office, the Scottish Government, National Prison Healthcare Network, Her Majesty's Inspectorate of Prisons for Scotland and Citizens' Advice Scotland.

In Scotland there have been a number of developments that underpin this field of enquiry, including the *Patient Rights (Scotland) Act 2011*[5] and associated revised *Guidance on Handling and Learning from Feedback, Comments, Concerns and Complaints about NHS Healthcare Services CEL 8 (2012)*[6]. Indeed, in line with the *Can I Help You?* guidance, there is an aspiration for the whole of NHSScotland towards a culture that:

> *"Actively encourages and welcomes feedback, comments concerns and complaints. A culture that values all forms of feedback whether it is good or bad in order to learn from patients, carers and service user's experiences."*

This entails empowering people to be at the centre of their care and listening to them to see what is working well, or not working well. Efforts have also been made to make progress with this agenda in prison healthcare[7] - although the findings presented in this report suggest there is still more that can be achieved.

Listening and Learning

In April 2014 the Scottish Health Council Report, *Listening and Learning: How Feedback, Comments, Concerns and Complaints Can Improve NHS Services in*

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[5] http://www.gov.scot/Topics/Health/Policy/Patients-Rights

[6] http://www.sehd.scot.nhs.uk/mels/CEL2012_08.pdf

[7] cf. https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/policies-and-briefings/scotland/policies/2016/five-years-on-prison-report.pdf

Scotland[8] considered complaint handling in the NHS and the learning from this process. It picked up a range of issues in the general NHS environment in relation to complaints:

- people not knowing how to make contact or who to make contact with
- people not knowing the support available to help them do so
- a fear of repercussions for their own or relatives' treatment
- a lack of confidence that anything would be done.

The three most significant learning points that emerged were:

1. *Remove the fear factor* – There was a clear message from the public that a key barrier to giving feedback or making a complaint was fear of repercussions for their own or their relatives' treatment. This was compounded by the fear and defensiveness some staff reported when dealing with feedback. The report concluded that: "*considerable effort should be made on transforming the culture to support staff and the public to be open and confident."*

2. *Welcome feedback* – While the shared importance that everyone places on understanding people's experiences of NHSScotland was clear, a significant number of the public still reported a lack of knowledge of the opportunities to share all types of feedback, or make a complaint. The report concluded that: *"NHS Boards should encourage and support people to openly share."*

3. *Show the Improvement* – A necessity to learn and improve as a result of complaints and feedback was also highlighted. However, challenges were noted for NHS Boards in closing the 'learning loop', and for members of the public who believed nothing happened with the information they shared. The report concluded that these challenges: *"must be met by learning from feedback, implementing changes and informing people what improvements are made."*

It can be argued that some or all of these factors might also apply in the prison healthcare environment. Yet while *Listening and Learning* noted issues in relation to the handling of healthcare complaints in Scottish prisons, the prison healthcare environment was not fully considered, with no direct contact with service staff or prisoners. It was therefore recognised that further evaluation would be required to focus improvement. Some further work has since been done to assess NHS Boards' progress as part of the *Participation Standard*[9]. The research contained in this report was conducted to help follow up further on these issues.

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[8] http://www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx#.VzR6rtIrJhE

[9] http://www.scottishhealthcouncil.org/patient__public_participation/participation_standard/idoc.ashx?docid=8372eb77-6c65-4fb3-8593-5d4e11f741b6&version=-1 see pages 7 and 17

2. Background and Research Brief

There are 15 prisons in nine out of 14 territorial NHS Board areas in Scotland, and some Boards have up to three prisons in their area. Responsibility for prison healthcare transferred to the NHS from the Scottish Prison Service in November 2011. The main drivers for this were the principles of equity and equivalence; in other words, that prisoners should not receive a worse healthcare service than they might expect in the community[10]. The transfer of responsibility to the NHS is widely considered to have been helpful in this respect, with access to a better range of health services.

Following the transfer of responsibility for delivering healthcare services in Scottish prisons, NHS complaints handling staff assumed the management of feedback, comments, concerns and complaints received from prisoners about their healthcare. The *Participation Standard National Overview (2015)* states that *"several Boards have experienced an increase in prisoner complaints and some have seen this as a challenge".* There have been various attempts to resolve that challenge; it was noted in the *Listening and Learning* report that many complaints teams had reported to the Scottish Health Council that the volume of prisoner complaints received in NHS Boards was reducing again and that early resolution for prisoners at local level was increasing.

This research sought to take a further, more detailed look at some of the above issues relating to prisoners' experiences of giving feedback and complaints on healthcare in the three NHS Boards visited. It addresses three inter-related issues:

- what is the nature of the handling and management of prisoner healthcare complaints?
- what is the prisoner experience of complaining about healthcare? How can this be improved?
- what learning is taken from prisoner healthcare complaints?

In considering these questions, the research sought to identify what is important to develop NHSScotland's effectiveness in listening, engaging and responding to prisoners' concerns. It examined the extent to which different stakeholders take responsibility and ownership in the complaints process, and the role of communication, information sharing, sensitivity and engagement in supporting and communicating good outcomes.

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[10] https://isdscotland.scot.nhs.uk/Health-Topics/Quality-Indicators/Publications/2016-10-04/2016-10-04-Complaints-Report.pdf?87685793639 see p.11.

The research considered the potential for a more integrated and person-centred approach to hearing the voice of complainants, and for this to support the delivery of high-quality care. It also considered the extent of NHSScotland's capabilities, culture and commitment to effective complaint handling and learning from complaints. It is hoped that this will help inform the processes and management of prisoner healthcare complaints in the context of the new NHSScotland Model Complaints Handling Procedure which is being implemented from April 2017.

A summary of complaint volumes in Scottish prisons is provided in Table 1. This shows that there is some variation in different NHS Boards, from very low volumes in four Boards, to much higher volumes in another four. This report is based on information from NHS Boards that reflect this variation. However, such variations deserve exploration in further research in the future; for example, to consider how they might be affected by prison population characteristics and/or practice variations in particular prisons.

TABLE 1.

Number of complaints received and response times for Hospital and Community Health Services.
By PRISON SERVICE and NHS Board, 2015/16

PRISON SERVICES 2015/16			
NHS Board	Number of Complaints Received[11]	**% of Complaints dealt with within 20 working days.**	**% of complaints acknowledge within 3 working days.**
Scotland	**3612**	**95**	**94.7**
Ayrshire & Arran	12	58.3	100
Dumfries & Galloway	43	95.3	100
Forth Valley	366	99.2	100
Grampian	30	90	90
Greater Glasgow & Clyde	1732	96.2	99.7
Highland	10	80	100
Lanarkshire	420	99.3	100
Lothian	755	91	77.7
Tayside	244	88.5	93.4

Source: ISD(Scotland). NHSScotland Complaints Statistics 2015/16. Numbers and response times.
Publication date – 04 October 2016. (Data as at July 2016)

[11] In the NHS Complaints Procedure, a complaint is defined as “an expression of dissatisfaction requiring a response”.

3. What we did

The project took a largely qualitative approach to researching the above issues. One of the goals of qualitative research is to help understand the meanings, experiences and views of the participants. This approach helps to illuminate aspects of complaint-handling in prison healthcare that are difficult to measure numerically and might otherwise be missed. The 'Process of Analysis' section below shows how every comment received in the course of this research was subjected to robust and careful analysis. Nothing that was said was left unconsidered and no important theme was left unreported. Nevertheless, the limitations of this approach are that it is difficult to capture the full range of possible responses in a small and selective sample. Respondents in this research spoke in good faith and were widely identified to the research team as being knowledgeable about the subject of prison healthcare complaints. However, this is not to say that every important theme relating to complaints in prison healthcare in Scotland has necessarily been captured by this research or this report. It remains important therefore to establish the extent to which:

- the findings of this report are more widely recognised across the prison healthcare environment in Scotland
- additional factors may be identified that were not raised or identified by the participants in this research, however well-positioned and knowledgeable they may be.

