Patient Feedback & Complaints

A GOC Revalidation Project

Final Report
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Any errors or omissions are entirely my responsibility.

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Executive summary

The project

1. The project was commissioned and funded by the General Optical Council to inform its work to develop a scheme of revalidation for optometrists and dispensing opticians.

2. The remit was to identify and examine the different types of patient feedback already gathered by optical businesses and to explore how complaints are handled; to assess whether this is suitable evidence for revalidation; to determine whether optical businesses are willing to tailor their systems for revalidation; and to establish whether the General Optical Council should develop standards to accredit patient feedback and complaints systems.

3. A research framework was devised setting out the most likely types and sources of information for review. Web-searching, desk research and both telephone and face-to-face interviews were used to gather data. Sample documentation was collected and analysed alongside the interview data and judgements were made about the relevance and feasibility of using the different types of information for revalidation.

Findings – patient feedback

4. There is no national survey of patient experience or customer satisfaction. For many optical businesses customer retention, unsolicited customer comments, and the absence of complaints are considered sufficient information about customer satisfaction. A minority of independent practices adopt more structured approaches but systematic surveys are mostly confined to the large multiples and supermarket chains. The structured surveys reviewed vary in design, content and frequency, are motivated by commercial imperatives, and are generally regarded as commercially confidential.

5. The methods used to collect patient feedback include evaluation questionnaires distributed to all patients immediately following an eye test or other transaction, postal questionnaire and telephone interview surveys of samples of recent customers, panel surveys and focus groups. Mystery shopping surveys are popular among multiples and supermarket chains. Some surveys are designed and conducted in-house but postal, telephone and mystery shopping surveys are usually outsourced to specialist market researchers.

6. The main focus of the surveys is customer satisfaction – they do not address registrant competence or fitness to practise explicitly, and most do not attempt to identify individual registrants.

7. It was judged that none of the methods used to gather patient feedback or assess customer satisfaction currently produce information that could easily be used or adapted for revalidation. The majority of those consulted did not think their business would be willing to share what is regarded as commercially sensitive information, nor amend what are essentially tools to help improve commercial performance.

8. It was concluded that little would be gained by attempting to set standards against which to accredit patient feedback mechanisms as sources of evidence for revalidation. One alternative would be to commission research and development to

produce a validated patient feedback instrument for universal application that could be used to assess all registrants against common standards.

Findings – complaints procedures

9. Little information is published about the number of complaints in the optical sector but anecdotal evidence suggests that complaints are a rarity, especially when compared to the overall number of patient contacts and customer transactions. National bodies that deal with serious complaints, or complaints that cannot be resolved locally, publish annual statistics. These also suggest that the number of complaints is small compared to the total population of registrants.

10. The vast majority of optical businesses have and publicise complaints procedures (a requirement for those contracted to provide General Ophthalmic Services) and follow best practice guidance by dealing with complaints quickly and effectively.

11. Such data as there is suggests that the majority of complaints concern aspects of the retail transaction, the supply and fitting of spectacles and the attitude of staff. Very few complaints concern serious issues such as missed pathologies. It is considered necessary to understand all the circumstances of a complaint to be able to make a judgement about culpability, and even then a complaint may indicate very little about a registrant's competence or fitness to practise.

12. Patient, practitioner and commercial confidentiality, and the absence of agreed definitions, systematically collected data or uniformly applied standards and remedies, are obstacles to the use of information about complaints for revalidation. In addition, using information about complaints for revalidation would create an incentive to under-report, undermining a culture of transparency and fairness. Knowing that a complaint might count against a registrant would compromise the discretion some businesses exercise to try to resolve even unfounded complaints to avoid potentially protracted and costly disputes.

13. It was concluded that there is little to be gained from attempting to accredit complaints procedures as approved sources of information for revalidation, not least because this would duplicate NHS contractual requirements and compliance monitoring, and because it could compromise the GOC's statutory duty to investigate complaints referred to it about performance and conduct without prejudice.

Conclusion

14. It was concluded that neither patient feedback mechanisms nor complaints procedures currently provide information that is sufficiently comprehensive, standardised or meaningful for registrant revalidation; that in the main optical business are not disposed to amend existing systems to satisfy regulatory requirements; and that accreditation would not help to secure information about individual registrants of a type and quality required for revalidation.

Introduction and background

The General Optical Council (GOC) is the statutory body responsible for regulating the optical professions. Its aim is to protect the public by setting and promoting high standards of education and conduct. As part of this remit the GOC is currently developing a scheme of revalidation for optometrists and dispensing opticians.

Revalidation is a process designed to ensure that all health professionals remain competent and fit to practise throughout their professional careers. It was proposed by the previous Government in a White Paper published in 2007.[1]

All the bodies responsible for regulating the health professions are now engaged in developing revalidation schemes for their registrants – work which is being informed by a set of principles intended to promote a common approach across the health professions.[2]

The GOC has made it clear that it is committed to developing a revalidation scheme that is risk-based, targeted and proportionate – a scheme designed to sustain, improve and assure the professional standards of optometrists and dispensing opticians, as well as to identify and address poor practice. To help achieve this it has adopted a transparent, evidence based approach to policy development, commissioning independent research[3] to inform its thinking and consulting widely on emerging options.[4]

The project reported here was commissioned to further inform the General Optical Council's revalidation work programme by establishing whether information from patient feedback and complaints procedures can provide evidence for revalidation.

Remit and approach

The project was commissioned to:

- identify and examine the different types of patient feedback already gathered by optical businesses, and how complaints are handled, and assess whether this is suitable evidence for revalidation purposes

- determine whether optical businesses are willing to tailor their systems for revalidation purposes

- establish whether the GOC should develop standards in order to accredit patient feedback and complaints systems.

A research framework was devised setting out the most likely types and sources of information for review. This was used as a guide for data collection. Web-searching, desk research and both telephone and face-to-face interviews were used to gather data. Sample documentation was collected where it was publically available or where informants were willing and able to share key documents.

A purposive sample of informants was identified to ensure representation from the main sectors and types of optical business. The sample was expanded as initial research indicated additional lines of enquiry. No claims are made for sample representativeness in a statistical sense.

An interview schedule was developed but was used flexibly to accommodate the different levels of knowledge and experience of interviewees about the issues under investigation. Face to face interviews were digitally recorded with the consent of the informants concerned. Contemporaneous notes were made of telephone interviews.

Informants were given an undertaking that nothing reported would be attributed to – or be easily identifiable as coming from – a particular individual or company without their express consent. At the reporting stage a decision was taken not to name businesses or informants in the main text because the small sample size could compromise the anonymity of those who shared information in confidence, and because it could be inferred – erroneously – that informants not cited by name had made a less significant contribution.

Documentation was analysed alongside the interview data and judgements were made about the relevance and feasibility of using the different types of information as evidence for revalidation. In some instances customer survey instruments were not accessible for review, either because of concerns about commercial confidentiality or because the surveys are undertaken by third party organisations. Nevertheless interviews and other data have provided a reasonable measure of confidence about the inferences that have been drawn where survey instruments have not been available for direct scrutiny.

A note about terminology

During the study informants referred to the recipients of optical services variously as customers, patients, clients and service users. While descriptors such as ‘customer satisfaction survey’ tended to be used consistently, informants used other terms to refer to the methods used to elicit patient views and opinions more loosely and

interchangeably. Similarly, the terms store, outlet, practice and business were used to describe the places where eye tests take place and optical products are dispensed. In the absence of an agreed nomenclature the terms used in this report are those most frequently cited by informants, as they appear in documentation, or as seems most appropriate to the context in which they are discussed.

Patient feedback

This section outlines the principal methods used by optical businesses to gather patient and customer feedback. It explores each method and examines issues relevant to the use of such data for revalidation. It also considers whether optical businesses would be willing to tailor their systems for revalidation and whether the GOC should develop standards for accreditation.

The remit for the project refers explicitly to patient feedback, a term used widely in the NHS to refer to the collection of information about the patient experience in order to improve quality. This notion is by no means alien to the optical sector but the concept of customer satisfaction is by far the more pervasive. This suggests a subtly different perspective and purpose which reflects the fundamentally commercial nature of most optical services.

For many optical businesses customer retention, unsolicited customer comments, and the absence of complaints serve as crude but practical measures of patient satisfaction. For the smaller optical business in particular, there is little incentive to adopt a more structured approach,[5] not least because:

> *Gathering the views of patients and service users is more complex than it may initially appear. To obtain reliable, rigorous evidence the exercise must be carried out systematically.*[6]

Information about the extent to which systematic approaches are used is limited. There are no national surveys of optical patient experience as there are for other aspects of health service provision,[7] and the commercially competitive nature of optical services militates against the disclosure and sharing of information about patient experience and customer satisfaction.

Inferences drawn from interviews for this study are consistent with the results of a large scale survey which found that no more than a fifth of independent optical businesses seek patient feedback in any formal sense .[8] The rate appears to be significantly higher among multiples and supermarket chains but the frequency, focus and methods used vary widely.

The methods used by informants consulted for this study are examined below.

