



THE ICAS PILOTS: BENCHMARKING AND LEARNING

A MAC ASSOCIATES REPORT

JANUARY 2003

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A Report by MAC Associates

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LIST OF APPENDICES (TO FOLLOW)

1. QUESTIONNAIRE DATA REPORT
2. COPY OF QUESTIONNAIRE AND COVERING LETTER
3. CONFIDENTIAL ANNEX –LIST OF PILOT SITES AND IDENTIFYING NUMBERS

1. EXECUTIVE SUMMARY

Benchmarking- A Definition

- 1.1. Benchmarking for our purposes here is the identification of practices in one organisation that can be put into practice by others in different organisations adapted as necessary. See it, modify it, try it, modify it again if necessary and repeat the dose. The governing assumption of this report is that complaint handlers share many concerns and issues that are common across different markets and types of organisation. The successful benchmarker recognises both those points in common as well as the differences.
- 1.2. This report takes the six elements of the complaint handling job and developing processes and best practice under each of them. The headings are:-
 - Management
 - Measurement
 - People
 - Process
 - Technology
 - Access.
- 1.3. The MAC view of complaint handling is as a measured and managed process which contributes to satisfactory solutions that meet consumer expectations as to fairness and timeliness and makes a contribution to the improvement of services to all users. The complaint handling process must not attract complaints about its own lack of quality. The successful complaint office promotes solutions for individual complainants and then uses the data of the cases handled to effect improvement.

Identifying the Learning

- 1.4. After consideration of the results, we pull out what appears to be the principal learning points under the heading “**Benchmark Learning**”. The discussion identifies good practice whether it emerges from a pilot or is included on the basis of MAC observations and experience elsewhere.

MANAGEMENT

Benchmark Learning- CAB example about nature of service

- 1.5. Examples of this sort of debate would be firstly the debate about how best to give money advice – could it be accommodated best within the CAB or was it necessary or indeed feasible to establish a specialist service separately funded? Elements of this

debate had been seen in an earlier discussion about the need for Consumer Advice Centres concentrating on advice about goods and services supplied on the high street and not touching the consumer needs for advice about such matters as benefits? The findings of this research show success across a range of agencies.

Benchmark Learning – Competition for Consumer Custom and Confidence

- 1.6. Consumers will have confidence in the service that is most likely to meet their needs and goals. They are not interested in the niceties and details of who does what. The field of offering help to users is crowded with those vying to sort things out for citizens and consumers from the MP to the volunteer in a community advice centre. Consumers will browse these services and act in their own interests in pursuit of their own agendas. We heard that consumers were already using the ICAS freephone 0800 number as a means of accessing the host CAB whose line was engaged. We also heard of the energetic PALS who insisted in sticking with the complaint and the complainant when the PALS service should have withdrawn in favour of ICAS. For one bidder from a non-health organisation, the introduction to the difficulties came when the local CHC refused to become a bid partner. Negotiation about boundaries and the establishment of 'who does what' protocols may well reduce but it will not eliminate what some would call 'wasteful duplication' and others beneficial competition offering consumers choice. Consumers will make their own decisions and will remain happily ignorant about intra-professional debates amongst advice givers for example about the precise definition and practice of 'advocacy' within the constraints of the NHS complaints process.

Benchmark learning – 'Active' Closure policy for Case Management

- 1.7. Resource planning must therefore take account both of the length of the case pipeline as well as the number of cases within it. If the ICAS remains with the case through all the local stages, there may be calls for support for a long time. Silence or apparent inactivity cannot be presumed to mean the complaint is resolved or no longer being pursued. Policies will therefore have to be put in place that allow for complainant prompting and regular follow-up of dilatory health service correspondents. This process can be automated and is a feature of most case management softwares with cases being flagged for attention after a defined elapsed time. A policy of 'active close' is necessary to have a clear measure of the 'active' case load that flags both 'active' and 'dormant' cases –distinguishing the latter from the 'extinct' case. By follow-up, we mean a call or similar to a user whose case has been dormant for a defined limit – 3 or 6 months perhaps – asking if the matter had been resolved and what the outcome was. This otherwise uncontroversial approach does need to be done sensitively with reference to the case to assess, for example, the likelihood of the death of any of the parties. An update can also be obtained by sending out a reply-paid complainant satisfaction survey asking for news of the case and for the questionnaire to be completed and returned if the case is closed. Cases otherwise subject to survey follow-up by the Financial Services Ombudsman's insurance-related cases are flagged for exclusion if there has been 'a catastrophic loss' such as death.

Benchmark Learning – A Management Measure for Activity not just Cases

- 1.8. The ICAS manager must measure more than the number of cases open and closed at any given level. This statistic is not a reliable guide to workload. There has to be a means of measuring case-related activity by level of case. Level 1 contacts must also be measured to understand enquiry volumes since if these rise, there may be a need to review staffing to manage a small enquiry telephone front-end unit. One rural service whose software enables comprehensive contact logging had recorded 400 telephone contacts in 3 months –prior to full public launch. One site had a contact pattern different to all the others with 50 contacts at Level 1, 12 at level 2 and then none at levels 3&4 with a further 11 as level 5. Was their website or other information material giving complainants enough to try the system on their own? The pilot manager said that this phenomenon had been seen before with other services offered by the pilot's parent organisation.

Benchmark Learning – ICAS Issues of Viability, Size and Access

- 1.9. These comments throw up a very important issue for the new ICAS service in terms of the planned network and the size of the individual units. A network of many small complaint handling offices may offer a poorer service than a large one covering a large geographical or densely populated area. Larger numbers of staff will better support a wide range of experience and specialities and offer more flexibility in terms of work patterns. There is a minimum number of complaints below which an ICAS office is no longer viable. Our data is not sufficient to allow us to calculate what that number might be.
- 1.10. The new service has to discover the shape and size of what is known in complaint handling circles as 'its iceberg'. The broad base of the iceberg is represented by the numerous incidents that create dissatisfaction amongst health services users. How many are then made or 'voiced' at each level of the complaints process all the way up to the Ombudsman who sits at the tip of the NHS complaints iceberg? How many exit the process? The metaphor encapsulates the situation where many problems although a source of concern to users, are not voiced at all and remain invisible beneath the surface.

Benchmark Learning – Innovative Pilot Practice In Management Of Decentralised Complaint Handling And Disbursement Of Budget

- 1.11. One pilot is co-ordinating the efforts of no fewer than 14 partner advocacy agencies. This is a bold and interesting experiment in building a novel form of service in a mixed urban area. The central resource acts as a brokerage distributing funds to the advocacy partners. The funds are packaged as 'advocacy units' representing 4 hours of staff time. The level of funding was calculated on the basis of an estimate of complaint volumes as experienced by PCT/Trusts in the past. There is provision for partial units or supplementary full units if a case is made. The approach puts a premium on very exact forecasting and is vulnerable to sudden rises in complaint volume. If the coffers are exhausted, no further work can be done except on a pro bono basis. However the experience will provide a valuable piece of learning from the pilot – can management adequately monitor both the expenditure of time and also the

quality of the service being given in a dispersed and decentralised ICAS environment? The balance between productivity and quality is difficult to sustain in complaint handling where workers have to react flexibly to the facts of individual cases .

Benchmark Learning – No More Cross-Subsidy in ICAS Budgets

- 1.12. It was not part of this exercise to analyse the expenditures of the pilot sites. It is however essential both for the pilot managers and the Commission to discover what the true costs of an ICAS operation are and to strip out any elements of subsidy coming from host agencies – CHC, CAB or any other organisation. One pilot site was being subsidised to the tune of all premises costs and management time. Organisations can presumably sustain this for a short while especially if the spending is seen as an investment in a new line of business. However if future bids for funds for long-running ICAS offices are not based on realistic costings (based in turn on a clear understanding of the labour involved in case work), there is a risk of services being withdrawn from complainants. The corollary is that some schemes may be over-funded as a result of over-estimation of case volumes and resources needed.