To enhance these findings, therefore, further open discussion amongst stakeholders would be productive about the extent to which the findings are felt to apply more generally (i.e. in different NHS Boards and different parts of the prison estate that could not be included in this project).

In this way, the findings in this report are not intended to be statistically representative, nor to test a hypothesis against a standard set of pre-established criteria. They are intended to show something of the range of meanings, experiences and views of participants, rather than a generalisable distribution of them. To establish something of this distribution, additional research involving a quantitative survey methodology would be required. This report provides additional value in helping to identify some of the key factors that might be investigated in such a survey.

Engaging with prisoners

Focus groups of between 45 and 90 minutes were conducted with three groups of prisoners across two NHS Health Board areas. These groups took place in March and April 2016. Each focus group engaged with prisoners to ask what they knew

about making a complaint or giving feedback about their healthcare, what the experience of making a complaint was like, whether that process could be improved, and whether they felt that healthcare services had changed as a result. Groups consisted of prisoners who were identified by prison healthcare centres to have complained about their healthcare. Some had complained frequently, others less regularly. A total of 15 prisoners participated in the research. (NB. there were 7460 prisoners in custody as at Friday 25th November 2016)[12].

Engaging with NHS Boards and other stakeholders

Semi-structured interviews of between 30 and 180 minutes were conducted with 20 staff and stakeholders involved in the area of NHS feedback, comments, concerns and complaints. These interviews took place between January and March 2016. The majority of interviews were conducted face-to-face; where this was not possible, they were conducted over the telephone.

Three NHS Boards in Scotland contributed to the findings in this report. This included strategic leads at the NHS Board, as well as patient relations staff and staff based directly in prison healthcare centres. NHS Boards responded positively to the request for their involvement in this research. We also spoke with colleagues in the Scottish Public Services Ombudsman's office, the Scottish Government, National Prison Healthcare Network, Her Majesty's Inspectorate of Prisons for Scotland and Citizens' Advice Scotland.

This enabled meaningful dialogue and a richness of information to be gathered that reflected activity at different levels in the system.

As the Scottish Prison Service (SPS) declined to participate directly in the study, their views are not represented here. However, the research team is grateful to SPS for ethical approval and facilitation of access for this study.

Process of analysis

A detailed and careful process of analysis was conducted. Every single comment recorded during the focus groups and interviews was coded at least twice to ensure that key themes were identified and nothing was missed. In the first phase, comments were coded according to various themes that emerged from the data. The data coded under each theme was then examined in depth to provide a detailed account of what different respondents had to say. In the second phase these themes

[12] http://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx

were reorganised (merged or divided) and consolidated as sub-codes under a broader set of headings.

Limitations

Due to resource constraints, this study was limited to engagement with three out of nine NHS Boards, which together have responsibility for healthcare in seven out of 15 prisons in Scotland. It was not possible to include all NHS Boards or all Scottish prisons.

It should be noted that insights from this study cover a considerable range of experiences from within this study sample. It is therefore expected that there may be further variation in the experiences of NHS Boards or other institutions in the Scottish prison estate that were not included in this sample. Hence, this small-scale study cannot answer questions about the extent to which these themes apply across the Scottish prison estate as a whole, whether from the perspectives of prisoners or health professionals.

It should also be noted that the timing of publication means that some of the data in this report are now nearly one year old. Some of the issues identified may have moved on in the meantime. Others will move on as the NHS begins to implement the new NHS Complaint Handling Procedure. However, this report identifies a range of issues that warrant ongoing attention, and any suggestion that developments in this intervening period have been sufficient to overcome them could reasonably be the subject of further research and open discussion between stakeholders in the months and years ahead.

In sum, this report is not intended to provide a comprehensive and summative review, but to be explorative and to encourage further discussion around the themes that have emerged. The report's value will therefore be determined not only by the extent to which people recognise these themes in their own settings but by the extent to which they are able to provide further insights from their own experience. Thus, it is hoped that further discussion of this report will be conducted in the spirit of the research itself – in ways that seek to engage openly and positively with what is happening and to identify further opportunities to improve.

4. The Complaints Process in Prison Healthcare

This section considers:

- the background to the complaints process
- the complaints process in action
- tespondents' views on the complaints process
- information, support and advice available to prisoners.

Background to the complaints process

Before the transfer of prison healthcare to the NHS in November 2011, there was a two-tier complaints system, in which local resolution was attempted first within the prison establishment, with escalation to Scottish Ministers if the prisoner remained unhappy. While some respondents felt that this process protected prisoners' right to complain effectively, others felt it could lead to complaints being dealt with rather summarily.

None of the Prison Healthcare Managers interviewed for this research expressed a desire to go back to this process. However, the NHS complaints procedure that has evolved in the intervening period had reached a point where it was generally felt that *"it is a more cumbersome system now"* (Prison Healthcare Manager). Initially, following transfer the SPS prevalence of 'form filling' was supplanted by a preference for personal interactions in the NHS. As a result, lots of issues started to be resolved effectively without going to a formal complaint. However, with levels of complaints dropping, questions were raised by the Ombudsman and Scottish Government about whether prisoners were enjoying fairness and equity of access to complaints, so that no genuine issues were missed:

> *"SPSO raised the issue of access to the NHS complaints procedure based on evidence that barriers were being put in place of prisoners being allowed to directly access the complaints procedure. For example, there was evidence that prisoners were being told that they must engage through the feedback process before being allowed to complain. This deprived prisoners of their right to take their compaints to SPSO[13]."* (Scottish Public Services Ombudsman)

[13] cf http://www.spso.org.uk/investigation-reports/2013/may/ayrshire-and-arran-nhs-board-0 and http://www.spso.org.uk/sites/spso/files/communications_material/commentary/2013.10.23_SPSO_Ombudsmans_Commentary.pdf.]

In response to these concerns, Scottish Government introduced a combined feedback and complaints form in 4 July 2013, to allow prisoners to clearly indicate, by ticking a box, whether they wish to give feedback, comments, concerns or raise a complaint. It was made clear that this form, which replaced the existing feedback, comments and concerns form and the separate complaints form, was to be used immediately and made freely available and accessible to all prisoners. The rationale was that prisoners have a right to choose whether they want to make a complaint and that NHS Boards should have processes in place to ensure that the complaints process is easily accessible and that complaints are recorded and dealt with appropriately.

Respondents in this research reported that, in practice, prisoners tended to tick the box for a complaint. This led to concerns quickly being raised by NHS Boards about the increased number of issues raised following the introduction of the form and the additional pressure this placed on complaints handling staff who were required to respond. In this research, for example, respondents spoke of complaints 'process maps' with between 46 and 63 steps – although it should be noted that the role of the new form in increasing the complexity of the process was not made clear.

Equally importantly, the new form was perceived in some NHS Boards as a change in procedure that has *"taken away the filter of trying to resolve locally*" (Prison Healthcare Manager). In a letter to NHS Boards in September 2013 the Scottish Government pointed out that the 'combined form' was neither intended to change the responsibilities placed on NHS Boards under the *Patient Rights (Scotland) Act 2011* and the supporting legislation, nor the *Can I Help you?* guidance for handling and learning from feedback, comments, concerns or complaints about NHS healthcare services, where the emphasis is on early and local resolution. SPSO concur:

> *"It has always been the case that non complex complaints should be resolved within 3 working days (where possible); equally it has always been SPSO's aim that all complaints should be resolved quickly/early and as close to the point of service delivery as possible. Rather than take away the responsibility of local resolution, we have always encouraged this."* (Scottish Public Services Ombudsman)

The new NHSScotland Model Complaints Handling Procedure, which is being implemented from April 2017, may help to address some of the above matters as it introduces a distinct, five working day stage for early, local resolution, ahead of the 20 working day stage for complaint investigations.