Surveys

Most of the techniques to gather patient and customer feedback mentioned by informants are derivatives of the survey method. The survey method is used mainly to assess customer satisfaction retrospectively, to check that standard operating procedures have been adhered to and that established service standards have been met. Panel surveys are sometimes used prospectively to explore customer expectations or to seek views and opinions about new services that could be offered in the future.

A defining feature of the survey method is that it is a structured approach to data collection that produces a detailed and quantified description of a population. It can be descriptive – or through the demonstration of an association between the variables measured – explanatory.

In contrast to a full census most surveys sample the population under investigation to make the task more manageable and less costly. However to draw conclusions about the population from which the sample is drawn, it must be representative (that is to say it must have population validity). Further methodological challenges arise in respect of validity of measurement (the extent to which the data constitute accurate measurements of what the survey purports to measure), and validity of design (the extent to which the comparisons being made are appropriate to establish the arguments which rest on them).[9] These matters are sometimes overlooked in survey design and can therefore undermine the results.

Two types of self-completion questionnaire survey predominate in the optical sector: evaluation forms or questionnaires issued to patients on completion of an episode of care, either following an eye test alone and/or dispensing, supply and follow-up; and postal questionnaire surveys of a sample of recent patients or customers. Some informants also referred to telephone surveying, also undertaken with a sample of recent customers.

Customer or patient evaluation forms are usually distributed by the optical business providing the service, whereas postal questionnaire and telephone interview surveys are usually outsourced to a market research company, and as such are more commonplace among the larger multiples and supermarket chains. However an informant in an independent practice described buying into a customer satisfaction survey run by a third party organisation. It provided evaluation questionnaires for distribution to patients by the practice but for direct return to, and analysis by, the third party company. The company then provided results for the practice together with anonymous aggregated results from similar practices to permit comparisons to be made. However the results were said to be of limited value because the majority of customers in most of the practices reported high levels of satisfaction.

Customer or patient evaluation forms appear to be used by only a minority of independents, and in many cases only sporadically. However they are used by the major domiciliary care providers as a matter of routine. This may reflect a greater concern to ensure that potentially vulnerable patients – or their carers – are given an opportunity to provide feedback about the service received (in contrast to high street customers who can leave at any time and take their custom elsewhere). Since the examination or dispensing takes place in a residential setting, and because each episode is well-circumscribed, it is easy enough for practitioners to leave an evaluation form at the end of the consultation as a matter of course.

Evaluation questionnaires of this sort are completed by the patient, a relative or carer, or by residential or care home staff, and are then returned to the optical service provider in a pre-paid envelope. Informants reported return rates of between 33% and 40%. On receipt questionnaires are scrutinised so that any significantly adverse comments can be followed-up immediately, but otherwise all responses are collated and analysed for lessons and learning about the standards of service provided.

One contributor to this study reported undertaking regular analyses of evaluation questionnaires for each domiciliary visit, scoring the responses and presenting the results using a traffic light system to more readily demonstrate to practitioners whether their performance was consistent with the standards expected. The results are used as one of several measures in regular performance reviews with staff.

Two features of this method are of particular relevance to this study: in the domiciliary setting evaluation forms are distributed to every patient examined or to whom an optical product has been dispensed (although it is important to stress that only a third

or so choose to respond); and in each case the optometrist and/or dispensing optician is named on the evaluation form (or is identifiable from the appointment or record). In this approach patient feedback relates specifically to the quality of service provided by identifiable registrants and could in theory therefore be used as a source of evidence for revalidation. There are, however, other considerations which are explored further in the discussion below.

Typically, patient evaluation forms distributed to all patients on conclusion of a domiciliary examination comprise a limited number of items, require either a simple binary forced choice response or have a Likert-type rating scale, and fit on one side of A4 paper. A facility for free text comments is also commonplace. Questionnaire items commonly occurring in patient evaluation forms are shown in Box A.

Box A
Examples of items typically found in patient evaluation forms

Basic patient biographical details and when the examination/visit occurred (the questionnaires reviewed are not intended to be completed anonymously).

Name(s) of optometrist and/or dispensing optician (the questionnaires reviewed for this study were registrant-specific).

The patient is asked to indicate their satisfaction (or to rate their level of satisfaction) with matters such as:

- the initial contact/appointment process
- the professionalism of staff (for example whether the team introduced themselves properly, whether they were well presented)
- the team's helpfulness (for example whether they provided sufficient information)
- whether the patient felt they were treated with dignity and respect
- whether there was a choice of frames
- how satisfied they were with the fitting of spectacles
- whether aftercare services were satisfactory
- the standard of the service overall
- whether the patient would recommend the service.

A free text section for comments.

Self-completion questionnaires are also used in the optical sector on a sampling basis. As an example, one contributor to the study from a large multiple referred to the businesses' routine survey of customer care which samples around 5% of recent customers at each of its practices. The survey is undertaken by a third party organisation which distributes and analyses responses to a postal questionnaire. The value of this approach was said to be the facility to identify recurring poor results in a particular practice, rather than to act on any impressions that might be gained from the snap-shot available from a single survey round.

The survey cited does not currently seek information about individuals but because many patients recall (from introductions or name badges) precisely who it was who

examined them or dispensed their spectacles or contact lenses, respondents do sometimes indentify individual registrants in free text comments. The informant indicated that the survey could be amended to explicitly identify staff, but noted that the scope of the questionnaire is broader than the contribution of any individual, so there might be limited value in doing so.

An informant from a different multiple referred to its use of telephone surveys in which a random sample from a particular category of customer is interviewed by a third party organisation to establish levels of satisfaction with an aspect of service, a particular product, or a store. The focus of each survey varies. The results are fed back to the stores concerned (in this case with only limited headquarters scrutiny of the results). As with other types of customer feedback survey undertaken by large multiples, because the survey is conducted by a company independent of the sponsor, information is not readily available about sampling frames and population validity; but since this is precisely the kind of research expertise the optical business is purchasing, it seems reasonable to assume a rigorous approach to sampling and survey design.

Item types included in postal questionnaires and telephone interview surveys vary according to their purpose and the aspects of service under review. In terms of questionnaire design, some items require a simple forced binary choice, either as a yes/no response or agreement/disagreement with a statement, while others require selection from a menu of answers or a response to a Likert-type rating scale. Typical questionnaire survey items are shown in Box B, but it is important to emphasise that this is a composite list for illustrative purposes only.

Panel Surveys

Whereas the surveys described above approach respondents on one occasion only, and are essentially retrospective reviews of services received, panel surveys involve repeated rounds of surveying. They can be used prospectively to explore expectations about quality standards or services for the future (in other words 'what would you like to see?' questions rather than 'what was your experience like?').

A panel survey involves an established cohort of respondents questioned at intervals over time. Panel surveying provides an opportunity for longitudinal study (that is the facility to follow-up and track a particular issue over time). The method can have a cost advantage because subsequent surveys do not incur sampling and recruitment costs (other than from planned replacement due to cohort attrition). Panel surveys can also achieve a good response rate because the cohort is recruited on the understanding that the survey will involve subsequent rounds, so recruits who do sign-up are likely to have considered the commitment more thoroughly than might otherwise be the case. Conversely, while initial sampling and recruitment may guarantee representativeness, subsequent attrition and repeated testing can result in a smaller self-selected 'expert' panel that no longer reflects the wider population from which it was drawn. However in some cases respondent expertise is valued because it enables market researchers to pose more complex questions than would otherwise be possible.

Box B
Examples of item types included in postal questionnaires and telephone customer satisfaction surveys

Surveys are usually designed to be completed anonymously, and do not normally attempt to identify individual staff.

Questions include those about:

- the initial contact (e.g. telephone manner; whether informative; convenience of appointment)
- access (e.g. travel, parking, disabled access)
- first impressions (e.g. signage; reception; welcome; surroundings; waiting area; cleanliness; name badges)
- the handover to the optometrist (e.g. introductions)
- punctuality (e.g. appointment started on time)
- the conduct of the eye examination
- the quality of the welcome
- whether the test(s) were explained fully
- whether a medical/optical history was taken
- which tests were undertaken (from a list of stated options)
- whether there was an opportunity to ask questions
- whether the results were explained fully
- whether the patient was able to discuss a range of vision correction options
- whether the examination and tests were conducted professionally
- the personal presentation of the optometrist
- the comfort of the examination room
- whether the test felt rushed
- impressions of the range and quality of equipment
- whether the optician discussed new glasses/lenses/contact lenses
- the handover to the dispensing optician
- whether the prescription changed as a result of the eye examination
- whether a selection was available in store and how this was presented
- payment – options/handling/value for money
- particular areas of satisfaction/dissatisfaction
- whether the patient felt confident about the service received
- whether the patient would recommend the service to others.

Recruiting and repeatedly surveying a panel is particularly valuable to large retailers that have a wide product range, frequent return custom and a national retail profile, such as supermarket chains. As a method it is of much less value to most optical businesses because the type of product and service offered is limited and because there are long intervals between customer visits. However optical services within multi-product supermarket chains can exploit established panel surveys by using them periodically to explore aspects of their current or proposed service. In theory it would be possible for other optical businesses to do the same by buying into a composite questionnaire submitted to a market research company's established retail consumer panel, although no instances of this were observed in this study.