PEOPLE

Benchmark Learning – Sustaining Staff Quality

- 1.13. Some call it the Hawthorne effect where the performance of staff reacts favourably to being observed as they go about their work. Also organisations when faced with an experiment – effectively a new product for many – may bring in the best of their staff to make as good a go of the project as possible, especially if there is little or no training material available. An impressive range of experience and expertise is exhibited in the pilots surveyed. As one pilot manager said “ICAS is no place for beginners.” This is an issue which underlines a possible change taking place after the pilot period in the transition to a more settled existence. There may be a temptation or indeed a necessity to recruit people without that same depth of experience and commitment. Staff quality must be replicated and preserved in the new dispensation – a sentiment which is strongly stated in the responses to the concluding section of the survey.

Benchmark Learning – Innovative Recruitment

- 1.14. The most creative recruitment process entailed 3 candidates being given a case study in advance of their interview and being asked to prepare a presentation of their proposal for handling the case. They could use whatever audio and visual equipment they needed. This process certainly covered many of the points on the questionnaire. Others had tried less elaborate versions of that process, using an interview task to see how candidates would listen, gather information etc and then ask them to present it or as another put it “used evidence-based interview skills” to give someone a problem scenario and see how they handle it.

Benchmark Learning – Training Planning and Content

- 1.15. Training must be ready in advance before the launch of any new scheme and the syllabus linked to an agreed competency profile covering both cognitive and affective

domains and for those using case management software, the psychomotor domain as well. The other need our respondents stressed was a detailed understanding of the relevant NHS processes. In time, ICAS work may well be recognised with its own professional qualifications.

PROCESS AND TECHNOLOGY

Benchmark Learning – Resource Reconfiguration

- 1.16. We will consider the issues of process and technology together since they are very closely related. One important example is the role of administrative staff – a resource which we have already noticed that some need and cannot get and others have discovered they can do without because of low case volumes. What are administrative staff there to do? How does case or complaint management software change the answer to that question? The modern best practice complaint handling department in the private sector has no administrative staff. What might the ICAS best practice office look like?

Benchmark Learning – Unproductive Use Of Technology

- 1.17. 12 or more sites used some form of technology to support case management. Many CAB-based pilots used the CAB software. Others had specially purchased or been provided with CAMS. One site had taken advantage of a locally developed health services performance management system and adapted it to the ICAS environment. Another had bought the market leading complaint handling software package Respond. A third was using a bespoke software built with Microsoft Access. Only these last three users professed themselves happy with their software. There was a degree of dissatisfaction with CAMS around its perceived lack of user-friendliness and difficulty in getting reports out of the system. One site commented on the CAMS report generation feature “cumbersome so we don’t use it”. There is a clear training or re-training need and no doubt user familiarity and ease with the system would improve over time. Case workers faced with an unresponsive and difficult to use system will retreat back to paper and minimal recording and reporting practice. Confident computer use is a key skill and given the high quality of staff and volunteers, all should be expected to have it or learn it. Continuous user training and support is the key to successful use whatever system is chosen. The technical specification is the easy bit. Modern case management software is powerful and well-designed for the most part. Successful and productive use depends on the well-trained, well-practised and supported user and is harder to achieve. An ICAS-focussed common system specification was requested by one site.

Benchmark Learning – Two Tests for Effective Software

- 1.18. There are two principal tests of a ‘good’ software system. The first is that users turn to it first to record and manage cases. The second is that the system enables users to produce actionable reports without further technical assistance. To be actionable, reports should not consist of listings of cases and/or incidents but represent data that has been consolidated and cross-referenced.

Benchmark Learning – Make Quality Accreditation Process Useful Early On

- 1.19. The process of accreditation can be overwhelming for a fledgling service with its demands for documented process. However it can provide a platform to develop good working practices and so make an early contribution to service quality well before full accreditation. A full commitment to quality may entail down the line the appointment of a designated Quality Manager – consider combining that with a research responsibility to create a Research and Development capability with a permanent brief to identify best practice.

MEASUREMENT

Benchmark Learning – Intention to Recommend is Key Measure

- 1.20. No pilots had objective evidence of which elements were most successful in raising awareness – a number of sources were named of which the most important organisers guessed, was word of mouth via family and friends. One pilot with experience of offering other user services said that their previous research had shown that 47% of users came as a result of personal recommendation. This is a strong and reliable signal of customer satisfaction and the 'intention to recommend the service' is the key question for any complainant satisfaction survey. Satisfaction levels are very closely bound to case outcome – the 'very satisfied' are on the whole those who got what they wanted and believed they deserved – whereas the 'would recommend' measure signifies a degree of confidence in the system that is to a greater degree independent of outcome. (No subjective complainant-based ratings can be wholly separated from the question of what happened in the end.)

Benchmark Learning – Ask All the 'How Hear About' Question

- 1.21. The key learning comes from routinely asking new contactors the question 'How did you hear about us?' using the categories set out in the benchmarking questionnaire. The answers to this will drive cost-effective promotional investment.

Benchmark Learning – Satisfaction With What?

- 1.22. The complaint resolution process in the NHS is a hybrid and by the time of its conclusion a case will bear the imprint of many hands. It is the conventional wisdom which we generally endorse to wait until the case is closed before enquiring about satisfaction. However our experience in researching Ombudsman cases especially those that reach the Legal Services Ombudsman argues against this course of action. Cases can take over two years to wind to a conclusion – a Complainant Calvary was our description – and the consumer is no longer capable of distinguishing clearly who did what to whom when. There is a general recollection of the process but the data that comes out of such a survey over that timespan is not useful to an ICAS whose involvement may have been a one-off or occasional. By all means wait and do it on the closed case if ICAS has stuck with the case all the way to the Ombudsman or the point of its conclusion. If however the contact is catalogued as a Level 3 or below, ask the satisfied and ready to recommend questions immediately. These customer surveys are not rocket science. Their job is to give ICAS managers useable data within a

timeframe where they can still do something about it. So like the election advice to vote early and vote often, sometimes it is better to survey early and survey often rather than once right at the bitter end. (And the feelings may well be very bitter by then).

Benchmark Learning on Aims and Principles – Independence and Complaint Handling

- 1.23. Independence is an essential ingredient of the identity and purpose of ICAS. This has to remain the case for the successor organisation. We would however add a gloss to this principle connected to the values of pragmatism associated with best practice complaint handling. The achievement of solutions will entail a high and continuing level of involvement with process partners such as a PALS. Assertion of principle must not get in the way of solutions for complainants. A staff confident of their ethical and formally established status should be able to engage with others without invoking the attribute of independence with the formality and disengagement that that can sometimes imply .

2. INTRODUCTION

BACKGROUND

- 2.1. At the time this report was commissioned by the Department of Health in December 2002, over 100 ICAS pilots are up and running. There is a pressing need to take some 'early learning' from the experiences of these pilot sites and to begin the process of recognising and promulgating those elements of performance and achievement that signal a job being well done.

Project Goal

- 2.2. MAC Associates were asked to prepare a report which will bring together the experience of a sample of pilot sites and provide principles and standards underpinning ICAS service quality. MAC consultants worked with Christopher Hayes and his team at the ICAS Network Support Office. That team had already collected material which assisted in the choice of the sample and the framing of the questions. The ICAS pilots were notified of the exercise in the December 2002 edition of the newsletter 'icas EXCHANGE'.