The complaints process in action

A broadly similar complaints process was found to be operating in each of the three NHS Boards included in this research. First the patient's complaint form comes in to the prison healthcare centre or is sent directly to a Patient Relations Team at the

NHS Board, where it is acknowledged. It is then allocated for investigation within the prison to clinical staff (according to specialism – GP, mental health, addictions, primary care) or dedicated patient relations staff. These staff are given three days to review records and interview the patient before either resolving the issue locally, or compiling a draft response to their complaint. This draft response is checked by a first management tier (Healthcare Manager, Patient Relations Manager), and sent to a second tier (NHS Board lead) for sign off within 20 days. If it cannot be signed off at this level, the response will go to a third tier (Senior Management Team).

A small number of prisoners will fully exhaust the complaints process before contacting the Ombudsman (who report that in the last three years over 50% of all health cases reported were upheld). Others will involve their lawyer – healthcare centre managers reported that the prisoners tend to inform their lawyers of their case far more readily than complaints from the wider community. At this point, the issue will stop being investigated as a complaint and be passed to NHS legal departments. Anecdotally it seems that prisoners enjoy little success pursuing their case through this route.

There is little doubting the faith of NHS staff in the robustness of the above complaints process:

> *"We jump through all the hoops, do everything to fully resolve within three days."* (Prison Healthcare Manager)
>
> *"Some complaints are 14 pages long and [the HB Lead] is forensic about seeing that every detail has been investigated.*" (Prison Healthcare Manager)
>
> *"If I am not satisfied I will send it back – there has to be rigour.*"(NHS Board Lead)

However, there are concerns that the system has become rather 'cumbersome'. This is exacerbated if the volume of prison healthcare complaints is high. As shown above, this volume varies from prison to prison and from one health Board to another, often in relation to the prevalence of key prisoner issues (e.g. medication, waiting times for treatment), and the capabilities and commitment to respond to the wider issues summarised elsewhere in this report.

High volumes of complaints were not always anticipated by NHS Boards at the time of transfer, and variations in complaint volumes have contributed to different caseloads and associated pressures. The evidence from this project is that this needs to be properly resourced. All three NHS Boards had experienced issues with severe pressure in dealing with prisoner healthcare complaints:

"Last year was horrendous, we were so short staffed. We were very aware of the time pressures on this. It was too much." (Prison Healthcare Manager)

"We used to have to deal with this ourselves. Nurses were not nursing - everything else went on hold because you were always on the clock. Even dealing with complaints, things were messy and bitty. There was duplication of effort and things often weren't followed through properly." (Prison Healthcare Manager)

"The amount of work required is unrealistic and disproportionate. Nurses can have 12 complaints forms to investigate at any one time. This is additional to a normal day's work –and they don't have ready access to prisoners." (NHS Board Lead)

This situation is much improved in the first two NHS Boards. In the first case, the answer was simply to employ more nurses:

"Things are more settled and working a lot better. Now we can cope with complaints and still maintain clinical care." (Prison Healthcare Manager)

In the second, a novel approach has been taken - as a pilot - of employing two dedicated part-time nurses to act as patient relations officers and investigate complaints within the prison environment, alongside dedicated administrative support.

"This looks like an extra, but it has saved us money. We could not have restructured/redesigned the service without this, we were swamped. The database we have set up stops duplication and makes sure we stay on top of timeframes… Not only is it more efficient, it allows the Patient Relations Team at the Health Board to perform better." (Prison Healthcare Manager)

The third NHS Board continues to struggle within existing resources.

"Staff are exhausted with it. It takes up huge parts of everybody's jobs. At the front-end it is very bad for morale, and the managerial time spent on this is very costly.'' (Prison Healthcare Manager)

Respondents' views on the complaints process

Properly resourcing the complaints process within prisons has clearly been important. In addition, there is now considerable discussion around how to rebalance the complaints process away from the 'process-bound' approach described above, so that issues can be dealt with in a more appropriate (less pressured, less

bureaucratic) way. One suggestion is to define certain issues differently - for example as 'requests for service' rather than complaints:

> *"What is a complaint? We need some recognition of this - and what is not a complaint - in the guidance."* (NHS Board Lead)

> *"For prisoners' first presentation of a relatively low-level issue, many could be presented as 'requests for service', which are not treated as a complaint."* (Scottish Public Services Ombudsman)

The new NHSScotland Model Complaints Handling Procedure, provides further clarity on the definition of what is and is not a complaint. Such redefinition may be helpful for addressing some relatively low-level but nonetheless common causes of discontent (such as medication) in a less subjective, adversarial and time pressured way, after which there is still the option for prisoners to escalate the issue to a complaint. As the Scottish Public Services Ombudsman points out, *"the ability to escalate is fundamental – there is a legal requirement to escalate for a genuine complaint."*

Another suggestion is to prioritise complaints more effectively, so that more of them are dealt with at the local level. NHS Boards reported colour-coding complaints as either red (high-level, complex) or green (low-level, straightforward). However, all complaints are still subject to the same overall process. Scottish Public Services Ombudsman respondents in this research suggest that responsibility for complaints could be decentralised, so that staff are empowered within delegated limits - pointing out that 'flags' in the process should mean that 'big' complaints would come to the NHS Board anyway:

> *"The empowerment of staff at the point of service delivery is key to effectively managing complaints - especially those simple straightforward complaints that can or should be resolved quickly. More complex complaints should be subject to a thorough, robust investigation. It is for the Board to determine how this happens."* (Scottish Public Services Ombudsman)

Indeed, having been side-lined to some extent following the introduction of the new form in 2013, a key part of the introduction of the new procedure is that local and early resolution are becoming more of a focus again, and this is to be welcomed:

> *"If managers are allowed local discretion over local designation of complaints, that's a power I would certainly welcome."* (Prison Healthcare Manager)

> *"We would argue that a lot of issues could be dealt with early without complaint."* (NHS Board Lead)

> *"We want to encourage local resolution a bit more."* (Patient Relations Manager)

The advantages of local resolution, other than taking pressure off the system, include the ability to respond more appropriately due to proximity to and familiarity with complainants, and more attuned knowledge of the prison environment:

> *"In an inflamed situation, proximity and the ability to have dialogue are very helpful. Rather than a faceless person they don't know managing their complaint, the face-to-face person is known to the prisoner."'* (HM Inspectorate)

However, such initiatives are currently cautious and uncoordinated amongst different NHS Boards. This is in line with the *Listening and Learning* report finding that the focus on early resolution is clearer in some boards than others (p.29). There is therefore a widespread sense of needing to:

> *"Strike a proper balance in determining which complaints can reasonably be resolved through frontline/early resolution and which complaints need a thorough robust investigation of the issue(s) raised before a decision can be communicated.*" (Scottish Public Services Ombudsman)

However, for many, the introduction of the new complaint form in 2013 was felt to tip this balance – in what was already "*a very difficult balance to draw"* (HM Inspectorate). As a 'technology', the form seems to have replaced the previously more informal, interpersonal approach as the main 'pressure release valve' through which prisoners are encouraged to express their discontent. Given the direct link between the form and the pressurised, formal NHS complaints process this can be alienating for prisoners, who can quickly become disaffected:

> *"We used to go and sort things out informally in the halls. We have now formalised this process, which brings positives and negatives."* (Prison Healthcare Manager)

> *"If things are too informal, it can be patronising. But if they are too formal it can be alienating."* (HM Inspectorate)

Implementation of the new NHS Complaint Handling Procedure may help to promote a better balance between the above 'positives and negatives'. This remains a matter for future research and discussion.

In terms of working towards more early and local resolution whilst still protecting the principles of equity and fairness that drove the introduction of the form in 2013, there

was recognition of the need for *"proper governance of who is managing what"* (National Prisoner Healthcare Network).