Mystery shopping surveys

In contrast to surveys of the recent experience and satisfaction of genuine patients and customers, a number of informants reported using fake customers to assess the quality of their services. Mystery shoppers pose as customers or patients to test and report on a service or product provided by an optical business. The crucial point is that they do so anonymously so that the test site remains unaware of their real purpose.

Mystery shopping is well established in the retail sector but is also used in healthcare evaluation.[10] In the optical sector it is usually undertaken by specialist third party market research companies. It is used by many of the larger multiples, either on an ongoing basis as a routine – in some cases quarterly – measure of performance, or as a one-off exercise to explore a particular aspect of the business. It can also be used as a means of gathering data about the quality of services provided by competitors.

The method is considered to be a specialist activity requiring expertise in survey design and execution. The degree of sophistication varies according to the nature and extent of the service under review. In most cases the commissioner specifies the purpose of the exercise and the service elements that are to be reviewed; the market researcher then determines the most appropriate survey design, establishes the criteria to be measured and develops the protocol for shoppers to follow, briefing them as to the nature and purpose of the exercise, managing the process, and collating and analysing the results.

Instances referred to by informants in this study included the use of a standardised and routine mystery shopping survey undertaken in a different geographical area each quarter; use of the same study population but selection of different aspects of service for each annual survey; and one-off surveys using smaller samples to explore a new service or a particular issue of interest or concern.

In cases reviewed for this study the results of mystery shopping surveys were presented by outlet and also in aggregate form, the former provided in confidence to the outlet manager and the latter to the wider business so that managers are able to see how they have performed against the standard for the business as a whole. Where mystery shopping surveys are undertaken routinely, regular reports of key themes and insights are submitted for consideration at a corporate level, and training or management interventions initiated as judged appropriate.

Mystery shopping is of greatest value to the larger multiples because it has the potential to generate comparable data which can be used to benchmark the performance of one outlet against the norm for the business as a whole (or against competitors); because it can reveal variations in the uniform standards to which the larger multiples aspire; and because the greater the number of outlets the easier it is to sample without loss of population validity. The cost of large-scale mystery shopping surveys is likely to be beyond the reach of smaller independents, unless the exercise is undertaken co-operatively by pooling resources and by involving enough practices to make it possible to benchmark results against similar businesses.

Focus Groups

A small minority of informants (exclusively from multiples) referred to the use of focus groups. Focus groups are an established market and social research method[11] which

provide an opportunity to explore patient experience[12] and customer satisfaction in more depth than would be possible through questionnaire surveys.

The method involves recruiting a small group (usually 8–12) of similar individuals from the population under investigation. The group is invited to report their experiences or to offer their views and opinions about a particular issue or service. Typically the focus group is directed, moderated and interactive, enabling participants to discuss issues rather than simply respond to formal questions. The content is often recorded (or noted by an observer) to provide a source of qualitative data about the beliefs and preferences of the group, which is taken to be representative of the wider population from which it is drawn. The focus of discussion could be retrospective, for example by exploring the experience of group members as optical patients or customers, or prospective, for example by focusing on products, services or quality standards the group would like to see in the future.

The outcome is usually a qualitative report highlighting significant themes and issues (such as the consumer preferences and purchasing propensities of certain categories of customer), which can provide rich and potentially valuable information to an optical business. However focus groups would not normally identify individual practitioners and reports would usually reveal only general themes and trends. The focus group method does not, therefore, constitute a useful source of information for revalidation.

Other methods

Other methods used by optical businesses to gather patient feedback include in-store touch screens and online data collection. The former enables customers to provide immediate feedback about the standards of service received, and the latter an opportunity to submit free text comments for review by a central customer service department. Both of these methods are associated particularly with the larger multiples; a number of corporate websites have the facility for customers (or indeed anybody) to comment online, although the option is not always especially well signposted but reached via website menu options associated with consumer affairs and complaints.

In independents, small groups of established patients – or 'patient circles' – which meet regularly but infrequently to discuss matters associated with the practice were also mentioned as a source of patient feedback. However no instances of this method were encountered during this study.

Another form of feedback occurs as a by-product of the verification of claims for NHS funded eye tests during routine practice visits or sport checks. An unusual pattern of claims can prompt a review of sight test records. One informant referred to a 'look-back' exercise which was undertaken following discovery of suspected fraud. A large-scale interview survey of past patients was conducted and as a consequence a significant retesting exercise initiated. Many of the patients interviewed had been suspicious about the quality and rigour of the eye test they had received but had not complained and were unaware that they had been put at risk of missed pathology.

Some informants highlighted the importance of unsolicited oral and written feedback, both positive and negative. Unsolicited negative comments which might not constitute a formal complaint were considered especially important if they repeatedly referred to a particular member of staff. By way of contrast, in some businesses individuals who have been praised by patients for providing high quality customer care are recognised and congratulated in newsletters or at company conferences.

Some informants suggested that written testimonials ought to count as evidence for revalidation, although the incentive this would create for registrants to solicit positive feedback was acknowledged.

Analysis and discussion

It is important to stress that the analysis that follows occurs in the context of the research question that was posed: can information from patient feedback be used for revalidation? The discussion is not a critique of the methods adopted by optical businesses but an assessment of their potential for use in the revalidation of optometrists and dispensing opticians.

Understandably, for many optical businesses methodological rigour will be of little concern if the approach adopted delivers what is required – in other words if it is fit for the purpose intended. It may therefore be considered inappropriate to assess methods used to gather patient feedback for a purpose for which they were not intended, but doing so is necessary to enable a judgement to be made about whether or not a practitioner's continued registration can be put at risk by reference to information from these sources.

For many optical businesses seeking patient feedback is not a high priority. A number of those contributing to this study made the point that dissatisfied customers take their business elsewhere, and practices that fail to offer a satisfactory service quickly go out of business. For many, repeat custom from a loyal customer base and the absence of complaints is sufficient feedback about service quality. For others, commercial interests and the need to maintain competitive advantage provide the motivation to explore customer satisfaction and service quality in a more structured and systematic way.

The more structured approach usually involves surveying recent customers by questionnaire or telephone, or by mystery shopping some or all outlets. However the frequency, design and sophistication of these surveys vary. There is no national survey of optical patient experience. The absence of a universal and uniform approach to patient feedback means that only a minority of registrants are captured in these exercises, and only a minority of those who are can be readily identified.

The rudimentary structure and content of some of the survey methods and instruments used by optical practices suggests that questions of population validity and instrument validity are not always fully considered, and that survey instruments are not always piloted and refined to improve validity and reliability.[13] This situation is not unique to the optical field.

A recent study assessing instruments approved for the measurement of patient satisfaction in general practice – where doing so earns contractors points under the Quality and Outcomes Framework (QOF) associated with the General Medical Services Contract – concluded that:

> *The validation of the two questionnaires approved by the QOF to assess patient satisfaction with general practice appears to be sub-optimal. It is recommended that future patient experience surveys are piloted for validity and reliability before being implemented widely.*[14]

Achieving consistently valid and reliable measures of customer satisfaction and acting on the results can be challenging.[15] For example sampling frames can be difficult to establish in the absence of accurate and up-to-date customer lists; dissatisfied

customers who go elsewhere can be difficult to reach or reluctant to contribute; and relying on staff to issue evaluation forms or customer satisfaction questionnaires can result in selective distribution or introduce bias as a consequence of the different levels of encouragement given to customers to participate. In addition it can be difficult to achieve sufficient objectivity to exclude bias in the design of surveys and questionnaires if development is undertaken in-house.

The importance of piloting and refining survey instruments is underscored by the work currently being undertaken to develop a patient satisfaction questionnaire for use in the revalidation of doctors. In an initial pilot, questionnaire responses from 13,754 patients attending one of 380 participant doctors were assessed in a survey to test a draft patient questionnaire.[16] If this questionnaire is further tested, refined and subsequently adopted for medical revalidation as planned, its development will set a benchmark that other regulators who opt for patient feedback as a source of evidence for revalidation may feel compelled to match.

Another validity issue arises in respect of the use of patient feedback surveys for revalidation. None of the methods reviewed above were designed with revalidation in mind. Furthermore, the precise standards against which optometrists and dispensing opticians will have to revalidate have yet to be published, so the content of existing patient feedback and customer satisfaction surveys cannot yet be mapped as potential evidence sources. A recent exercise to assess patient feedback instruments used in general practice against standards in the Royal College of General Practitioner's guide to revalidation concluded that just three of the nine approved instruments reviewed mapped sufficiently well and had acceptable levels of reliability.[17]

There are therefore strong grounds for questioning the use of patient and customer satisfaction survey data as a source of information for registrant revalidation. In addition to issues of validity and reliability there are wide variations in the frequency, regularity and methods used to collect data; the content differs from one survey to another; and only in a minority of cases is it possible to match the data to individuals. Furthermore, a reasonable estimate is that nearly four-fifths of independents do not currently formally gather patient feedback, and although many multiples do undertake some form of systematic assessment of customer satisfaction, there is little consistency across the sector. Most of the data collected is considered to be commercially confidential, and informants indicated that their companies would resist calls for disclosure. One informant from a multiple conceded that it might be possible to amend or adapt data collection instruments to incorporate issues of relevance to revalidation, but the majority considered it unrealistic and/or inappropriate to do so.