Project Methodology

- 2.3. The project took a sample of some 20 pilot sites, representing a cross-section of the 113 pilots then running in England, and researched their experience. The Network Support Office identified those sites against an agreed set of social and geographic parameters. In the event the final sample was 19 pilots.
- 2.4. MAC then prepared a questionnaire to be used to collect information in a consistent and structured way from the chosen pilot sites. A set of questions and areas for discussion were agreed in consultation with the ICAS support team and Liz Dimond for the Department of Health. There was an opportunity to test the questionnaire on two ICAS pilots before sending out the final version which was done electronically in early January 2003
- 2.5. Appointments were then made with each site for an interview over the phone. No visits were made to pilot sites. The interviews were conducted in the period 13/01/03 to 24/01/03. The answers to the questions predicated an operational experience. The interviewee was generally the Project Manager – the person best placed to observe the reality of the day to day work of the whole office. That person was also generally the person given the management task of overseeing the pilot and managing the budget. The interviews took about an hour – the longest lasted for two hours. Respondents were given the opportunity of expanding and clarifying their answers. The notes made of those comments are not verbatim but are a summary of what was said. All data in this report are anonymised. Comments are given in direct speech to convey specific views on a key point.

Readership

- 2.6. This report is for
- Pilot ICAS personnel and partner agencies
 - Sponsoring and funding bodies
 - The CPPIH
 - PCT Patients' Forums (when established).

RECOGNITION AND THANKS

- 2.7. We are happy to recognise early in this report our thanks and appreciation to those who responded so generously and promptly to our request for information. We appreciated the honesty and frankness with which the questions were answered. Many had consulted in the short time between becoming involved and the actual interview, with bid partners and co-workers and the results were all the more valuable for the more broadly-based opinions that came out of those consultations. We cannot pretend that all were thrilled with their experience of aspects of the pilot exercise but we can bear witness to the commitment and energy of the pilot ICAS sites we approached for an interview. This research chronicles the fruits of that approach and uses it to build a provisional vision of the future ICAS service.

THE MAC APPROACH

- 2.8. The MAC consultancy is a relatively new alliance between people with experience of and a strong commitment to working with consumers, users and citizens in a number of contexts. We have relevant expertise in
- the NHS
 - Complaint Handling
 - Supporting pilot networks e.g. the Pilot Patients' Forums.

Currently we are involved in the preparation of the NHS Guide to Complaint Handling for the Welsh Assembly Government. One of our number is an independent complaints convenor and another is an expert on private sector complaint handling in both unregulated and regulated markets. . A third has wide experience of complaints handling in the legal profession .

BENCHMARKING COMPLAINT HANDLING

Benchmarking- A Definition

- 2.9. Benchmarking for our purposes here is the identification of practices in one organisation that can be put into practice by others in different organisations adapted as necessary. See it, modify it, try it, modify it again if necessary and repeat the dose. The governing assumption of this report is that complaint handlers share many concerns and issues that are common across different markets and types of organisation. The successful benchmarker recognises both those points in common as well as the differences.
- 2.10. The emphasis of the exercise is to improve performance all round by beginning the benchmarking process of identifying the standards, goals and measures that will help existing pilots and the organisation that is to come to be accessible, trusted and effective. Complaint handling has emerged from the shadows of organisations to be a more widely discussed function. It is now considered to be a vital activity because effective complaint handling can create satisfied and loyal customers whose confidence in an organisation following a poor experience is renewed by speedy and responsive solutions. However this higher profile does not mean the job has become easier. User expectations have risen too. Users have become more demanding and litigious. Organisations set out to protect their staff and reputations. Complaining about the quality of care or service received as a user of National Health services can be complex and emotionally bruising. So a new degree of expertise is called for in the management of complaints. The modern complaint handler and his or her manager cannot rely on common sense and appeals to everyone's better nature to arrive at a solution agreeable to all. Success depends on having the right policies, resources and measures in place to meet levels of demand and consumer expectations of quick and favourable decisions.
- 2.11. The ICAS service has a number of dimensions but the core task is connected with handling complaints and the people who make them. The most appropriate basis of comparison that we have used is best current practice in complaint handling. We are aware of the debate around the use of the word 'advocacy' and what that may mean in this context. Whatever the answer is in the long term, we believe that there are ways of managing and measuring performance in this area that remain useful whatever the label. The sort of service the ICAS pilots were offering can be defined as 'escalated third party complaint assistance'. The service cannot provide, insist upon or enforce a particular decision. It does not intend or pretend to be impartial – it is there to assist the user of National Health Services with a problem or complaint. It must work with other offices such as PALS and will often find itself in a difficult place between outraged user and apparently indifferent health service provider. The service cannot bring complaints to the attention of a regulator as complaint handlers may still in gas, electricity, water, rail and telecom markets nor does it have direct connections to the Health Services Ombudsman, although it can support and assist clients up to and including this stage. Nevertheless there are lessons it can learn from practice in other areas and in so doing provide a rich legacy for the organisation/network that comes after the pilots.

2.12. This report takes the six elements of the complaint handling job and developing processes and best practice under each of them. The headings are:-

- Management
- Measurement
- People
- Process
- Technology
- Access.

The MAC view of complaint handling is as a measured and managed process which contributes to satisfactory solutions that meet consumer expectations as to fairness and timeliness and makes a contribution to the improvement of services to all users. The complaint handling process must not attract complaints about its own lack of quality. The successful complaint office promotes solutions for individual complainants and then uses the data of the cases handled to effect improvement.

3. THE PRINCIPAL FINDINGS

GENERAL

3.1. Appendix A contains the responses collated from the individual questionnaires. Numeric values are given to most answers. The reader will understand that there is no statistical significance that can be attached to these numbers given the small size of the sample.

Identifying the Learning

3.2. After consideration of the results, we pull out what appears to be the principal learning points under the heading "**Benchmark Learning**". The discussion identifies good practice whether it emerges from a pilot or is included on the basis of MAC observations and experience elsewhere.

The Replication of Good Practice

3.3. When making benchmarking comparisons and evaluating good practice, it is important to understand context and whether what is being observed will be replicable in another place or at a time in the future. The ICAS pilot was an experiment with a defined time limit. For many the time was too short and in some cases, uncertainties about the future hampered efforts in the present. Therefore when observing such areas as staff recruitment, allowance has been made for difficulties connected with the need to offer short-term contracts with no job security in the longer term. In another area, many have not bothered to install software since the investment – both of money and staff user training – was not considered worthwhile in the short-term. The future service and

its managers will not suffer from such difficulties – there will be without doubt others – because the experimental nature of the pilot exercise will not prevail. Nonetheless we can draw some general lessons about recruitment and IT deployment for example and these are set out in the report.

- 3.4. More fundamental and more damaging to the levels and type of assistance available to users with problems have been the reporting by a minority of institutional hostilities – it is not too strong a word sadly – as between PALS, CHCs and some specific pilot sites. Managers of pilots are moving or have already moved to grasp this nettle of non-co-operation where it exists and have negotiated protocols and created working relationships where previously there was suspicion and distance. The experience of both problem and solution will strengthen any future system. There will still be tricky issues to be resolved between different advice giving agencies and different philosophies of user and complainant support. The world of consumer advice has already seen great debates between specialist and generalist advice giving. The debates raises such questions about separate channels or can the specialities be developed and accommodated within the generalist agencies?

Benchmark Learning- CAB example

- 3.5. Examples of this sort of debate would be firstly the debate about how best to give money advice – could it be accommodated best within the CAB or was it necessary or indeed feasible to establish a specialist service separately funded? Elements of this debate had been seen in an earlier discussion about the need for Consumer Advice Centres concentrating on advice about goods and services supplied on the high street and not touching the consumer needs for advice about such matters as benefits? The findings of this research show success across a range of agencies.