Better "governance" in this sense could be helpful to reduce complaint levels. Respondents also raised a number of practical operational and relational issues that could lead to complaints about healthcare. For example, healthcare staff in more than one prison reported that access to prisoners is not always guaranteed, and requires liaison with prison officers. These staff told us that individual prisoners may be locked up and prevented from attending clinics for disciplinary reasons; they may also be moved without notice, or have their route movement changed. In this case, healthcare staff may be unable to locate them easily to administer medication. Similarly, if prisoners need to be escorted for clinics or outside treatment in hospital, this can also prove problematic. Due to demand and supply issues, there may not be enough prison service escorts to take prisoners to appointments. In each case, where treatments are missed, this can lead to complaints. This was particularly apparent in one NHS Board.

NHS staff are dependent upon SPS to be able to do their job. In general, this relationship was felt to work on a day-to-day level. Both organisations share common goals around the care of prisoners: care (specifically, *"supporting wellbeing and treating with respect and humanity all in our care"*) is one of SPS' guiding principles, along with custody, order, and opportunity[14]. Yet there are occasions where different concerns and priorities can come to the fore, as highlighted by one NHS Prison Healthcare Manager:

> *"For example, there is NHS guidance that some prisoners should see the doctor, not a nurse, but SPS say "you cannot make that decision for us - it has operational implications". In other cases, SPS say: "the prisoner must go to work", while the NHS says: "but he's got toothache and needs treatment."*
> (Prison Healthcare Manager)

HM Inspectorate suggests a more balanced position, that there should not be *"an over-emphasis on the operational aspects of the prison, nor an under-emphasis on clinical care."* For the National Prisoner Healthcare Network, this provides scope to consider how to ensure a '*better spirit of collaboration and better relationships*'. For HM Inspectorate, there will never be a perfect solution and this requires bridging:

> *"Compromises are required on both sides, it's negotiating that. How do you build that 'mutuality'?*"

[14] http://www.sps.gov.uk/Corporate/AboutUs/Vision.aspx

Indeed, there is a sense from some respondents that things have gone as far as they can without such compromises. A practical start would be better communication in both directions, for example in giving better notice over issues that have operational implications for the other, and enhancing mutual respect:

> *"If patients are not being seen, it is not just an NHS issue, it is joint working with SPS on the delivery of prisoners."* (Prison Healthcare Manager)

> *"But we also have to recognise their priorities and work with SPS to help maintain order."* (Prison Healthcare Staff)

At a more strategic level, policy and practice is supported by the National Prisoner Healthcare Network[15], which was set up in 2011 to play an advisory role across the nine NHS Boards, and is supported by a Memorandum of Understanding between NHS Board Chief Executive Officers and the Scottish Prison Service.

The purpose of the National Prisoner Healthcare Network is to operate through collaboration across Scottish Government, NHS Boards, the Scottish Prison Service and other key agencies, ensuring their combined services promote excellence and consistency in the healthcare available to offenders during and after their release from prison. The Network is chaired by the NHS Director for Health and Justice in the Scottish Government and is supported by professional health advisors hosted in Healthcare Improvement Scotland. The Network has a workplan that is enabled by a number of standing and short-life working groups including a NHS Prison Board Leads Operational Group which meets regularly. The NHS Prison Board Leads Group have also created a number of workstreams and have a dedicated workplan of activity that supports developments in and knowledge of prisoner healthcare. These mechanisms have been important in managing the transition of healthcare from the Scottish Prison Service to the NHS. The over-riding sense from respondents was that this transition had been successfully negotiated, and that the Network played a central and essential role in this success. This makes the Network a trusted actor in this environment, and its structural oversight position continues to be valued. Complaints issues are discussed in these forums and it seems highly beneficial that learning should be shared in this way. Yet some respondents expressed a degree of uncertainty about whether this was sufficient to promote the next level of necessary change:

> *"The Network is helpful, there is good discussion and sharing of good practice. However, meetings and membership have been cut back and Health Boards are starting to disengage. Part of this is just 'getting on' now that we*

[15] http://www.nphn.scot.nhs.uk/

have been up and running a while. But there is also some frustration that nothing gets done." (NHS Board Lead)

"The Operational Group is really a talking shop. It does not help that that Board leads sit in a different bit of every health Board and there is quite a high turnover amongst leads. We identify issues and write letters, but can't enforce anything and it is hard to have influence." (NHS Board Lead)

Given the small sample size in this research, it is unclear whether, and to what extent, these views are more widely held. A recent RCN report (2016: p.27) independently identified similar issues in their own research[16]. However, the Network itself reported that its work is ongoing and that Board leads have produced a detailed work plan for the Network following a recent away day.

Information, Support and Advice

To further support notions of fairness and equity, there is recognition of the need to inform, support and advise prisoners to articulate their complaints effectively. The extent to which this happens in the prison healthcare environment is unclear from this study. There is evidence of steps being taken and a number of possibilities were raised, some of which appear to hold promise. Currently, however, these initiatives are often piecemeal and/or under-developed. One of the key findings from the Scottish Health Council's *Listening and Learning* (2014) report, of *"people not knowing the support available to help them to complain"*, is (at least) equally applicable in the prison healthcare environment.

In terms of educating prisoners about the complaints process, NHS Boards provide written information at prisoners' induction. There have been some attempts to compensate for prisoners' potential lack of literacy or educational skills. For example, in one Board a complaints flowchart has been produced in an easy-read/illustrated format. In another, a nurse goes up to see the prisoner on admission and gives them relevant information in person.

In the NHS Board in which two dedicated part-time nurses have been employed to act as Patient Relations Officers, there has been further work to educate prisoners about complaints. This has involved setting up 'Patient Relations Forums', with both staff and prisoner representation, to improve patient care. As part of this work, more information has been provided on what a complaint is, and what happens to a complaint once it is submitted. Minutes are taken and distributed and some prisoner representatives have held meetings to feed back to the wider population. This has *"increased communication*", "*helped manage expectations*" and given reps "*a bit of*

[16] https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/policies-and-briefings/scotland/policies/2016/five-years-on-prison-report.pdf

ownership for their own health environment" (Patient Relations Officer). Introduction of the forums "*brought the number of complaints down and the number of 'feedbacks' up*" (Prison Healthcare Manager). This is widely considered to be a very positive result, although lately, the number of complaints has started to rise again. One idea to emerge from the forums was for a regular drop-in session in each hall by the Patient Relations Officers. These now take place weekly for 45-minutes and provide a further source of support:

> *"We hope they'll speak to us at the drop-ins, rather than put in a complaint."* (Patient Relations Staff)

In addition, in each of the three NHS Boards included in this research, informal peer support was provided, whereby prisoners on each floor helped write complaints on behalf of others. One prisoner claimed that:

> *"There is no formal help here for the ones who can't read or write. Without me, this guy wouldn't be able to put a complaint in. He can't read."*

One of the NHS Boards included in this research expressed an appetite to develop a peer mentoring scheme based on a Red Cross initiative in Ireland[17]. This would establish a system of peer mentors who would decide on issues to address (e.g. the dangers of paracetamol, handwashing, bullying) and establish a co-productive conversation about these issues involving both staff and prisoners. The "*transformative*" experience of the Red Cross scheme was considered to hold prospects of "*a win-win in every sense*" (NHS Board Lead). However, there was a sense of being *"too busy fire-fighting"*, so that taking time out to implement this scheme would be very difficult.

Beyond the above measures, there is a further range of organisations which are able, in principle, to provide support and advice. These include advocacy services and a 'listener scheme' that are either used exclusively by particular groups (such as prisoners with mental health problems) or, more commonly, not used at all. However, two further organisations are potentially more important.