Mystery shopping is used by many of the larger multiples to establish levels of customer satisfaction and to maintain service standards (and sometimes to assess competitors). It can generate valid and reliable data about the nature and quality of optical services but there are a number of reasons that militate against its use as a source of evidence for revalidation.

The primary motivation for mystery shopping is commercial. As a tool to establish and maintain competitive advantage the focus and frequency of mystery shopping surveys are entirely commercial decisions. In this respect surveys vary greatly in both design and regularity of execution – some are undertaken as a matter of routine on a regular basis while others are conducted as ad hoc exercises to explore a particular concern. As a consequence they do not constitute a nationally systematic or uniform programme of data collection.

Mystery shopping evaluations typically focus on the practice or outlet rather than on the performance of individuals (although some informants considered it would be possible to infer the contribution of particular individuals from some survey data – for example where the focus was on a particular aspect of the patient journey which was always conducted by the same member of staff). Mystery shopping survey results are used to inform training activities, amendments to standard operating procedures and other management interventions, but these are generic not registrant-specific responses.

The results of mystery shopping surveys are considered to be commercially sensitive and as such are regarded as confidential. None of the informants questioned about this could envisage their business sharing data of this sort because it goes to the heart of a company's commercial performance. Furthermore, the results do not belong to registrants so are not easily accessed by those who might wish to cite such evidence in support of an application for revalidation (although it was suggested that registrant practice managers might be in a position to use evidence from mystery shopping surveys about their practice as an indicator of their personal professional performance).

Informants who do or had used mystery shopping surveys indicated that they thought it highly unlikely that their company would be willing to tailor the design, content or frequency of mystery shopping surveys to incorporate criteria or generate evidence that might be of value to registrants seeking revalidation. In short, mystery shopping surveys are regarded as business tools to provide data to improve commercial performance.

In this study panel surveys were found to be confined to supermarket chains in which optical services represent only a small part of the retail services provided. In these businesses panel surveys can provide a unique opportunity to explore aspects of optical service provision on a limited basis, as one-off explorations of customer views about an aspect of service, pricing or product, or to test perceptions about a proposed new service or price plan.

As with mystery shopping surveys, data from panel surveys are not collected about individuals per se; outputs are fundamentally about commercial aspects of optical services rather than an individual's competence or fitness to practise. Panel surveys are not widely used within optics and do not generate data sufficiently often or of type that could easily be used by registrants seeking revalidation.

Gathering patient feedback through focus groups occurs rarely in the optical sector and does not generally produce information about individual registrants or of a type that could be used as evidence for revalidation.

In summary, none of the methods reviewed for this study produce information that could easily be used or adapted for use for revalidation. The majority of those consulted could not envisage their businesses sharing what is regarded as confidential information or amending their data collection methods or instruments to collect information for revalidation.

Accreditation

If it was decided that it was both appropriate and feasible to accept information from patient feedback systems as evidence for revalidation, the question arises as to whether the GOC should accept information from any source, or only from sources approved as having met certain specified standards. In other words, should the GOC

set standards against which to accredit patient feedback systems for use by registrants wishing to cite information from these sources in support of an application for revalidation?

Presumably the rationale for doing so would be to restrict the number and methods of patient feedback that could be used to those judged as capable of delivering the standard and quality of evidence considered necessary for revalidation. This would help to secure equity for registrants and obviate the need to assess the credibility of every patient feedback source cited in revalidation applications. Accrediting patient feedback systems would enable the GOC to exclude those of dubious quality or which fail to deliver the robust and reliable evidence that it is anticipated will be required for revalidation.

Standards might include the criterion that patient feedback is collected independently of the registrant – for example by an employer or a bona fide third party – to minimize the risk of patients being unduly influenced or coerced into responding, and to responding in a positive manner. Other criteria might concern matters such as design and instrument validity, population size and sampling, and the frequency and regularity of data collection. Essential criteria would have to address matters such as patient consent and confidentiality, and clearly only patient feedback systems that delivered registrant-specific results would warrant accreditation.

It is clear from the discussion in the preceding sections that few if any existing patient feedback systems satisfy these sorts of requirement. There is currently no national survey of optical patient satisfaction. The methods adopted by optical businesses that do undertake systematic assessments vary between companies, do not conform to any nationally agreed definitions or measures, and in some cases are not necessarily designed to achieve high levels of validity and reliability. They are commercially driven and tend therefore to focus on customer care and satisfaction, not competence and fitness to practise; and they are not conducted with sufficient frequency or regularity to produce data of comparable quality across the sector. Few are able to identify individual registrants.

A voluntary accreditation scheme might not attract sufficient interest from optical businesses whose primary purpose in seeking patient feedback is commercial. It seems unlikely that the GOC has or could obtain powers to compel optical businesses to seek accreditation for existing schemes or to introduce patient feedback systems where they do not currently exist.

An alternative would be for the GOC – perhaps in association with professional and representative bodies – to fund research and development to design and pilot a universally applicable, standardized, patient feedback questionnaire(s)[18] focusing on areas relevant to revalidation. A specialist market research company could be commissioned to mange distribution, receipt and analysis of responses, in the way that the General Practice patient survey in England is currently conducted.[19]

Complaints

This section examines the way in which complaints are handled in the optical sector and explores whether or not information from complaints processes could be used for registrant revalidation. It also considers whether optical businesses would be willing to tailor their systems for revalidation and whether the GOC should develop standards in order to accredit complaints systems.

Most of the informants consulted during the course of this study asserted that complaints about optical services are a rarity, and that rates are very low when compared to the total number of patient and customer contacts. It appears that the overwhelming majority of patients and customers are satisfied with the optical services they receive, but because there is a dearth of information about the number of optical complaints this conclusion is difficult to substantiate.

How many complaints?

There is no national system of data collection about optical complaints. Commercial competition means that independent practices and multiples have no incentive to collect or publicise information about the number of complaints they receive about their private transactions with customers. In contrast, the General Ophthalmic Services contract (in England) requires contractors to report details of complaints annually to their Primary Care Trust. This data is not published but anecdotal evidence suggests that rates are exceptionally low (although doubt was expressed by some informants about the accuracy of returns). National aggregate data about written complaints in the NHS does not separately identify complaints concerning optical contractors or optometrists and dispensing opticians in NHS ophthalmology services.[20]

At a national level the Care Quality Commission does not hold data on optical complaints. Its immediate predecessor – the Healthcare Commission – does not refer to opticians at all in its 2009 report about complaints.[21] However the Parliamentary and Health Service Ombudsman reports that 18 complaints about opticians were received in 2009/10 (as compared to 15 in the previous year), but none were accepted for investigation.[22] The Scottish Public Services Ombudsman received 2 enquiries and 5 complaints about opticians and ophthalmic services in 2008/09. [23] In Wales it is understood that there have been no recent complaints about optometrists to the Assembly Health Department or to NHS local health boards.[24] There is no information currently available about complaints to the Northern Ireland Ombudsman.

None of the services or organisations that provide advice, support or advocacy for NHS patients who wish to complain about their care or treatment – such as the NHS Patient Advice and Liaison Service, Community Health Councils in Wales, the Patient and Client Council in Northern Ireland, the Independent Complaints Advocacy Service, Trading Standards Departments and Citizens Advice Bureaux – publish any data about complaints against opticians. Similarly, neither the Association of British Dispensing Opticians nor the Federation of Ophthalmic and Dispensing Opticians publishes data about complaints concerning their members, although both provide advice and guidance to members about handling complaints and both arrange professional indemnity insurance.

The Association of Optometrists (AOP) indicates that it provided legal advice and support to more than 1000 of its members during 2009, but this advice concerns a wide range of issues, not only those arising from complaints. However the AOP does report

that it supported 84 members referred to the General Optical Council Investigating Committee and that it defended 16 members at Fitness to Practice hearings.[25]

The Optical Consumer Complaints Service publishes data about the number of cases it handles in its annual report, and the General Optical Council publishes data in its annual reports about the number of fitness to practise investigations undertaken. Both are examined in more detail below.

In summary then it is clear that information about the number of complaints from optical patients and customers is scanty, but anecdotal evidence and the data that is available support the contention that the rate is very low.

Advice, guidance and requirements

Despite the apparently low level of complaints professional associations and representative bodies clearly take the issue very seriously, both to protect the interests of their members and to promote high quality care. They publish comprehensive advice and guidance,[26] provide legal advice and representation, and arrange professional indemnity and public and product liability insurance for members.[27] On this last point, as has been noted elsewhere, data about individual insurance claims is strictly confidential,[28] but it is known informally that the number of claims is exceptionally low and has remained so for some time.

In terms of general advice, the Association of Optometrists provides its members with tips about dealing with complaints (Box C) and the Association of British Dispensing Opticians offers the following advice:

> *Wherever possible complaints should be given priority and speedily resolved within the practice. Unwillingness on the part of any registered dispensing optician to deal with a complaint does not reflect well upon either the individual or on the profession as a whole. It is therefore essential that a sound procedure for handling complaints exists and can be explained to patients by all members of staff.*[29]

This advice is further reinforced by the terms and conditions of NHS contracts and in associated guidance about complaints handling. The ubiquity of complaints procedures across the sector suggests that injunctions to deal with complaints openly and fairly have had a positive impact.