Benchmark Learning – Competition for Consumer Custom and Confidence

- 3.6. Consumers will have confidence in the service that is most likely to meet their needs and goals. They are not interested in the niceties and details of who does what. The field of offering help to users is crowded with those vying to sort things out for citizens and consumers from the MP to the volunteer in a community advice centre. Consumers will browse these services and act in their own interests in pursuit of their own agendas. We heard that consumers were already using the ICAS freephone 0800 number as a means of accessing the host CAB whose line was engaged. We also heard of the energetic PALS who insisted in sticking with the complaint and the complainant when the PALS service should have withdrawn in favour of ICAS. For one bidder from a non-health organisation, the introduction to the difficulties came when the local CHC refused to become a bid partner. Negotiation about boundaries and the establishment of 'who does what' protocols may well reduce but it will not eliminate what some would call 'wasteful duplication' and others beneficial competition offering consumers choice. Consumers will make their own decisions and will remain happily ignorant about intra-professional debates amongst advice givers for example about the precise definition and practice of 'advocacy' within the constraints of the NHS complaints process.

The ICAS Role - Empathy and Humanity

- 3.7. The organisations that will 'win' the competition and gain consumer confidence and trust are those that recognise the truth behind the MAC-aphorism that 'complaints are emotions disguised as process'. The NHS complaint handling service suffers from a large deficit of human emotion and contact. Its fact-based investigative processes impose burdens upon the complainant calling for a stamina and a fortitude that most of us lack. One advocacy agency moving into complaint work commented on how disappointed they were by the impersonal manner NHS staff used to deal with their users.

MANAGEMENT

Opening for Business

- 3.8. The first test of the successful pilot manager is that of getting the service off the ground as soon as possible after the receipt of funds. We found that the usual elapsed time between hearing that the bid had been successful and opening the doors for business was around one or two months. That figure is affected by considerations of recruitment and also by the timing of a formal launch which could come after the pilot had in fact started dealing with cases. The schemes that were fastest out of the gate were those who did not have to recruit – they relied on seconded staff – and were able to work out of established premises. Examples of such organisations would be the CHCs and CABx..

Case Volumes

- 3.9. The pilot ICAS service is not on this evidence a high volume environment. The maximum number of cases taken on in the sample surveyed was 322 with the smallest number was 4. The large number was associated with a CHC-based ICAS located in a London Borough. The figure of 4 cases was again an urban ICAS with the service provided by an agency new to this form of work. Five cases had been opened by a profoundly rural CAB-based service. However these are early days and as the service gets well known, numbers of contacts at all levels will increase. Volumes are also affected by referrals from other parts of the system once the service is seen as being a permanent feature with a role that is widely known and understood by health care providers. Some such providers had held back from referring cases to this 'temporary' service.
- 3.10. The figures are not yet robust enough to be related to general populations. However the data on the proportion of cases closed is enough to indicate an important general feature of the system. While enquiries at Levels 1&2 can be dealt with expeditiously, some Level 3 cases and by definition all of those at levels 4 and 5 take much longer to close. ICAS pilots are not in a position to control the time taken to reply by other agencies or offices involved in the case. The complaints process is a long one, subject to unpredictable spasms of activity if dates for independent review for example bunch up and an ICAS presence is required.

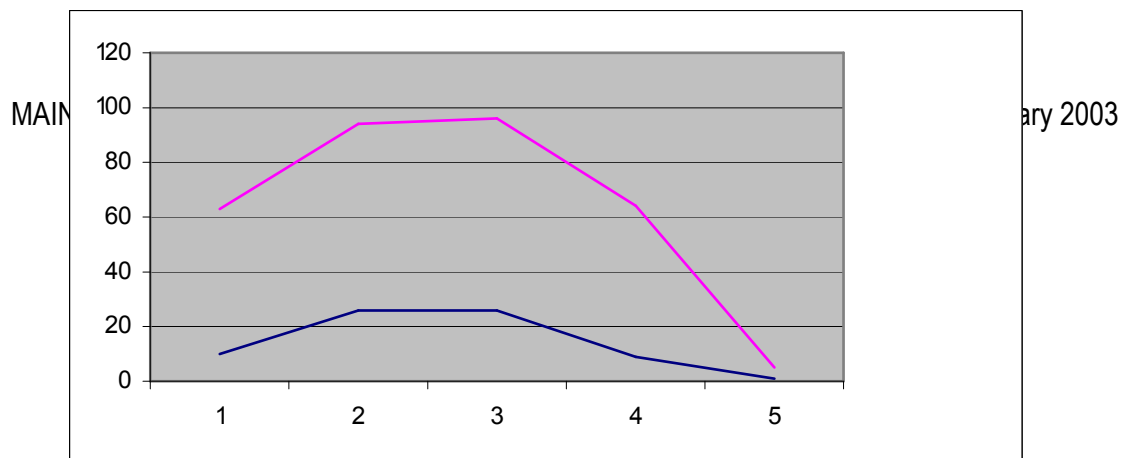
Benchmark learning – ‘Active’ Closure policy

- 3.11. Resource planning must therefore take account both of the length of the case pipeline as well as the number of cases within it. If the ICAS remains with the case through all the local stages, there may be calls for support for a long time. Silence or apparent inactivity cannot be presumed to mean the complaint is resolved or no longer being pursued. Policies will therefore have to be put in place that allow for complainant prompting and regular follow-up of dilatory health service correspondents. This process can be automated and is a feature of most case management softwares with cases being flagged for attention after a defined elapsed time. A policy of ‘active close’ is necessary to have a clear measure of the ‘active’ case load that flags both ‘active’ and ‘dormant’ cases –distinguishing the latter from the ‘extinct’ case. By follow-up, we mean a call or similar to a user whose case has been dormant for a defined limit – 3 or 6 months perhaps – asking if the matter had been resolved and what the outcome was. This otherwise uncontroversial approach does need to be done sensitively with reference to the case to assess, for example, the likelihood of the death of any of the parties. An update can also be obtained by sending out a reply-paid complainant satisfaction survey asking for news of the case and for the questionnaire to be completed and returned if the case is closed. Cases otherwise subject to survey follow-up by the Financial Services Ombudsman’s insurance-related cases are flagged for exclusion if there has been ‘a catastrophic loss’ such as death.

Case Management by Level

- 3.12. The distribution by level of case shows level 3 accounting for most of the cases. The diagram in figure 1 gives the distribution curve for one relatively large case load and a smaller one. If over time, there is an accumulation of lengthy and active level 4 and 5 cases, the distribution may change. The ICAS manager must beware of the creation of a resource ‘black hole’ whereby a relatively small number of cases absorb most of the energy and resource of the case team. One manager said that while the number of cases was in line with pre-bid assumptions, the complexity was higher with some cases taking between 20-40 contacts. With small complaint handling units, it does not take much to gum up the works. Only three respondents
- 3.13. stated that they *disagreed* with the statement that “we invariably have to take a pretty hands-on approach e.g. drafting letters or making phone calls for complainants”. This is now and will remain a contact-intensive service with high levels of contribution from ICAS. Implementation of policies for self-empowerment and client ownership of the complaint will have to recognise the complainant’s relative lack of experience in dealing with the NHS and consequent need for assistance and support from those more knowledgeable about the process.