The first is the Patient Advice and Support Service (PASS), operated by Citizens' Advice Scotland, through a a contract funded by the Scottish Government. The role of PASS is to provide information, advice and support about providing feedback, or comments, raising concerns or complaint about NHS treatment. This includes helping people understand their rights and responsibilities as patients, providing support at meetings about issues raised, and help to write letters and make phone

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[17] https://www.redcross.ie/CBHFA

calls. This contract was extended to include prison healthcare in 2011 to cover complaints at a ‘sufficient level’.

Each of the three NHS Boards included in this research were aware of PASS, and each claimed to be supportive of their involvement in supporting prisoners. However, PASS was not being widely used in any of them. Various reasons were given for this:

> *“We have put up the PASS posters and there is a telephone line that prisoners can call. But it isn’t a Freephone number, so nobody uses it - they don’t want to use up their phone credit.”* (Patient Relations Officer)

As of April 2017, a national freephone telephone line providing access to PASS Patient Advisers will be available, which should help to address any concerns that prisoners may have about the cost of telephone calls to the service.

> *“The PASS posters are up, but prisons are very strict on who they allow in. You need to be given de-escalation training and to be escorted all the time.” (NHS Senior Manager)*

PASS staff confirmed that access was variable across the Scottish prison estate, with some prisons much more open to their participation than those included in this research. This tended to vary according to promotion (outreach, posters) and relationships (lack of understanding, resistance). Given the level of support and demand for this service from the NHS Boards included in this research, there is widespread hope that the situation will change:

> *“I would say to Governors that we are a free ‘win’ - we are already funded.”* (PASS National Co-ordinator)

In response, positive indications from SPS have been given about a more consistent strategic national approach, co-ordinated via SPS HQ and connected to all Prison Governors, to enable access to each prison and mandatory training requirements.

The second organisation, the Independent Prison Monitoring service, operated by Her Majesty’s Inspectorate of Prisons for Scotland, is guaranteed access to prisons. Prison monitors, who are volunteers, have recently replaced the previous ‘prison visiting committees’. They will provide an independent viewpoint on the humane treatment and conditions for prisoners in all prisons across Scotland and will conduct investigations either as a result of a prisoner raising an issue or from observations that are made during prison visits. Monitors will also be expected to report formally on their findings.

There have been discussions between PASS and the prison monitors to establish how they might work best to support one another. The National Prisoner Healthcare Network and NHS Boards are also engaging positively:

> *"Advocacy and monitors are a helpful way forward."* (National Prisoner Healthcare Network)
>
> *"At the height of our prisoner complaints we learned from the State Hospital that what helped was an advocacy service. Monitors can play that role. We have met with the local Prison Monitor Co-ordinator, and the lead GP and pharmacist have done some training with monitors."* (NHS Board Lead)

Key learning points

- Despite good intentions, the prison healthcare complaints procedure had become unwieldly and cumbersome and a need was identified to be able to respond more appropriately to prisoners. Greater clarity on the redefinition, prioritisation and early resolution of prison healthcare complaints is provided by the new NHSScotland Model Complaints Handling Procedure, which is beingimplemented from April 2017.

- There is a need to properly resource the healthcare complaints function within Scottish prisons. This may even help create financial efficiencies if it facilitates service restructuring.

- A continued focus on 'good governance' is required to ensure that the complaint process remains fair and accessible to all. Prisoners need to be aware, supported and advised properly about their options to pursue the healthcare issues they face. Peer mentoring and the Independent Prison Monitors scheme are each promising ways forward for this. PASS can also play an important role if any issues relating to access are addressed.

- There is scope for more to be done in response to background conditions in the prison healthcare environment – for example, through a more person-centred approach with patients and a stronger sense of partnership with the Scottish Prison Service - so that the cycle of complaints can be minimised or eliminated and a more responsive and effective complaints process established.

5. The Prisoner Experience of Complaining About Healthcare

This section considers:

- prisoners and the complaints process
- impacts of relational issues
- prisoners' concerns about the complaints process
- breaking the cycle?

The focus groups held with prisoners considered their experience of complaining about healthcare. The focus groups considered prisoners' perceptions about access to the complaints process, the effectiveness of complaint handling and management, and the outcomes of their complaints. As the researchers were only able to speak with a small number of prisoners, the views they expressed cannot be representative of all prisoners. However, these views do provide a unique and useful insight into the kinds of issues that can/do arise as a basis for further discussion.

Prisoners and the complaints process

When asked if making a complaint about healthcare was easy or difficult, prisoners universally agreed that the process is "easy" and were able to describe the process of obtaining and submitting a form to the health centre. Some were also aware of how to escalate their complaint. This may reflect the nature of the sample, which was deliberately drawn from those prisoners who were known to have used the complaints procedure. It may also reflect that guidance on how to make a complaint is a feature of the induction procedure for prisoners:

> *"It's a formal process here in the prison, so you are aware. You get a form, it goes straight to the Health Centre. You can write down your issue and they will try to resolve it before it gets into a complaint."*
>
> *"You have to go through all the complaints stages before you can go to the Ombudsman".*
>
> *"If you go through a lawyer, they won't speak directly to you any more."*

In one NHS Board, prisoners noted that the design of the form had "*evolved*", having initially "*mixed up complaints and feedback*", which was "*confusing*". The form has since changed three times and is "*better now*".

Despite the claimed robustness of the NHS complaints process, prisoners often remain unhappy. In particular, while the process of making a complaint was well

understood, prisoners were much more sketchy about the ‘journey’ of their complaint once it had been submitted:

> *“There are hundreds of complaints, now they pass it all about. It might be a better system for them, but it’s not for us.”*

> *“You get a letter telling you it’s under investigation, but no clarity about what you do next.” [Others: “Nothing!”]*

> *“I put a complaint in. I was seen on the fifth day. The nurse asked me to say ‘that’s me’. But I wanted to take it further. I still don’t know if it has gone further – they haven’t told me.”*

Prisoners’ experience of using the complaints process was also variable. Some had found it worked fine for them, at least on occasions:

> *“I got an answer that night.”; “The answer is sometimes instant.”*

Others took a balanced approach to communication, despite a sense of disappointment with using the complaints process:

> *“I’ve given a positive feedback. I complain a lot, so I thought it was only right to tell them when something good happens too. But I’ve never had a complaint dealt with well.”*

The majority of prisoners in this research described their experience of using the complaints process as frustrating and disappointing. They reported not being kept informed, and that outcomes were not always explained properly:

> [Interviewer] *“How long before you get answers?”* [Prisoners] *“You don’t automatically get answers. Six times out of ten you get a letter back, ‘thank you for your complaint’, then you hear nothing.”*

> *‘‘Some complaints don’t make it out of the jail – we are not getting an answer.”*

Prisoners also reported their complaints being treated summarily, or that they were being ‘fobbed off’. They were particularly critical of the letters they received back:

> *“The nurses say ‘So this is your problem?’ Fine. Sign here and close the case.’’; “They are ‘litigation aware’ - ‘we are very sorry to hear you feel that way’. It’s a brick wall. We are not listened to. We are still looking for answers.”*

> *"The language in the letters is difficult, the jargon. And when they know they are at fault, they make the language more complicated"; "They bamboozle you!"*

In all focus groups, prisoners were asked what they wanted to happen as a result of their complaints. Their answers were clear (and did not include financial compensation, even when they were prompted about this):

> *"You want to have your voice heard and something change as a result";*
>
> *"We just want a better service."*
>
> [Interviewer] *"Are there occasions you would like an apology?"*
> [Prisoner Group 1] *"Yes!"*
> [Prisoner Group 2] *"If they mean it! It makes us really mad when they say 'sorry' but it happens again and again."*

Impacts of relational issues

In many instances, relationships between prisoners and NHS staff had become strained, and the complaints process had become adversarial. This is reflected in prisoners' language about 'winning cases' and 'taking sides':

> [Prisoner 1] *"I have had a lot of complaints. I won a case to see a [clinician] once – that's it!"* [Prisoner 2] *"I'm the same – I won one case too!"*
>
> *"Complaints are not fit for purpose - they will always side with the doc."*
>
> *"The nurses come to investigate, but they talk vague – they will always believe the other side."*