Complaints concerning NHS patients

In England the NHS Constitution gives patients the right to complain and to have their complaint properly investigated.[30] The same entitlement is implicit in the complaints guidance which applies to NHS services in Scotland, Wales and Northern Ireland.[31] It is acknowledged that handling complaints about NHS services as swiftly and effectively as possible is essential, and that the sooner and closer this occurs to the origin of the complaint the better. There is no shortage of guidance to NHS staff and contractors about customer care and the procedures to be followed in the event of a complaint.[32]

Box C
Advice to members from the Association of Optometrists about handling complaints

Do...
- contact the AOP Legal Defence Team immediately
- keep full records of what you have done for each patient
- keep a record of all communications between yourself and the patient (or their representative), or your employer
- draft a fresh account of your dealings with the patient, or your employer, and your comments on their complaint, for your information

Don't...
- admit liability to anyone – including your employer
- enter into any further discussions or correspondence with any party
- offer to settle any claim
- incur any costs in connection with a claim or complaint
- disclose the terms or nature of your insurance
- make any statement or comment on any situation that could give rise to a claim of negligence
- alter the patient's records
-

Source: AOP undated leaflet: More than a friend - professional insurance.

Complainants can get advice and support from the Patient Advice and Liaison Service (in England), the Independent Complaints Advocacy Service, Community Health Councils in Wales, the Patient and Client Council in Northern Ireland, and Citizens Advice Bureaux. Complainants who are not satisfied with the outcome of an investigation by the service provider or local NHS can take their case to the Parliamentary and Health Service Ombudsman in England, to the Scottish Public Service Ombudsman's Office, or the Northern Ireland Commissioner for Complaints (the Ombudsman). In Wales patients who are dissatisfied with a response from the local NHS can approach an Independent Review Panel, and only if this does not deliver a resolution are they permitted to approach the Public Services Ombudsman for Wales.[33]

General Ophthalmic Services (GOS) contractors are required to operate the NHS complaints system under the terms and conditions of their contract. A revised complaints procedure came into effect in England under new regulations that commenced in April 2009.[34] The new scheme allows patients to complain directly to the Primary Care Trust if they wish, which must then consider the complaint but can decide to refer the matter back to the optician for resolution if the complainant agrees. The regulations relate only to GOS and any locally commissioned enhanced services. If a patient raises an issue orally and it is resolved within 24 hours, it is not considered a complaint for the purposes of recording, but otherwise complaints must be recorded together with the remedial action taken and the lessons learnt. The number and nature of complaints and the action taken should be reported annually to the PCT. PCTs should therefore hold records of all complaints concerning NHS funded optical services which could in theory provide a source of information for revalidation.

In England a new Contract Compliance Framework[35] was published in 2009 to help standardise what GOS commissioners look for during audit visits. This is supported by a checklist designed to help practices (in England and Wales) prepare for a compliance visit. The checklist includes items seeking confirmation that the practice has a written complaints procedure, that it is available to patients and staff, that there is a named person responsible for dealing with complaints, and that records and associated paperwork is maintained for two years.[36] In Scotland a Practice Checklist used during the inspection of premises includes a similar set of questions.[37]

Complaints from private patients

Optical businesses are at liberty to determine their own complaints procedures for non-NHS patients. In practice the principles inherent in the NHS scheme appear to be replicated in the procedures adopted to deal with private patient complaints. For the large multiples customer care is central to their retail ethos. Time scales and escalation procedures may differ, but the objective of delivering a courteous, swift, fair and effective response to complaints is near universal. The impression gained during this study was that independent practices share this view but may be less inclined to acquiesce to demands arising from what they consider to be an unfounded complaint.

Optical businesses recognise that dealing with complaints swiftly and effectively is crucial to maintaining their reputation. Many of the multiples have well-publicised commitments in the form of a customer promise or a no-quibble guarantee of satisfaction. Most have dedicated customer care departments or teams who have sufficient optical knowledge and customer care skills to deal with telephone, email and written complaints unsupervised by optical professionals. Professional services managers and other optical staff are on hand to offer advice, especially on clinical and professional issues or where a complaint is escalated because of a perceived risk of subsequent litigation for negligence, or because it could result in fitness to practise proceedings. Where this does occur corporate complaints procedures usually require that the company's legal department and insurers are put on notice.

Most of the informants from corporate optical businesses emphasised the importance of learning from complaints, both to update risk registers and to inform generic training and development with a view to preventing similar complaints from occurring in the future. In cases where a complaint had raised particular concerns about the performance of an individual or branch, informants said that counselling, guidance and other management interventions would follow to prevent a recurrence, and if necessary internal disciplinary procedures would be instituted.

The idea of taking action to mitigate the risk of minor concerns becoming full-blown complaints shades into another issue referred to by a number of informants – the problem of defining precisely what constitutes a complaint. For example some informants considered that an issue raised by a customer that is resolved quickly and to their satisfaction, or a product defect which is rectified as quickly as possible at no cost to the customer, ought not to count as complaints. This chimes with NHS guidance which is explicit in excluding oral complaints that are resolved to the complainant's satisfaction within 24 hours. So what kind of complaints do optical businesses deal with?

In the absence of published data the illustrative list that appears in Box D is derived from interviews conducted for this study. The most significant point to emerge was that complaints about the professional or clinical aspects of an optical service represent a

very small minority of complaints overall. For example, in the case of one large multiple willing to disclose data about the volume of complaints it handles, last year less than 0.5% related to the 'professional practice' of registrants that might conceivably be of relevance to revalidation. One domiciliary provider noted that while 16% of complaints had been about clinical issues, all but one were minor matters that were resolved quickly. For the large multiples, the vast majority of complaints are about products and aspects of the retail transaction. Any complaints that relate to the eye test or missed pathology are taken very seriously.

A number of informants were able to refer to comprehensive computerised reporting systems that provide both a record of the complaint and a means by which senior professional or headquarters staff can track progress. Some systems provide the facility to produce alerts about cases where professional intervention might be required. The importance of good record keeping – not just about the complaint and the action taken but clinical records and prescriptions too – was reinforced by a legal adviser who observed that all forms of record are potentially extremely valuable sources of evidence when investigating or defending complaints. Yet despite what appear to be generally very good in-house reporting systems to record and track the progress of complaints, because of patient and commercial confidentiality data about volumes and analyses of type of complaint are not accessible.

None of the informants consulted for this study could envisage making other than very general information about complaints available outside the business and, for a variety of reasons that are discussed below, none considered that information about or from complaints was an appropriate source of evidence for revalidation.

Box D
Issues typically arising in optical complaints

Value for money issues – for example:

- unanticipated or higher than expected costs
- problems with expectations regarding sale and other offers, and buy-one-get-one-free offers
- not being shown or advised of cheaper options
- failure to meet advertised price/deal
- cheaper elsewhere

Product issues – for example:

- dispensing errors
- poor quality
- poor fit
- unhappy with style/appearance
- delivery times

Communication/attitudes of staff – for example:

- manner in which customer was spoken to
- disinterested attitude of staff
- absence of proper explanation
- poor communication about appointment/re-check/delivery

Optical Consumer Complaints Service

The Optical Consumer Complaints Service (OCCS) exists to try to settle complaints from members of the public who are dissatisfied with the goods or services received from an optometrist or dispensing optician, and who have been unable to resolve the complaint directly with the optician or company.

Anyone who is receiving or has received goods or services from an optometrist or dispensing optician registered with the General Optical Council can complain to the OCCS by letter, email or by telephone; or if the patient is unable to do so, a representative can act on their behalf (but the OCCS requires written authority from the patient in order to register the complaint and initiate its processes). The OCCS makes it clear that complaints related to NHS services delivered under the terms of a General Ophthalmic Services Contract must be dealt with under the NHS complaints procedure.

The OCCS is funded by a grant from the General Optical Council but is entirely independent of the GOC with its own Independent Committee of Management. It has no statutory or other powers to adjudicate disputes, to impose sanctions on optical practices or practitioners, to insist on a particular resolution, or to provide compensation. Its processes are without prejudice to any legal rights or other formal action the complainant may choose to pursue.

The OCCS plays an impartial role in assisting in the mediation of a dispute, which it says it does by:

> *...not taking sides and using our best endeavours to explain to each party the concerns of the other, and to promote a dialogue which hopefully leads to an acceptable compromise.*[38]

It does not bring disputants face-to-face but mediates through correspondence, email and telephone contact. The OCCS says its success rate is around 50% (but has no record of what happens to the complainants who remain dissatisfied).[39]

Of 2479 contacts with the OCCS in the year between 1 January 2008 and 31 March 2010, 990 cases were opened; an increase of 35% on the previous year, a rise the OCCS attributes to factors including greater public awareness about its work, particularly through the internet, rather than to a worsening of standards.

The main categories of complaint received are shown in Figure 1 but the OCCS cautions that some complaints fall into more than one category. Over a quarter of complaints concerned prescriptions, although in some cases it was subsequently found that the error concerned dispensing; just over 11% of complaints revealed an error in dispensing to patients. Around a quarter of all complaints were categorised as miscellaneous which included allegations of rudeness, refusal to supply a prescription, refusal to undertake an eye examination if the prescription was to be taken elsewhere for dispensing, and queries about costs and pricing.