Figure 1



Benchmark Learning – A Measure for Activity not just Cases

- 3.14. The ICAS manager must measure more than the number of cases open and closed at any given level. This statistic is not a reliable guide to workload. There has to be a means of measuring case-related activity by level of case. Level 1 contacts must also be measured to understand enquiry volumes since if these rise, there may be a need to review staffing to manage a small enquiry telephone front-end unit. One rural service whose software enables comprehensive contact logging had recorded 400 telephone contacts in 3 months –prior to full public launch. One site had a contact pattern different to all the others with 50 contacts at Level 1, 12 at level 2 and then none at levels 3&4 with a further 11 as level 5. Was their website or other information material giving complainants enough to try the system on their own? The pilot manager said that this phenomenon had been seen before with other services offered by the pilot’s parent organisation.

The Pros and Cons of Promoting and Maximising Level 1 and 2 contacts

- 3.15. As the service becomes better known and is perceived to be the health service users’ ‘easy to access’ independent friend and ally, telephone contact volumes at levels 1 and 2 may rise substantially. The enquiries may well be about such issues (reported by one pilot) as ‘can you help me change my doctor?’ which are not within the current ICAS brief. Many may be even less related to ICAS work. However calls at these levels fulfil a positive purpose if they minimise escalation to higher levels of assistance while giving the person with a problem enough information to solve the problem on their own. Also logged and reported data on the nature of these enquiries can be a valuable source of knowledge on general issues and concerns that may or may not lead to formal complaints. Nevertheless the staffing and cost implications are such that a policy of referral to NHS Direct or other advice sources better equipped and resourced to handle telephone enquiries must be the preferred course of action if such enquiries threaten service levels to other users. Lines and staff must be kept free for the core business users. While many pilot sites prefer to see customers, the rural ICAS pilots in particular were developing telephone-based case handling with one actually using the title of ‘Telephone Advocate’. The ‘engaged’ signal is a rationing device that customers do not like to hear. (Although evidence seen by us suggests that they may prefer the engaged signal to the set-up that allows initial access that keeps them hanging on for many long minutes even if the call is free or leads them down long avenues of complex ‘press 1’ choices).

Other Volume-related issues

- 3.16. We enquired whether the number of cases were in line with what was anticipated at the time of the bid. In those cases where there was a variation – and some had not made any estimates at all of numbers – the numbers received were lower than anticipated. One site had estimated 200 cases over 6 months and had received only 59 by the end of December 2002. There were a number of possible reasons for this – for example, a relatively small population in the ICAS catchment area or a strong local PALS was taking all the business. Another commented that while their estimates were based on Trust figures, this had not proved a reliable guide. There had been a very slow uptake of the new service which as a non-health agency needed to ‘earn respect’ from the NHS. Things were picking up now.

Benchmark Learning – Issues of Viability, Size and Access

- 3.17. These comments throw up a very important issue for the new ICAS service in terms of the planned network and the size of the individual units. A network of many small complaint handling offices may offer a poorer service than a large one covering a large geographical or densely populated area. Larger numbers of staff will better support a wide range of experience and specialities and offer more flexibility in terms of work patterns. There is a minimum number of complaints below which an ICAS office is no longer viable. Our data is not sufficient to allow us to calculate what that number might be.
- 3.18. The new service has to discover the shape and size of what is known in complaint handling circles as ‘its iceberg’. The broad base of the iceberg is represented by the numerous incidents that create dissatisfaction amongst health services users. How many are then made or ‘voiced’ at each level of the complaints process all the way up to the Ombudsman who sits at the tip of the NHS complaints iceberg? How many exit the process? The metaphor encapsulates the situation where many problems although a source of concern to users, are not voiced at all and remain invisible beneath the surface.
- 3.19. In turn this raises important issues of Access –defined as accessibility in the eyes of service users - which we will discuss under that heading.

BUDGET ISSUES

- 3.20. We enquired whether spending was in line with expectations. Fourteen of the 19 sites replied that it was. Where there was a variation, the reasons most often quoted were underspending on staff or publicity. Three pilots commented that they had not recruited the administrative staff foreseen in the bid. One had tried and failed because they could not find someone willing to take up such a short contract. Agency staff were being used instead. Other sites had not recruited because case volumes were lower than expected. A site which had not filled all its posts will compensate by spending more on publicity. Caution about promotional spending was quoted by another site as a reason for an underspend at this stage of the pilot. Before committing another tranche of funds to promotion, they were waiting to see the effect of the first round of spending.

Benchmark Learning – Innovative Practice In Management Of Decentralised Complaint Handling And Disbursement Of Budget

- 3.21. One pilot is co-ordinating the efforts of no fewer than 14 partner advocacy agencies. This is a bold and interesting experiment in building a novel form of service in a mixed urban area. The central resource acts as a brokerage distributing funds to the advocacy partners. The funds are packaged as 'advocacy units' representing 4 hours of staff time. The level of funding was calculated on the basis of an estimate of complaint volumes as experienced by PCT/Trusts in the past. There is provision for partial units or supplementary full units if a case is made. The approach puts a premium on very exact forecasting and is vulnerable to sudden rises in complaint volume. If the coffers are exhausted, no further work can be done except on a pro bono basis. However the experience will provide a valuable piece of learning from the pilot – can management adequately monitor both the expenditure of time and also the quality of the service being given in a dispersed and decentralised ICAS environment? The balance between productivity and quality is difficult to sustain in complaint handling where workers have to react flexibly to the facts of individual cases .

Benchmark Learning – No More Cross-Subsidy

- 3.22. It was not part of this exercise to analyse the expenditures of the pilot sites. It is however essential both for the pilot managers and the Commission to discover what the true costs of an ICAS operation are and to strip out any elements of subsidy coming from host agencies – CHC, CAB or any other organisation. One pilot site was being subsidised to the tune of all premises costs and management time. Organisations can presumably sustain this for a short while especially if the spending is seen as an investment in a new line of business. However if future bids for funds for long-running ICAS offices are not based on realistic costings (based in turn on a clear understanding of the labour involved in case work), there is a risk of services being withdrawn from complainants. The corollary is that some schemes may be over-funded as a result of over-estimation of case volumes and resources needed.

COMMON GOALS AND MISSION STATEMENTS

- 3.23. Most pilots either did not have a mission statement at all or relied on one that existed for the parent organisation. Those that did not have one said that it was of interest for the future but there had been other and more pressing set-up priorities. Three sites had a mission statement to offer. The most succinct was "to provide a quality assured client focussed 1:1 ICAS service with the full involvement of the client at all times". That was a CAB – other CABs relied on the statement of the parent organisation. Another ICAS had used the CHC's values statement. A specialised mental health ICAS offered "... provides a high level of inclusive service and support through advocacy to mental health service users with NHS complaints issues towards resolution and service user satisfaction".
- 3.24. The fullest and longest reads "*The Independent Complaints Advocacy Service (ICAS) for Patients in (place) is a crucial element in achieving social justice through providing free & confidential advice, assistance and support to anyresident who wishes to*

complain about NHS care or treatment. ICAS for Patients in (place) will ensure that (place) residents have information about the availability of NHS services in, are able to enforce their rights as patients, and carers', and will help to improve the general health of the people who live in by influencing services, recommending changes to policy and practice, and assisting patients to have access to central and local NHS services.

These services are freely available to all Residents including people who are at risk of exclusion either by:

- Age*
- Gender*
- Social or Ethnic Background*
- Disability*
- Any other reason."*

Where are We now? - Summary Questions

- 3.25. We offered managers the opportunity to agree or disagree with a number of statements about elements of the pilot. The questions sought a view on the way reality matched up to expectation, the quality of the service offer, the characteristics of that service and the quality of its links with other health service providers. The final statement with which respondents were asked to agree or disagree was "we feel it is too early to know if the pilot is working out well". 13 disagreed with that statement – 6 strongly. The sample felt that they had got it right in terms of their objectives for the exercise, that they were in a position to give people the help they needed. The only areas where a significant minority reserved their position was on how well the ICAS scheme was working with either primary care providers or local PALS. With that qualification, the mood reflected in the answers was positive.