Poor relationships are also reflected in prisoners' perceptions of how they are treated by NHS staff. This included technical treatment issues, such as prescribing regimes, as well as a sense that they were treated differently as prisoners as they would be if they were in the community:

> *"The NHS has made it worse. If you go from jail to jail to another jail you can be taken off meds you've been on for years."*
>
> *"Mis-prescribing should be taken more seriously"; "When medicine is reviewed, we should be part of the review."*
>
> [Prisoner 1] *"You get treated like you're second rate."* [Prisoner 2] *"You can't come into prison and complain about being treated as a prisoner!"*

> [Prisoner 1] *"Of course you can! It's the NHS – you treat people as normal."*
> [Prisoner 2] *"True."*
>
> *"We should be treated the same as people on the outside - or better, because of the risk of suicide/self-harm'; 'Outside you would get help straight away, but not here. We are stripped of all dignity"*

A particular element of concern that was clearly important to a number of prisoners was that of patient confidentiality. Where this was compromised, it was felt to be embarrassing and disrespectful:

> *"SPS know what you're on. They shouldn't know. They judge you on which meds you are on."*
>
> *"When dishing out weekly meds it is meant to be confidential, but the prison officers are right next to the nurse. It is confidential. They shouldn't be near."*
>
> *"They openly discuss people's meds with about 20 guys about."*

Prisoners' concerns about the complaints process

As expected from the findings of the Scottish Health Council's *Listening and Learning* (2014) report, some prisoners feared repercussions for their treatment if they pursued a complaint. The recommendation in *Listening and Learning* to "*remove the fear factor*" is therefore repeated here. There were further concerns about the independence of the complaints process. The fact that the whole process was undertaken within NHS Boards was seen to be problematic in getting unbiased answers:

> *"You can ask for a second opinion, but they're all in cahoots."; "Is there nobody independent?"*

Another major concern was the time taken by the complaints process. It was commonly felt to take too long. There were also concerns about the 'buck passing' prisoners felt was involved as complaints moved through the 'chain':

> *"It takes too long to get an answer. If it's about missing meds, you need action so you don't miss your treatment. But it's not just drugs. It always takes too long to sort it out."*
>
> *"Lots of things falls through the gap between SPS or the NHS – problems originate from there. Then the buck passing starts"; "They'll say it goes against prison policy. Policy, policy, policy…"*

When this happens, there is a strong sense of futility about making a complaint. On the basis of their experiences some prisoners saw no point any more, while others continue to carry hope over expectation:

> *"The form is a waste of time - there's no point!"* [Others] *"No point!"; "I waited six weeks. It's pointless."; "There's no point complaining, we aren't going to get heard."*
>
> *"But if you don't say anything, you get nothing. So you hope something will change… but generally it doesn't."*

Contextualising Prisoners' Concerns

Anecdotally, it was claimed by interview respondents that variation in the nature of the prison population in different prisons (e.g. long-term v. short-term prisoners; holding prisons v. admitting prisons; prisons that group together certain populations such as sex offenders, long-termers, young offenders or women prisoners) can mean different patterns of healthcare complaint behaviour. Such analysis lay beyond the scope of this study, but merits future analysis. For example, long-term and older short-term prisoners tend to have heavy addiction profiles that increase the degree to which they complain about their medication:

"There is a group of people on huge medication. Older prisoners in poor health, especially sex offenders, can be in their 70s/80s." (Prison Healthcare Manager)

Some respondents also observed that prisoners had often taken poor care of their health on the 'outside'.

"You are dealing with a client group who have a lack of awareness about health. They become more concerned about this on the inside - want to deal with things, and have more time to think about it." (Prison Healthcare Manager)

HM Inspectorate added that the *"subtleties of how a person feels they are being dealt with is a different situation inside."* Such inabilities can cause frustrations that can make the complaint handling process much more challenging. Anecdotally, this can sometimes spill over into abusive behaviour which can get in the way of effective complaint resolution. Respondents observed that:

> *"Addictions guys are aggressive even in complaints…Nurses go over to investigate or explain and get verbally abused. SPS put them on report, but it doesn't work. In the rest of the NHS we would withdraw treatment, but we can't do that here."* (Prison Healthcare Manager)

"There are high levels of abuse. We have become inured to it - don't DATIX the amount of verbal abuse we get. We say we have zero tolerance but we don't always record this." (Prison Healthcare Manager)

Similarly, impatience for treatment is common amongst prisoners. In this situation, patient anxieties can grow. This is particularly true if prisoners' medications are reviewed and withdrawn – a commonly complained about aspect of prison healthcare:

"Things prisoners might be prescribed in the community won't be prescribed on the inside. This is a cause of anxiety."(NHS Senior Manager)

"Prisoners get agitated if a prescription is discontinued: 'I was used to getting drug 'x', now it's been taken away – it's outrageous'… Any change in the pressured environment of prison is a bigger deal." (HM Inspectorate)

It is worth noting that variation in prescribing habits can be unhelpful here - not just between prisons and the community, but between different prisons. Feedback from some stakeholders suggested that prescribing can vary across the prison estate. Prisoners found this variability confusing, and this contributed to their expectations of treatment. It seems there is a lack of clarity on these issues that might be further addressed.

Prisoners' expectations on NHS services can also influence their complaint behaviour in other areas. This is particularly the case for dental care services – another commonly complained-about aspect of prison healthcare:

"When they come in, prisoners' dental conditions are often poor. They get free dental care, but we are limited as to who we can treat – there is rationing, the same as elsewhere. So we cannot meet prisoners' expectations." (NHS Senior Manager)

In addition, there was sometimes a sense amongst respondents of 'game-playing' and attempts at manipulation amongst prisoners:

"You don't mind if the complaint is about a long-term problem, but it's the spuriousness and game playing that is soul-destroying." (Prison Healthcare Manager)

"Some can be quite manipulative and try and draw you into their problem." (Patient Relations Officer)

As a result, there was agreement on the need to both manage expectations and counter opportunism amongst the prison population. Despite this, it was accepted

that many complaints are genuine, and representative of prisoners' healthcare needs. For example, there are acknowledged problems with the ordering and administration of medications:

> *"There are ordering issues – I have some sympathies with this. Prisoners don't always get their meds in time. Pharmacy contractors are not always reliable – they send partial amounts or don't tell us if there are shortages or production problems. And if the drugs come in late on the day, we can't get them out."* (Prison Healthcare Manager)

> *"Some complaints around meds are reasonable – they are without meds for three to four days. It is entirely appropriate for them to pick that up."* (NHS Board Lead)

> [Prisoners] *"We fill out a form, make an order – no meds. So we get gaps in treatment."*

From the prisoner perspective there was some consternation that service professionals do not always recognise their complaints or requests for service as legitimate:

> *"They always think you have an ulterior motive. You never get given the benefit of the doubt." [ALL: "Never!"]*

> *"They assume you're attention seeking – like puppies saying 'feed me biscuits'."*

Breaking the Cycle?

There is some evidence in this study of an appetite from prisoners for rebuilding relationships with NHS staff based on mutual recognition and respect, if this is earned on both sides. Prisoners provided various thoughts here about what they would like to see done to improve things. These included the availability of more informal approaches to raising issues, and demand for a more personal, more 'human' approach to interactions. There was support for the appointment of a personal keyworker, but also things like the prisoner forums and drop-in sessions that have been piloted in one NHS Board.

The bureaucracy of the formal complaints process meant that a more informal route was popular with some prisoners:

> *"I don't have good concentration, so I find these forms difficult. I prefer to deal with things informally."; "I would start with an informal route if I was confident*

enough. Otherwise more formal."; "There should be a more informal way of complaining."