In its annual report the OCCS identifies three particular areas of complaint for special comment: buy-one-get-one-free offers (where the precise terms of the offer are not made sufficiently clear to the customer prior to purchase); patients whose sight deteriorates due to cataracts and who believe the previous prescription and dispensing was unnecessary or too costly because of the short time elapsing before needing a different prescription and new spectacles; and the failure of opticians to measure interpupillary distance (which the optician has no obligation to measure if not supplying

the spectacles). As with other complaints the OCCS encounters, it believes that clear terms and conditions, adequate explanation and good interpersonal communication go a long way to minimizing misunderstandings and resolving differences before they escalate into disputes.

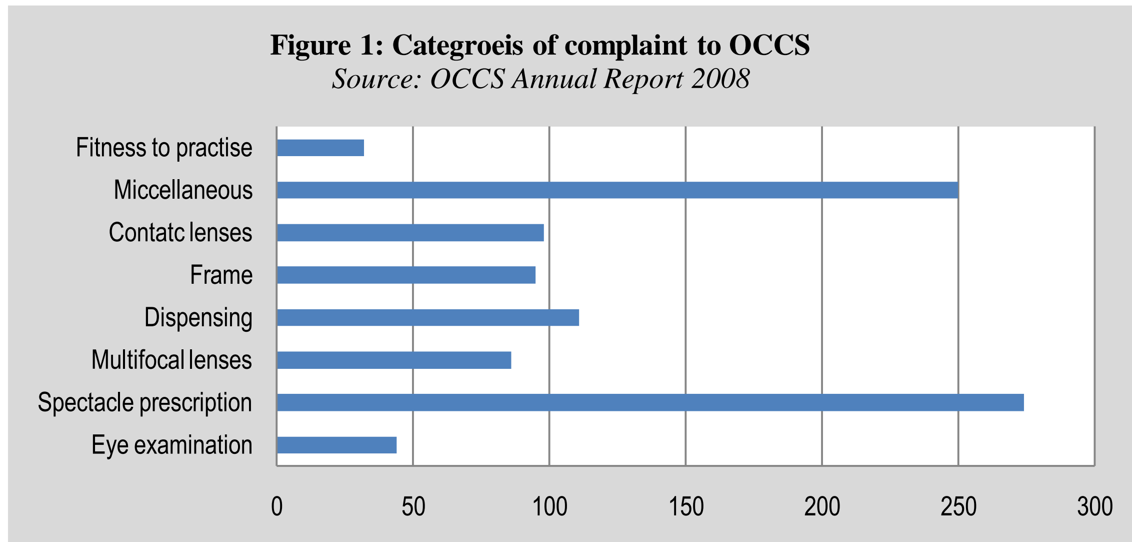


Figure 1: Categroeis of complaint to OCCS
Source: OCCS Annual Report 2008

The information the OCCS acquires about optical practices and practitioners, both through the complaints it receives and the mediation it undertakes, is held in the strictest confidence. As a matter of operational policy, and its obligations under data protection legislation, the OCCS does not and will not share any of the information it has about individuals or individual practices. OCCS information about registrants could not, therefore, be accessed for use in revalidation. Even if this were not the case, only a few of the registrants the OCCS encounters are likely to be involved in cases which involve matters that might be relevant to revalidation.

The General Optical Council

The General Optical Council is responsible for protecting the public. To enable it to do so it is empowered to investigate and take action in response to complaints about an optician's fitness to practise. A registrant is considered fit to practise so long as they:

> *...meet standards of health, character, knowledge, skill and behaviour necessary to do the job safely and effectively.*[40]

In its information for the public the GOC makes it clear that anyone can complain about an optician whose fitness to practise they believe to be impaired.[41] However fitness to practise is not an everyday concept and its nature and scope may not be immediately obvious to members of the public. The GOC helpfully provides examples in layman's terms of the reasons why an optician's fitness to practice might be called into question, and also sets out areas that fall outside its remit (Box E).

Box E: The nature and scope of complaints about fitness to practise

Concerns about an optician's fitness to practise may be about:

- poor professional performance, such as failing to notice signs of eye disease
- physical or mental health problems affecting their work
- inappropriate behaviour, such as violence or sexual assault
- being under the influence of alcohol or drugs at work
- fraud or dishonesty; or
- a criminal conviction or caution

The GOC in not able to:

- arrange refunds or compensation
- give legal advice
- give a detailed explanation of what has happened to the complainant during a visit to an optician
- make a registrant apologise to the complainant
- order a registrant to give the complainant access to their records
- take action against false or misleading advertising

Source: The GOC's public information leaflet: How to complain about an optician

The vast majority of complaints received by the GOC come from members of the public, and most concern optometrists (Table A). The complaints handling process requires the complainant to complete an investigation questionnaire which is used as a basis for gathering further information about the complaint, a process which may include calling in copies of clinical records and seeking a full witness statement from the complainant. All the information about the complaint is sent to the registrant concerned whose comments are invited. The registrant's response is then sent to the complainant to give them an opportunity to agree or disagree with the registrant's response. Each complaint is considered by the Investigation Committee.

Table A: Source and subject of complaints for the years 2006/7 – 2008/9
Sources: GOC Annual Reports, 2006/7, 2007/8 and 2008/9

SOURCE	2006/07	2007/08	2008/09
Individuals	106	156	148
Primary Care Organisations	9	7	11
Registrants	6	3	0*
Employer/universities	5	4	6
Counter Fraud Service	1	1	1
Police Circular	2	1	12
Self-declaration	0	0	8
College of Optometrists	0	0	34
Local Ophthalmic Committee	0	0	1
Other	0	0	17
** included with individuals*			
SUBJECT			
Optometrists	138	123	135
Dispensing opticians	21	26	32
Student registrations	4	8	14
Bodies corporate	15	8	8

The Investigation Committee can decide to take no further action, or it may ask for further investigations to be undertaken (such as an assessment of the registrant's health or performance); it can give a warning to the registrant, or it may refer the complaint to the Fitness to Practise Committee. On reviewing the complaint, if the Investigation Committee considers that a registrant may pose a risk to the public, to themselves, or that it is in the public interest to do so, it can instruct the GOC to ask the Fitness to Practise Committee to impose an interim order – which may be suspension from the register or the imposition of restrictions on the registrant's practise – until the complaint against the registrant has been considered. Investigation Committee outcomes for the past three years are shown in Table B.

Table B: Investigation Committee outcomes
Sources: GOC Annual Reports, 2006/7, 2007/8 and 2008/9

	2006/07	2007/08	2008/09
No further action	56	76	69
Withdrawn	18	27	14
Performance review	4	2	1
Performance assessment	9	4	4
Fitness to practice referral	22	23	31
Under investigation	18	34	66
No jurisdiction	2	6	4
Health assessment	-	-	1*

**plus two instances where the case was also referred to the FTP Committee*

If the Investigation Committee refers the complaint for adjudication by the independent Fitness to Practise Committee, a hearing is conducted in public. In advance of this a procedural hearing permits both parties to agree dates for exchanging witness and expert evidence, and for a date to be set for a substantive hearing. The principles of natural justice and due process enshrined in Fitness to Practise Rules means that the process of arriving at a decision about a complaint that is considered sufficiently serious and of a type that warrants referral to the Fitness to Practise Committee can take several years.

If following the hearing the Committee finds that the registrant's fitness to practise is impaired, it can impose sanctions which include: erasure from the register (the registrant is 'struck off'); suspension from the register (preventing the registrant from practising in the UK for the duration of the suspension); conditional registration (under which restrictions are placed on the types of practice the registrant is permitted to undertake, such as practising under supervision or being required to undertake further training); or a financial penalty of up to £50,000. Even if the Committee finds that the registrant's fitness to practise is not impaired, it has the power to issue the registrant with a warning. The outcome of Fitness to Practise Committee hearings for the past three years is shown in Table C.

The General Optical Council publishes data each year summarising the categories of complaint received. The volume of complaints for each category for the last three years is shown in Figure 2.