Are we pals with PALS?

- 3.26. We touched on this issue in an earlier paragraph and the issue falls both under the heading of Management and of Access. One respondent commented "working OK with local CHCs but not with GPs or the PCT as leading primary care organisations. They have had no direct contact from GPs despite writing to all local practices sending the ICAS leaflet." Another noted that the PALS relationships had improved since launch and another noted that PALS was much easier to work with than Trust complaints managers. Even if the ICAS pilots are not currently friendly with PALS or other health bodies, they are certainly trying to develop a much closer relationship and negotiate protocols. Where PALS, in particular a hospital-based PALS, had a good relationship

with the local ICAS, this was usually a key, if not the main, source of signposting clients to ICAS. PALS at PCT level was a much scarcer commodity and correspondingly of less direct relevance to ICAS at this stage.

PEOPLE

- 3.27. People are a key resource for complaint handling. We asked about how the people were recruited, the skills they possessed and the skills they needed most. The answers here gave important clues as to why the ICAS pilots are doing as well as they are. The quality of staff was very high with a wide range of skills and experience. While they may not have used some of the formal tests enquired about, the recruitment techniques did explore the competencies the questionnaire identified. For example, 17 sites said that they had a detailed understanding or expert knowledge of case-related skills such as Advocacy, Mediation and Conciliation. A majority of sites possessed the skills needed to deal with the media and the design and preparation of promotional materials. A mental health ICAS could draw on a very highly qualified pool of workers. One volunteer was a qualified barrister and other advocates within this ICAS were trained to law degree level with a colleague who had 20 years of experience with tribunal work. The mental health advocate seconded to the ICAS project had 3 years experience of running advocacy service. This pilot had taken the view that 6 months was too short a time to recruit and train new staff.
- 3.28. More generally, knowledge levels can vary between workers and can in the generalist services like the CAB extend to many other topics. One CAB ICAS Project manager pointed out that CAB statistics show that 25% of ICAS clients also need help on other issues which the CAB can give. One respondent pointed out that each ICAS manager should ideally have planning and developmental skills to ensure the growth of that service as well as having access to research skills.

Benchmark Learning – Sustaining Staff Quality

- 3.29. Some call it the Hawthorne effect where the performance of staff reacts favourably to being observed as they go about their work. Also organisations when faced with an experiment – effectively a new product for many – may bring in the best of their staff to make as good a go of the project as possible, especially if there is little or no training material available. An impressive range of experience and expertise is exhibited in the pilots surveyed. As one pilot manager said “ICAS is no place for beginners.” This is an issue which underlines a possible change taking place after the pilot period in the transition to a more settled existence. There may be a temptation or indeed a necessity to recruit people without that same depth of experience and commitment. Staff quality must be replicated and preserved in the new dispensation – a sentiment which is strongly stated in the responses to the concluding section of the survey.

Benchmark Learning – Innovative Recruitment

- 3.30. The most creative recruitment process entailed 3 candidates being given a case study in advance of their interview and being asked to prepare a presentation of their proposal for handling the case. They could use whatever audio and visual equipment they needed. This process certainly covered many of the points on the questionnaire.

Others had tried less elaborate versions of that process, using an interview task to see how candidates would listen, gather information etc and then ask them to present it or as another put it “used evidence-based interview skills” to give someone a problem scenario and see how they handle it.

- 3.31. When it came to the most important skills, ‘communication skills’ were the most frequently mentioned. The phrase covered a variety of skills such as advocacy, “getting people to open up” and negotiation skills. To complement these attributes, analytical skills were needed to take on board and work through complex information – perhaps with a legal slant - as well as being able to work from the users’ perspective. Being accurate and non-judgemental were also mentioned as well as understanding specialist client groups. To do this well demands both affective skills such as empathy as well as the organisational and time-management behaviours to be used by self-managing staff who need minimal supervision. One ICAS pilot had based all its case workers at their homes and we have already described the contracting-out model being used at another site. The means of measuring and managing these networks – especially if independent agencies are involved – will need a great measure of tact in the deployment of the sort of workplace practices common to dispersed networks such as filling in time sheets. Workers also need to feel trusted and supported by their distant managers.
- 3.32. Job descriptions were available for the great majority of staff and 12 had conducted formal induction training – although specialist training for ICAS situation was hard to come by at the beginning of the pilot – less so now. Induction training was on offer as part of CAB training. One respondent mentioned that ICAS Training was a “clean sheet of paper”. There is a need, noted one respondent, for a close supervisory eye on new staff. Supervisory here we assume carries both a general and specific meaning – the latter meaning being associated with support for staff in stressful situations. The point is a valid one whichever meaning is used. Many had avoided the problem by extensive use of secondment of experienced staff from their own organisations. If there was no formal training programme, staff team meetings offered an opportunity for staff development and learning.

Benchmark Learning – Training Planning and Content

- 3.33. Training must be ready in advance before the launch of any new scheme and the syllabus linked to an agreed competency profile covering both cognitive and affective domains and for those using case management software, the psychomotor domain as well. The other need our respondents stressed was a detailed understanding of the relevant NHS processes. In time, ICAS work may well be recognised with its own professional qualifications.

ACCESS

- 3.34. Opening Hours were very consistent across the pilots. Monday to Friday 9-5 was the most common pattern. CABs used the idea of reception service where only details were taken and no advice offered. One pilot offers a diagnostic service (non-medical) from 10am to 2pm with the offer of an appointment within a 9.30 to 5.30 timeframe. More interesting than the hours of a particular site or office were the provisions to

facilitate access using a wider network of offices to provide a outreach service. One pilot site operated over 10 sites in rural areas; 3 were main ones operating 9.30am till 4pm with the 7 satellite offices offering 2 hr drop in times. Extended and flexible opening hours allowed one organisation to offer evening home visits. The pressure from complainants for access at times outside conventional working hours will grow in proportion to the proportion of the complaining population who are economically active. Home visits were not offered by all pilots or demanded by all users. The lack of demand was a considerable relief to small ICAS pilots where there was a policy to visit only in pairs on grounds of staff safety. To do home visits could mean closing the office.

- 3.35. The sample was evenly split on the question of offering free or low-cost phones and whether they could be used by the hearing impaired. Almost all had a message taking system out of hours. 7 gave information about such matters as opening hours. 5 had webpages but none managed complaints through that medium.

Promoting Access.

- 3.36. Fourteen pilots claimed high levels of skill in the area of liaison with media and other external bodies. Sixteen claimed similar skill levels in designing promotional materials. So it is not surprising that the pilot promotional efforts were intensive and widespread with many avenues and channels being exploited to distribute a wide range of materials. We have noted earlier some signs of caution about further investment until the impact of such promotion was established. Others did not want to raise expectations too high amongst users in case the service had soon to be withdrawn. These reservations aside, the fact remains that pilot ICAS sites have been marketed energetically and creatively. The quality and impact of the promotional material produced is being reviewed by others and is not included in this report.
- 3.37. Other health care providers were an important publicity outlet for almost all sites. However one pilot told us that they specifically avoided GP's surgeries "because doctors handle complaints poorly". That pilot preferred channels like Tesco and shop window displays in town centre locations. Chemists, local authority leisure centres, community colleges and sheltered accommodation, hairdressers for disabled people and lunch clubs for the 60+ population were all mentioned. 'Silver surfers' were a growing phenomenon. The provision of web-based advice and issues around email management will be future issues. Already one pilot advised us they had had to think about separate email addresses for complainants and internal communications so the different types of communication did not get muddled up and clog the system. Some had held back on web site development just for the pilot – others like CABs had piggy-backed on their host organisation sites. 9 sites had produced material specifically for targeted groups such as the visually or hearing impaired.