However, a major theme of prisoners' responses to what might be done better, was that of personalisation. For some this just meant an improvement in existing relationships so that interactions were grounded in a more positive way. However, others suggested that a key worker be appointed for prisoners' healthcare as someone who could follow things through on prisoners' behalf:

> [Interviewer:] *'What Could the NHS do better?'* [Prisoners] *"Personalise it – a letter don't cut it."; "The nurse that comes round should make sure you are happy."; "It should be all-for-one and one-for-all, no?"*
>
> *"Everyone should be given a medical health worker – it's up to them to get you the health service. You have that for Mental Health and Addictions – why not have that for all prisoners? Say, one nurse for 30 prisoners?'; 'You need someone who could see the complaint all the way through rather than passing it on and on and on."*

Patient forums were another popular idea. In one NHS Board where a rep system was not in place, prisoners were initially divided in their support. Eventually however, in discussion, all agreed it would be a good thing. The points raised against were certainly legitimate:

> *"You are on the route of having meetings upon meetings."; "Another prisoner? That's a lot of pressure. They would have to be qualified."; "It would have to have teeth. We could talk all day. Yap, yap, yap."; 'There's a danger of creating 'super-prisoners' – some prisoners get nominated all the time."*

However, those in favour countered these arguments:

> *"You can get everyone round the table, prisoners and the manager of the healthcare that covers every department."*
>
> *"If the meeting gets minuted and videoed, everyone can see what gets said. Then the reps are accountable and we can hold the healthcare [staff] to their promises.*"

To some extent these arguments were borne out in the NHS Board in which patient forums have been introduced. These meetings are minuted, but not videoed. The exceptions seemed to be meaningful action on longer-standing, more difficult issues such as prescribing:

"What is good is the face-to-face answers. The paper system is not as good as face-to-face information. A lot of people do not have language and literacy."

"They are speaking to us as people rather than numbers. It's more personal."

"We are fed up bringing things up – all the time the same issues."

Moreover, it was generally agreed that the drop-in sessions that had been introduced in this NHS Board were useful for informally raising issues that can be solved quickly, such as getting the wrong meds. Drop-in sessions were seen as *"more responsive"* and *"better than the form"*. However, independence was still seen as a potential flaw:

"The nurses and doctors will cover for each other if there's been a mistake."

Key learning points

- In relation to the findings of the Scottish Health Council *'Listening and Learning'* report (2014), prisoners in this research seemed more aware of the complaints procedure than the population at large. However, they shared with other NHS patients in being unclear about the support available to help them, in fearing repercussions from complaining for their treatment, and in experiencing a lack of confidence that anything would be done as a result.

- Prisoners in this research were generally disaffected with the current prison healthcare complaints process. They claimed that it takes too long, they do not always receive answers and the answers they do receive are often either insufficient or incomprehensible.

- They feltl excluded from discussion of the big issues that important to them (such as prescribing policy).The evidence from prisoners who participated in this research suggests that breaking the cycle of complaints requires new thinking and a different approach

- Options that personalise and humanise the complaints process are popular, whether these are individual (keyworker, drop-ins) or collective (patient forums).

6. Learning from Prisoner Healthcare Complaints

This section considers:

- learning as sense-making
- practical and procedural improvements

It is clear that learning is taking place throughout the prison healthcare system as a result of the complaints process. This learning can be quite broad and general or quite narrow and specific. In this report it is broken down into three categories: 'sense making', 'practical' learning and 'procedural' learning – including the improvement of advocacy and support. In supporting this learning, the importance of recording and time for reflection are also discussed.

Learning as sense-making

Sense-making activity from complaints tends to provide broader, more general learning from complaints that allows NHS staff to interpret their environment more effectively. This kind of activity is becoming more popular now. The *Patient Rights (Scotland) Act 2011* and associated Regulations and Directions require that complaints are regularly and systematically reviewed, with a view to service improvement.

> *"Our checks show if there is any learning or meaningful information. What is the point in having this system of checks and balances if you are not going to take the positives from this?"*(Patient Relations Manager)

> *"Complaints are important for benchmarking and comparing progress over time. Gathering this learning can give good insights."* (SPSO)

Sense-making is an interpretive activity. In this way, themes and patterns may be examined within aggregate complaints data. Similarly, particular themed clusters of complaints can be examined in greater detail. There was evidence of this amongst the NHS Boards included in this research:

> *"It is not practical to plan for each individual, so we look for themes around which we plan actions and make a commitment to improvement."* (NHS Senior Manager)

> *"We have used complaints to understand bigger dental waits. This has enabled us to have a conversation with our Oral Health Directorate to explain how we need to improve, and why more of the same cannot happen."* (NHS Board Lead)

> *"Complaints have helped inform the new pharmacy contract."* (NHS Board Lead)

In this sense, as HM Inspectorate points out, "*high numbers of complaints are not necessarily a bad thing – they give free, easily accessible information".* On the ground, healthcare managers are also seeing some benefits from this information, even where the volume of complaints has put the service under pressure.

> *"The complaints process can be time consuming and costly. But it does give us an ongoing sense-check of what's going on in the prison."* (Prison Healthcare Manager)

> *"I would not want to go back to the old system. In a perverse way, complaints are useful. You are able to stay more closely in touch with issues."* (Prison Healthcare Manager)

At this level, staying in tune with prisoners' concerns can help the service to be more responsive and transparent. However, the detail of complaints – even individual complaints – can be helpful in identifying potential specific improvements in operational practice and procedure.

Practical and procedural improvements

Respondents reported numerous examples of practical changes that have been made to improve services as a result of prison healthcare complaints. First, there have been improvements in the information provided by the service. NHS Boards have introduced more easy-read/illustrated literature. This has included the use of pictures on self-referral forms in one Board, and smiley faces on a complaints flow chart in another. Both have been well-received by prisoners. New leaflets and noticeboards have also been introduced to provide information on healthcare issues such as dental hygiene, and information about the manual pharmacy ordering process is now provided to all prisoners at their induction as something that they have to regulate themselves.

Second, there have been changes to clinic availability. This includes putting on extra clinics for services that are in high demand, such as dental clinics. It has also included the introduction of new clinics to address prisoners' expressed needs, such as pain clinics as an alternative to the strong painkillers that some prisoners were no longer being prescribed. In one case, complaints had also led to the introduction of evening clinics for prisoners who were at work or otherwise unable to attend during the day. In one case, even the introduction of appointment cards so that prisoners could keep track of their care had come about as a result of a complaint.

There are numerous examples of procedural changes that have been made to improve services as a result of complaints. First there have been improvements in communication that have facilitated the better planning of treatment. For example, when prisoners have a sick line, healthcare staff are now given a ‘back to work’ date. The same applies with single cell markers; a date is given when this is up for review. Similarly, when nurses are required to prepare a patient for an investigation, they now get a date in advance. Improvements have also been made in relation to medical reviews in which the GP arranges to speak with prisoners. For prisoners, this ensures greater seamlessness of care.

Second, there have been back-office administrative improvements that have improved the quality of care. In one NHS Board they responded to a number of complaints by changing the way in which prisoners get their medications. They now have set days when prisoners re-order medications. Before, there was no way of tracking this, and the process is much improved. In another, reorganising the CARDEX system made the administration of medications much more streamlined and user-friendly. This has led to a reduction in complaints.

Procedural changes also include those relating to the complaints process itself. The introduction of drop-in sessions was a result of feedback at a patient forum, which itself was a response to the volume of complaints received in one NHS Board. The fact that so many other initiatives are under consideration to provide support and advice, and generally deal with the complaints process more effectively, is encouraging.