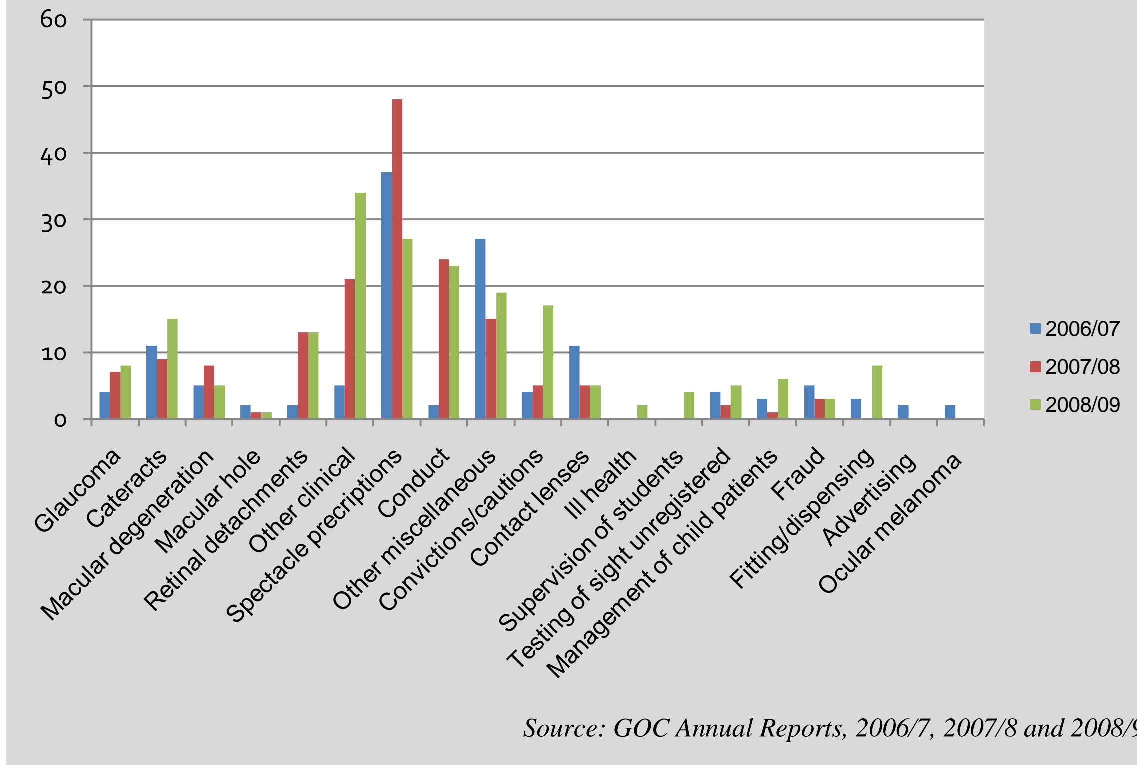
The published data also serves to highlight the exceptionally small number of fitness to practise cases as a proportion of the total registrant population.

Table C: Fitness to Practise Committee Outcomes
Sources: GOC Annual Reports, 2006/7, 2007/8 and 2008/9

	2006/07	2007/08	2008/09
Erasures	2	5	6
Suspension	-	-	3[(c)]
Conditional registration	2	1	-
Financial penalty	2	1	2[(c)]
Warnings	3	0	3
Fitness to practise not impaired	-	-	2
Interim orders	1[(a)]	4[(b)]	5[(d)]
Interim order reviews	1	2	5
Procedural hearings	19	16	29

(a) 1 failed application; (b) two failed applications; (c) one registrant received financial penalty and suspension; (d) plus three unsuccessful applications.

Figure 2: Reasons for complaints to the GOC



Source: GOC Annual Reports, 2006/7, 2007/8 and 2008/9

The GOC publishes the transcripts of Fitness to Practise Committee and Interim Order hearings and decisions (which are available on its website for the years 2005 onwards). Warnings and registration conditions that are currently in force (but not those that have expired or are 'spent') are published alongside the registration details that are available on the GOC's publicly-searchable registers.

The GOC is currently consulting on suggestions that the publicly-searchable registers should be annotated with information about expired warnings and conditions, and that the records of former registrants who have been struck-off or suspended from the registers should be made readily accessible to the public.[42] Clearly, individuals in the latter category would not be in a position to revalidate, and the 'spent' warning and conditions of those in the former category would be known to the GOC, so the greater transparency proposed has no material impact on the availability of information about complaints for revalidation.

Analysis and discussion

Most optical businesses act in accordance with best practice guidance and both have and also publicise complaints procedures (which they are required to do if providing services under contract to the NHS). Retaining brand reputation is crucial to the commercial performance of large multiples and supermarket chains, and independents survive on their local reputation by retaining a loyal customer base, so there is a strong incentive for optical businesses to deal with customers who are dissatisfied as quickly and effectively as possible. Most have well developed systems for handling, tracking

and recording complaints, yet there is a dearth of data about complaint volume, type and outcome because much of this information is regarded as commercially sensitive.

Aggregate data about complaints is available from Ombudsmen, the Optical Consumer Complaints Service and the General Optical Council, but their work represents only those cases that cannot be resolved locally or are of a type or seriousness that warrants the involvement of these bodies. Information about individual cases is held in confidence by the OCCS. The Ombudsmen carry out their investigations in private (but occasionally publish anonymised summaries of selected cases). In contrast to this, because of its public protection role, the GOC publishes the transcripts of Fitness to Practise hearings, information which is registrant-specific.

In England NHS optical contractors are required to submit reports to Primary Care Trusts about the complaints they have received, and patients can also complain directly to a PCT, but this data is not published other than in aggregate form as part of national statistical publications about NHS complaints, which does not separately indentify opticians. However anecdotal evidence suggests that the number of complaints in private and public sector optics is very low, and that where complaints do arise they are usually dealt with appropriately.

In addition to a paucity of data there is a lack of consensus about what constitutes a complaint. As a consequence such data collection as there is does not conform to universally agreed definitions and is not consistently recorded or collected against uniform standards. This could be a matter of concern if complaints data are to be used for the purpose of revalidation. For example registrants whose employers adopt a more exacting definition of ‘complaint’, or whose standard operating procedures or handling protocols rapidly escalate reporting and recording, would be disadvantaged compared to those whose employers exercise a more relaxed attitude or whose policies place greater emphasis on securing resolution at local level.

Some informants expressed concern about the use of information from complaints for revalidation because of the complexity which characterises many complaints. It was observed that despite common categories of complaint used for recording purposes, when investigating a complaint each is best viewed as a unique event because of the many variables the can contribute to the sub-optimal performance in question. It was also felt that it would be unreasonable to draw conclusions about a registrant’s fitness to practise from a single complaint, not least because there were often mitigating circumstances and because many came from unusually vexatious customers or ‘professional complainers’.

Concern was expressed that if information from complaints was to be used for revalidation, it would inevitably err towards the lowest common denominator in terms of the extent of information required and would thus exclude the nuances and measured assessment of circumstances that are a feature of rigorous local investigations. Informants questioned what useful information about a registrant’s fitness to practice could be gleaned from complaints, unless the purpose was to reveal individuals who were the focus of repeated complaints, in which case they would have been dealt with anyway through remedial training, enhanced supervision or disciplinary action.

A question was raised about whether or not it would be fair to use information about complaints for revalidation when, as was often the case, an unfounded complainant was nevertheless mollified by offer of a resolution (such as a refund) as the line of least resistance in order to avoid potentially protracted proceedings. Currently this sort of decision is a commercial matter, but it would still be recorded as a complaint about an optometrist or dispensing optician even though it was unproven or known to be

unfounded. Knowledge that complaints records could be used as a negative indicator in a registrant's attempt to revalidate would serve as a powerful disincentive to try to avoid cumbersome and costly proceedings by acquiescing to the demands of an unfounded complainant, and thus rob optical businesses of an opportunity to make a commercial judgement about what was in the best interests of the company.

The unwieldiness of complaints procedures was also a matter of concern for some informants. Many acknowledged that it was important to have structured, fair and transparent procedures to safeguard the interests of patients and customers, but some said that the cumbersome nature of complaints processes – particularly those of external organisations – was a strong incentive to try to achieve local resolution. Complaints that were referred to the OCCS or to the GOC often involved businesses in time and resources they considered entirely disproportionate to the nature and merits of the complaint in question. Some referred to these processes as having delivered conclusions that had been arrived at many months before but which the complainant had at that point refused to accept.

Some informants feared that if complaints were to feature in revalidation registrants would feel compelled to contest every one that arose, increasing the number of complaints referred to external bodies. Using information from or about complaints for revalidation would risk encouraging defensive practice and under-reporting, compromising the culture of transparency and learning which has been achieved across the sector.

Patient, practitioner and commercial confidentiality are significant obstacles to the use of information about or from complaints as an indicator or evidence source for revalidation. Even if it were possible to access relevant information, the complexity of complaints are such that it would be difficult to infer anything meaningful about a registrant's professional competence or fitness to practise without detailed scrutiny and careful consideration of all the facts of the case – in other words a process analogous to the work currently conducted by the GOC's Investigating Committee. Simply knowing whether a registrant had been involved in a complaint in the period preceding revalidation without a full understanding of its nature and nuances would add nothing to an assessment of their suitability for revalidation, and could expose the GOC to accusations of misinterpreting its significance.

None of the informants consulted showed any enthusiasm for use of information about or form complaints for revalidation, and a number expressed significant reservations about doing so.

Accreditation

Optical businesses that contract to provide NHS services must have complaints procedures that conform to the requirements and standards for complaints handling in the country in which they operate. This is audited during practice inspections and contract compliance visits. Similar standards are adopted in private optical practice, not least because there is a commercial imperative to deal with complaints swiftly and effectively.

It would seem therefore that little would gained by having additional GOC standards against which complaints procedures could be accredited as approved sources of information for revalidation. Doing so would duplicate existing systems and would be unlikely to improve the quality of complaints handling, recording and reporting for

revalidation, and might compromise the GOC's statutory obligation to investigate the complaints it receives without prejudice.

It is not obvious that optical businesses would have an incentive to seek accreditation of their complaints procedures from the GOC, and since a voluntary scheme would be unlikely to deliver the universal sign-up required, the GOC would therefore require powers to compel optical businesses to conform.