Benchmark Learning – Intention to Recommend is Key Measure

- 3.38. No pilots had objective evidence of which elements were most successful in raising awareness – a number of sources were named of which the most important organisers guessed, was word of mouth via family and friends. One pilot with experience of offering other user services said that their previous research had shown that 47% of

users came as a result of personal recommendation. This is a strong and reliable signal of customer satisfaction and the 'intention to recommend the service' is the key question for any complainant satisfaction survey. Satisfaction levels are very closely bound to case outcome – the 'very satisfied' are on the whole those who got what they wanted and believed they deserved – whereas the 'would recommend' measure signifies a degree of confidence in the system that is to a greater degree independent of outcome. (No subjective complainant-based ratings can be wholly separated from the question of what happened in the end.)

Benchmark Learning – Ask All the 'How Hear About' Question

- 3.39. The key learning comes from routinely asking new contactors the question 'How did you hear about us?' using the categories set out in the benchmarking questionnaire. The answers to this will drive cost-effective promotional investment.

PROCESS AND TECHNOLOGY

Benchmark Learning – Resource Reconfiguration

- 3.40. We will consider the issues of process and technology together since they are very closely related. One important example is the role of administrative staff – a resource which we have already noticed that some need and cannot get and others have discovered they can do without because of low case volumes. What are administrative staff there to do? How does case or complaint management software change the answer to that question? The modern best practice complaint handling department in the private sector has no administrative staff. What might the ICAS best practice office look like?

Vision of the Future

- 3.41. All casehandlers enter their own case details on a fully distributed computerised case management and reporting software. There are no paper files. Back office investment takes the form perhaps of a Research and Development person whose role is to manage the statistical data called up for reports recording customer views and case progress and outcomes. All staff face the customer. (Using administrative staff to batch enter paper-based case details and then keep both the paper and the electronic records harks back to the days when there were typists and filing clerks.) Voice mail takes phone messages and the peripatetic are linked to the office phone system where their mobile is just another of its extension. Home or "wandering workers" and their laptops are linked to the office network and if expense does not permit online case entry, then all case working can be downloaded each evening. Security is important and use may be made of encrypted data protection (as one pilot does already)

Benchmark Learning – Unproductive Use Of Technology

- 3.42. 12 or more sites used some form of technology to support case management. Many CAB-based pilots used the CAB software. Others had specially purchased or been provided with CAMS. One site had taken advantage of a locally developed health services performance management system and adapted it to the ICAS environment.

Another had bought the market leading complaint handling software package Respond. A third was using a bespoke software built with Microsoft Access. Only these last three users professed themselves happy with their software. There was a degree of dissatisfaction with CAMS around its perceived lack of user-friendliness and difficulty in getting reports out of the system. One site commented on the CAMS report generation feature “cumbersome so we don’t use it”. There is a clear training or re-training need and no doubt user familiarity and ease with the system would improve over time. Case workers faced with an unresponsive and difficult to use system will retreat back to paper and minimal recording and reporting practice. Confident computer use is a key skill and given the high quality of staff and volunteers, all should be expected to have it or learn it. Continuous user training and support is the key to successful use whatever system is chosen. The technical specification is the easy bit. Modern case management software is powerful and well-designed for the most part. Successful and productive use depends on the well-trained, well-practised and supported user and is harder to achieve. An ICAS-focussed common system specification was requested by one site.

Personal not ‘techno’ service

- 3.43. There were pilots who were committed to a very personal and client-focussed level and style of service who might feel that this style of service cannot be offered if the case worker is perceived as hiding behind their computer. There is also a suspicion of too much data being recorded and pestering with satisfaction surveys – “bureaucratic nagging” one pilot called this. We agree that in a small specialised pilot, the choice, expenses, installation and use of technology can be an unhelpful diversion of resources especially in the short term. As one site told us “most information is conveyed verbally and informally e.g. regular meetings with PALS worker. The complaints manager at (local hospital site) will feed back (if client does not) on how things are going. (We) try to keep paperwork to a minimum.”
- 3.44. The answer even in these circumstances is that the audience for information on how things have worked and what caused the difficulty in the first place is much broader than case team and client. If complaints are to fulfil their improvement role and ICAS is to be valued for its contribution, comprehensive and actionable reporting is essential. We will return to this topic in Measurement. Case management software can indeed be useful as a means of logging contactor and case details but its principal utility is the recovery of that information quickly and easily as the basis of case-workers’ and managers’ understanding of what is going on. As the site who bought RESPOND noted in the quarterly report immediately after purchase “a useful and time-saving acquisition. All communication with the client is recorded on to this system which also records time spent on a case This is a very useful tool for managing and monitoring caseloads as one client can generate many contacts and issues.”

Benchmark Learning – Two Tests for Effective Software

- 3.45. There are two principal tests of a ‘good’ software system. The first is that users turn to it first to record and manage cases. The second is that the system enables users to produce actionable reports without further technical assistance. To be actionable,

reports should not consist of listings of cases and/or incidents but represent data that has been consolidated and cross-referenced.

- 3.46. We turn now to the role of quality accreditation in developing good process.

Quality Accreditation

- 3.47. The pilot has brought together new bedfellows, uniting a range of organisations with different experiences, approaches and traditions. Even where CHCs have combined, there can be no assumption that they were all doing things the same way. So as one pilot site manager told us, the experience of the initial processes of accreditation were very helpful in making clear the differences and the need to present a consistent level and type of service to the complainant. Approaching the task of developing the policies and practices demanded of the standard in a collaborative way with co-workers, was very productive. Basic process documentation techniques such as designing an algorithm on a flow chart showing how a complainant might be handled are a valuable managerial tool that also has a valuable training role. One pilot manager added that they would support any Department of Health initiative to develop an ICAS specific quality mark. One site was exploring the European Business Excellence Model and another PQASSO™ - Practical Quality Assurance System for Small Organisations– a quality assurance scheme developed specifically for smaller voluntary organisations.

Benchmark Learning – Make Quality Accreditation Process Useful Early On

- 3.48. The process of accreditation can be overwhelming for a fledgling service with its demands for documented process. However it can provide a platform to develop good working practices and so make an early contribution to service quality well before full accreditation. A full commitment to quality may entail down the line the appointment of a designated Quality Manager – consider combining that with a research responsibility to create a Research and Development capability with a permanent brief to identify best practice.

Control of Quality

- 3.49. Frustrations can arise when the quality of a process in such important areas as timeliness are not under the control of any one manager. ICAS case to closure times will depend on the time to respond of the health organisation involved in the case. We have seen examples of two protocols negotiated between a PALS and an ICAS pilot. The focus of the protocols seen was on permissions for the passing-on of complaint and complainant information. There was no mention of time frames. The negotiation of common standards of service will contribute to a consistent level of quality and complainant satisfaction with all parties in the process. The ICAS support office is currently collecting examples of best practice in this area.

MEASUREMENT

- 3.50. The topic is closely associated with Management and as such some aspects have already been discussed under that and other headings. This reflects in part the fact that complaint handling has moved on from being an ad-hoc and unmanaged process.

An often emotional and judgemental approach created an environment where chance ruled the roost and consistent and reasoned redress and resolution were rare. Now complaint resolution in a timely and effective way is recognised as having the potential to contribute to quality and user confidence in the service being offered. We now need a way of understanding how to achieve high levels of quality and cost-effectiveness. Questions 9 and 10 asked about how management information was gathered and used. It was for most respondents the most difficult part of the exercise. We made it clear that we were exploring the collection of information for internal purposes and not as part of a compulsory return to the Department of Health.