One particularly important task that supports the effectiveness of learning from complaints is recording. While NHS Boards are required to have robust systems in place for recording complaints, there is still a sense that improvements could be made here. For example, ensuring things are investigated and recorded in sufficient detail to capture all the potential learning- even where issues are resolved locally through frontline interventions. In this sense it must be kept in mind that early resolution is part of the complaints process, and complaints dealt in this way should still be recorded so that the learning can be used for improvement. Moreover, as SPSO point out, there is also a need for more sophisticated interpretation of the recorded data:

> *“It is vital that complaints information is recorded and analysed to ensure that opportunities to learn from complaints are identified and actioned. This may include, for example using complaints data to identify the root cause of complaints, taking action to reduce the risk of recurrence and monitoring performance to ensure the issues have been properly resolved.”* (Scottish Public Services Ombudsman)

While there is some evidence that more sophisticated interpretation has been undertaken to a limited extent in specific cases (e.g. dental waits, pharmacy contract), there remains more to be done. One key to this is proper resourcing. As one NHS Board Lead put it, *”I would love to do more, but taking time out is impossible.”*

Key learning points

- Prisoner healthcare complaints provide a useful contribution to service improvement, whether in aggregate form, or as individual complaints. More can be done to record prisoners’ complaints, feedback, comments and concerns. Once recorded, more can be done to interpret and use complaints data, and to feed the results back to prisoners so they know that the learning has been acted upon. Appropriate resources are required for this activity.

7. Summary and Conclusions

The successful transfer of responsibility for prison healthcare to the NHS from the Scottish Prison Service has resulted in a period of adjustment in the handling and management of complaints. Throughout this research, it was clear that there was a strong commitment from NHS Boards to getting this right. This saw both close adherence to prescribed standards and an enhanced level of detail and oversight in complaint investigation and response. Where staffing levels allowed, there was evidence of a greater ability to resolve issues locally and early. There were also examples in some NHS Boards of good practice that went beyond these developments – for example, adding new opportunities for patient voice through drop-in sessions and patient forums.

One of the respondents in this research described prisoner healthcare complaints as "a voice in a tough place". For various reasons, this phrase resonates throughout the data, both as a description and as an aspiration. For the sense remains that there exists room for improvement and that, five years on, things have reached the point where they might sensibly be reviewed.

The current NHS complaints process is highly specified and robust, with a detailed system of checks and balances to ensure that criteria of equity and fairness are met. Yet it is almost universally recognised by respondents in this study that there may be some benefit in revaluating the way in which it is being interpreted and applied. The introduction of the new NHSScotland Model Complaints Handling Procedure in April 2017 offers the opportunity to improve matters.

There have been problems of things "taking too long" to come back from the complaints process, and of a repetitive focus on certain issues such as prescribing policy and waiting times for treatment that are not being resolved through complaints.

Amongst this there are calls for more early/local resolution of complaints within the prison. Yet this brings with it problems of a lack of independence in the process, and the *balance* in determining which complaints can reasonably be resolved through early/local resolution - and which complaints need a more thorough, robust investigation - can be a difficult one to strike. Firm and clear guidance on this for staff at all levels is attached to the new NHS Complaint Handling procedure, so it is to be expected that this situation will improve as it is implemented from April 2017.

Raising the effectiveness of the complaint handling process is fundamental in order to move the focus back to the provision of health services. The pressures of meeting complaint targets are intense. Where clinical staff are required to investigate and

resolve complaints alongside their clinical duties, this necessarily has implications for patient care.

This is not helped by any issues arising from the different guiding principles of care, custody, order and opportunity identified earlier between SPS and the NHS in the prison environment, whereby things can go awry on the ground even with best of intentions. In short, it is not always a perfect health service; it is not always perfectly facilitated by SPS; and it is not always perfectly co-produced by prisoners. People cope pragmatically with this situation. However, there is a sense that things may have gone as far as they can in working around these issues, so that further change means doing something different. In the relationship between the NHS and SPS, this could include an openness to further discussion in brokering a more constructive and beneficial sense of partnership. It should be noted that there is no suggestion from this research of any non-compliance in the Memorandum of Understanding between SPS and NHSScotland. The sense here is simply to work towards building a stronger sense of 'mutuality' between partners in the prison healthcare environment, in which expectations of more positive interaction, better information and better communication is an everyday experience.

In the prison healthcare environment, voice and complaints provide an essential outlet for discontent and disappointment, and there is generally a high volume and 'churn' of complaints that must be managed effectively. Where this is achieved most successfully, there is an appropriate level of prison-based staff for the system to cope. The dedicated resource of two part-time nurses employed in one NHS Board is even claimed to save money, by allowing other NHS staff to retain their focus on patient healthcare.

The new NHSScotland Model Complaints Handling Procedure provides an opportunity to improve systems for prisoners and staff in this challenging environment. For example, the new procedure raises the response time for first stage complaints to five working days instead of three. It also provides flexibility to extend the timescale in certain circumstances to achieve early resolution of a complaint without the need for a detailed investigation. This will undoubtedly help support more early and local resolution, but may not be enough on its own to solve the problem in prisons. Beyond this, there are calls in this research for better prioritisation in practice of what is (and what is not) a complaint, with the ability to escalate or de-escalate accordingly. Support is also evident for complaints to be governed by a principle of 'subsidiarity', whereby they are dealt with by people at the right level with delegated responsibility. In this scenario NHS Boards would retain full control of serious or complex complaints, which would always get investigated appropriately. To maintain checks and balances, it could also monitor and regulate at delegated levels through regular sampling and auditing. In response, SPSO report that:

> *"the revised NHSScotland Model Complaints Handling Procedure includes a definition of a complaint and provides further guidance on what is and what is not a complaint. It also provides further clarity on the threshold between matters that may be recorded as a 'concern' as per the Patient Rights Act, and matters which are clearly complaints."*

The current NHS complaints process provides prisoners with one choice about how to express their views about prison healthcare, but others are possible. This study shows demand for investment in the use of a wider range of tools and approaches. These include mechanisms that help to establish a more co-productive dialogue in the prison environment, such as patient forums, drop-in sessions and peer mentoring schemes. This more co-productive dialogue could be supported by other initiatives, including the development of workforce training tools for prison healthcare.

Achieving a truly person centred approach to delivering healthcare in the prison environment requires effective partnership between all of those involved. Bridging the relationships between the NHS, prisoners and SPS is important. Existing governance and oversight structures such as the National Prisoner Healthcare Network and Her Majesty's Inspectorate of Prisons for Scotland clearly have a role to play in this process. However, there is also a suggestion that it might be an unreasonable expectation of these structures, and that such things as multi-stakeholder consultation exercises and a short-life multi-stakeholder working group led by Scottish Government might help move things forward.

8. Key Considerations from this Research

This report shows that progress has already been made in recognising and trying to meet need in the handling of prisoner healthcare complaints. The following considerations are based on findings within specific NHS Boards. As NHS Boards are distinct and face different issues, some of these considerations may apply more readily in some than in others.

- Further research, discussion and debate as described above would help to explore whether the findings of this report apply only in relation to the individual prisons/NHS Boards within this research, or more widely.
- A short-life multi-stakeholder working group led by Scottish Government may be useful to consider the progress that has been made to the management of complaints since transition and the findings of this report, alongside the implementation of the revised NHSScotland Model Complaints Handling Procedure.
- Survey research within prisons would be valuable to further capture prisoners' views about healthcare complaints. Such research could be facilitated effectively by Prison Monitors.
- An audit by NHS Boards, reporting to Scottish Government, may be helpful to ensure there is adequate resourcing of complaint handling within each prison, in order to maintain the focus on clinical care.
- Discussion between the National Prisoner Healthcare Network and Her Majesty's Inspectorate of Prisons for Scotland may help to see whether and how their relative oversight roles might be further developed in relation to prisoner healthcare complaints.
- It may be helpful to promote initiatives to establish a more co-productive dialogue with prisoners, such as patient forums, drop-in sessions and peer mentoring schemes
- It may be helpful to develop specific workforce training tools (such as online modules) to ensure competence and commitment to positive change in this environment

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