- 3.51. The picture that emerged was very scrappy and it was rare to find a pilot site that had most (none had all) the information to hand. Four sites claimed to be logging 100% of the contacts. One was a small specialised ICAS service who reported that while it did not have any software and relied on informal reporting only, it had only had 13 cases. Most were collecting demographic socio-economic and ethnicity data. Two sites commented that they were uncomfortable gathering this data which, one commented, "can switch people off who need a personal service in difficult circumstances". Other pilots put this information at the top of their 'must have' report list. The point was made to us that such data as was given had to be retrieved by looking back at individual case records. The question asking about the aim of ICAS "to ensure lessons from users' experiences are fed back to the service" raised some reservations. Only three respondents thought that they were meeting the goal fully. One site said "not at all" and another three "a little". This was not because they were opposed to user involvement, but rather that they knew it was not easy to initiate or sustain and they had not had time to tackle it. They welcomed advice on how to manage getting users' input in a meaningful way and then doing something with it. But they believed there was no point asking people for their views if they couldn't follow up accordingly, especially with a very limited existence.

Customer Satisfaction Surveys

- 3.52. Don't these surveys "raise old ghosts, open old wounds and stir up feelings of dissatisfaction if client did not get the result they hoped for?" asked one site. That pilot would have preferred peer review as a means of assuring itself and others of its quality standards. Another site thought that the data would be biased because they would only hear from the satisfied. Nonetheless most were making plans to do satisfaction surveys on closed cases using a postal questionnaire with a telephone follow-up if they did not hear back. The CLS quality model supplied a model questionnaire which several sites were adapting. The hold-up in most cases in launching a regular survey or reporting complainant satisfaction was the dearth of closed cases.

Benchmark Learning – Satisfaction With What?

- 3.53. The complaint resolution process in the NHS is a hybrid and by the time of its conclusion a case will bear the imprint of many hands. It is the conventional wisdom which we generally endorse to wait until the case is closed before enquiring about satisfaction. However our experience in researching Ombudsman cases especially those that reach the Legal Services Ombudsman argues against this course of action.

Cases can take over two years to wind to a conclusion – a Complainant Calvary was our description – and the consumer is no longer capable of distinguishing clearly who did what to whom when. There is a general recollection of the process but the data that comes out of such a survey over that timespan is not useful to an ICAS whose involvement may have been a one-off or occasional. By all means wait and do it on the closed case if ICAS has stuck with the case all the way to the Ombudsman or the point of its conclusion. If however the contact is catalogued as a Level 3 or below, ask the satisfied and ready to recommend questions immediately. These customer surveys are not rocket science. Their job is to give ICAS managers useable data within a timeframe where they can still do something about it. So like the election advice to vote early and vote often, sometimes it is better to survey early and survey often rather than once right at the bitter end. (And the feelings may well be very bitter by then).

OVERALL AIMS AND PRINCIPLES OF ICAS – ACHIEVEMENTS AND CHALLENGES

- 3.54. Respondents were offered a list of aims and principles set out early in the life of the pilot exercise and asked to what extent they had managed to meet them in the time they had been up and running? (The full list of the attributes is given in the Analysis Report – Appendix A). Most considered that they had indeed managed to meet these aims and principles fully. However there remained some operational issues where there remained some way to go.
- 3.55. The aim that had been least fully recognised was to “ensure lessons from user experience are fed back to the service” and this was picked up again in the responses to a similar question in the list of principles. Another area where full achievement was not claimed was the stipulation about “users influencing and involved with pilot”. One pilot who claimed complete achievement did so on the grounds that theirs was a user-led organisation and that therefore there was no distinction between staff and user. Another area of less than full achievement has already been signalled earlier in this report – the principle of co-operation with other agencies where the early difficulties of putting themselves on the map of the NHS had been problematic.
- 3.56. The journey that remains to be completed in respect of the attributes identified above is not a sign of indifference. It reflects the realities of getting a new service off the ground and the time needed to complete the search for staff, users and process partners. There is a sequence dictated by events and the need to convince the sceptics. The new organisation will be able to build on the experience of making contacts and creating user networks to make sure that these attributes do not become the permanent Cinderallas of the future ICAS service.

Priorities

- 3.57. From the above weighted analysis of priorities there is no question but that the top priority “when getting the pilot up and running” was “ensuring clients have access to independent help and support according to their needs.” It was in a league of its own. This overwhelming emphasis is consistent with the placement of “independence and client focus” issues in the “messages for the CPPH” section (see below).

- 3.58. In second place, the emphasis shifts to embrace not only “clients empowered to be self-reliant and retain ownership of complaint”, but also something that is a healthy sign for new organisations “supporting ICAS providers/staff”. Though there was a preference for the client-focused priority, the importance given in the pilot phase to staff issues must also be recognised and built upon when the permanent agencies are established (see below).
- 3.59. In the middle ranks of priorities are “be visible and well publicised”, which requires no further comment, and also “working with other agencies” which reflects the hybrid federal nature of many of the sample pilots. The four and fifth priority choices are much less well differentiated. A high-scorer was “committed to quality”. This may reflect its generic wording rather than the adoption of any specific quality approach.
- 3.60. It would be instructive to run this priority ranking exercise again once all pilots are completed and compare the outcomes for these factors in particular. We are certain that, over time, there will be a growth in user influence and involvement in the pilots. Certainly in the permanent service to be established by the CPPIH, mechanisms to achieve this should be built in from the outset as part of the agencies’ core quality monitoring

Principal Lessons of the Pilot

- 3.61. It is no surprise that operational rather than philosophical considerations dominate what ICAS managers said were the “principal lessons of the pilot” thus far. “Funding, staffing/training and infrastructure” issues have to be dealt with before anything else can be initiated, much less sustained. Running a very close second however, were lessons about “working with NHS partners” and “bid partners”. Both of these are much closer to “street level”, which is where, and rightly, these new local services have been focusing their efforts. But there is also no doubt that they are continually glancing back over their shoulders at such pressing issues as “time scales” and the need to keep the emphasis on “client focus and independence” in terms of their “mission and aims”.
- 3.62. We believe this spread of “lessons learned” feels right for this stage in the evolution of these new organisations. As the end of the pilot phase has not been reached, however, such a conclusion must have a caveat attached as it could alter in the final two months of operation as case volumes rise and partnership working picks up pace.

In Charge of the Commission for Patient and Public Involvement in Health

- 3.63. Importantly, and contrasting with the operational slant of the lessons they said they had learned themselves from the pilots, the top-line messages from this sample of ICAS pilot sites for the CPPIH’s agenda “when setting up organisations to support complainants” emphasised matters of principle and quality.
- 3.64. Above all they stressed “independence and client focus”, with a companion high level of concern for continuity during transition and roll-over from pilots to permanent services - seen as a risk period for clients in particular.

- 3.65. The sense of urgency and commitment which the pilot sites wished central government to display in its decision making about establishing permanent, independent complaints services was also unmistakable.

Benchmark Learning – Independence and Complaint Handling

- 3.66. Independence is an essential ingredient of the identity and purpose of ICAS. This has to remain the case for the successor organisation. We would however add a gloss to this principle connected to the values of pragmatism associated with best practice complaint handling. The achievement of solutions will entail a high and continuing level of involvement with process partners such as a PALS. Assertion of principle must not get in the way of solutions for complainants. A staff confident of their ethical and formally established status should be able to engage with others without invoking the attribute of independence with the formality and disengagement that that can sometimes imply .