Conclusions

The project was commissioned to identify and examine the different types of patient feedback already gathered by optical businesses and to explore how complaints are handled; to assess whether this is suitable evidence for revalidation purposes; to determine whether optical businesses are willing to tailor their systems for revalidation purposes; and to establish whether the General Optical Council should develop standards in order to accredit patient feedback and complaints systems.

For many optical businesses customer retention, unsolicited comments and the absence of complaints are the main indicators of customer satisfaction. A minority of independent practices adopt more structured approaches but systematic surveys are mostly confined to the large multiples and supermarket chains. However these surveys vary in design, content and frequency and are motivated by commercial imperatives. There is no national survey of patient experience or satisfaction, and most surveys conducted by optical businesses are regarded as commercially confidential.

The principal methods used are evaluation questionnaires given to patients immediately following a sight test or the fitting and supply of spectacles or contact lenses, postal questionnaire and telephone interview surveys of a sample of recent customers, panel surveys and focus groups. Mystery shopping surveys are used by a number of the large multiples. Some methods – mainly evaluation questionnaire surveys – are designed and conducted in-house, whereas postal, telephone and mystery shopping surveys are often outsourced to a specialist market research company.

The main focus of these surveys is overall customer satisfaction, not the competence or fitness to practise of optometrists and dispensing opticians. Most surveys do not attempt to identify individual registrants. The validity and reliability of some of the instruments used and the sampling method adopted are not always as robust as they might be.

None of the methods used to gather patient feedback or assess customer satisfaction reviewed for this study produce information that could easily be used or adapted for revalidation. The majority of those consulted could not envisage their businesses sharing what is regarded as commercially sensitive information, nor amending what are essentially tools designed to help improve commercial performance.

The characteristics described above suggest that there would be limited benefit and considerable challenges for the GOC if it were to attempt to set standards against which to accredit patient feedback mechanisms as approved sources of evidence for revalidation. An alternative would be to commission research and development to produce a validated patient feedback instrument for universal application that could be used to assess all registrants against the same standards.

Little information is published about the number of complaints in the optical sector. Anecdotal evidence and such data as there is suggest that complaints are a rarity in optics, especially when compared to the overall number of patient contacts and customer transactions. National bodies that deal with serious complaints, or complaints that cannot be resolved locally, publish annual statistics. These too suggest a low number of complaints compared to the total population of registrants.

The vast majority of optical businesses appear to have and to publicise complaints procedures, and act in accordance with best practice guidance by dealing swiftly and

effectively with complaints. Where information is available about the types of complaint handled by optical businesses, it appears that most concern aspects of the retail transaction, the supply and fitting of spectacles and the attitude of staff; very few concern serious issues such as missed pathologies.

Patient, practitioner and commercial confidentiality, and the absence of agreed definitions, systematically collected data or uniformly applied standards and remedies, represent major obstacles to using information of or from complaints as an evidence source for revalidation. The fact that there has been a complaint against a registrant may indicate very little about their competence or fitness to practise, not least because many complaints are unfounded or come from vexatious customers, and because only by investigating the circumstances of a case is it possible to appreciate the degree of registrant culpability.

Using information of or from complaints for revalidation would create an incentive to under report and could undermine the culture of transparency and fairness which is considered to be a feature of contemporary complaints handling across the sector. Knowing that a complaint might count against a registrant would compromise the discretion some businesses exercise by trying to resolve even unfounded complaints to avoid potentially protracted and costly disputes.

There would seem to be little value in the GOC attempting to accredit complaints procedures as approved sources of information for revalidation, not least because this would duplicate NHS contractual requirements and compliance monitoring, and because it could compromise the GOC's statutory duty to investigate complaints referred to it about performance and conduct without prejudice.

It may therefore be concluded that neither patient feedback mechanisms nor complaints procedures currently provide information that is sufficiently comprehensive, standardised or meaningful for registrant revalidation; that in the main optical business are not disposed to amend existing systems to satisfy regulatory requirements; and that accreditation would not help to secure information about individual registrants of a type and quality required for revalidation.

End Notes

[1] Department of Health, 2007, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. Cm 7013, London: The Stationery Office.

[2] Department of Health, 2008, *Principles of Revalidation: Report of the Working Group for Non-medical Revalidation,* London: DH.

[3] Moore, 2009, *Appraisal: A Report of a General Optical Council Revalidation Project,* London: GOC; and Europe Economics, 2010, *Risks in the Optical Profession: Final Report,* London: GOC.

[4] General Optical Council, 2009, *Revalidation: Initial Consultation*, London: GOC; General Optical Council, 2010a, *CET Stakeholder Event,* London: GOC; General Optical Council, 2010b, *CET Survey Analysis*, London: GOC; General Optical Council, 2010c, *Revalidation Event Summary,* London: GOC; General Optical Council, 2010d, *Licence to Practise Consultation,* London: GOC.

[5] For example, and in contrast to other contractor professions, the General Ophthalmic Services contract (in England) does not require NHS optical contractors to survey their patients for levels of satisfaction; and the new contract compliance framework does not explore whether measures are used to assess patient experience.

[6] Picker Institute, 2009, *Using Patient Feedback*, Oxford: Picker Institute.

[7] For example in England the 2009/10 NHS Operating Framework requires each NHS Trust to obtain feedback from patients about their experience of care. The Care Quality Commission website provides details of all recent and planned patient surveys. None specifically address ophthalmic services (although ophthalmic medicine and surgery are likely to be included in the generic out-patient and in-patient surveys). As regards community provision, there is no current requirement in the General Ophthalmic Services contract for contractors to undertake patient experience surveys.

[8] In a recent survey of over 600 independent practices (around 18% UK independents) 21% reported having undertaken a patient satisfaction survey in the last twelve months. In some cases these were regular and routine, and in other cases ad hoc or one-off surveys (Source: personal communication: Patrick Myers of Myers La Roche, a consultancy specialising in optical business and practice development, which has undertaken extensive survey work in the UK and Europe on behalf of CIBA Vision).

[9] Sapsford R, 1999, *Survey Research*, London, Sage.

[10] See for example Moriarty H, McLeod D & Dowell A, 2003, Mystery shopping in health service evaluation, *British Journal of General Practice*, pp942-946.

[11] See for example O'Sullivan R, Focus Groups, in Miller & Brewer (eds), 2003, *The A-Z of Social Research,* London, Sage; and Norris P, 2004, Reasons why mystery shopping is a useful and justifiable research method, *The Pharmaceutical Journal* Vol 272, pp746-747.

[12] Ipsos MORI, Winter 2009, *Understanding the patient experience: Research to meet the needs of your patients,* London, Ipsos MORI Social Research Institute.

[13] Surveys undertaken by third party market research companies, which were not reviewed in this study, are assumed to be more methodologically rigorous.

[14] Hankins K, Fraser A, Hodson A, Hooley C and Smith H, 2007, Measuring patient satisfaction for the Quality and Outcomes Framework, *British Journal of General Practice*, pp737-740.

[15] Hague P & Hague N, Undated White Paper: *Customer Satisfaction Surveys*, Manchester, B2B International.

[16] General Medical Council, June 2008, Press Release: *New research supports the potential for using patient and colleague questionnaires in the revalidation process*, London, GMC.

[17] Lockyer J and Fidler H, 2009, *Comparison of Patient Satisfaction Instruments Designed for GPs in the UK: Report commissioned by the Royal College of General Practitioners,* London RCGP.

[18] It is likely that more than one questionnaire (or a questionnaire with discrete sections) would be required to accommodate the different functions and competencies of optometrists, dispensing opticians, contact lens opticians and prescribers.

[19] Survey specialist Ipsos MORI continues to run the GP Patient Survey on behalf of the Department of Health. It is working with academics to further develop the questionnaire to cover more of the issues that concern patients. The survey asks patients about a range of issues, including how easy or difficult it is for patients to make an appointment at their surgery, their satisfaction with opening hours, and the quality of care received from their GP and practice nurses. (See: http://www.gp-patient.co.uk/info/).

[20] The NHS Information Centre, 2009*, Data on written complaints in the NHS 2008/09,* The Health and Social Care Information Centre,

[21] Healthcare Commission, February 2009, *Spotlight on Complaints: A report on second-stage complaints about the NHS in England,* London: Healthcare Commission

[22] Parliamentary and Health Service Ombudsman, *Making and Impact: Annual Report 2009/10*, London: The Stationery Office

[23] Scottish Public Services Ombudsman, 2009, *Annual Stats 2008-09 received by subject: health*, Edinburgh, SPSO.

[24] Personal communication from Sali Davis, Optometry Wales, arising from work conducted for Optometry Wales (as in England, national complaints data does not separately indentify either NHS contractor opticians or NHS hospital optometrists and dispensing opticians – see *SDR 162/2009, Complaints to the NHS Wales 2008/09,* Cardiff, Welsh Assembly Government.)

[25] Association of Optometrists, 2010, *Annual Report 2010,* London, AOP.

[26] See for example the joint guidance about obligations under the NHS complaints procedure: ABDO, AOP, FODO, September 2009, *Joint Advice from ABDO, AOP, FODO On NHS Complaints System in England,* London. ABDO, AOP, FODO.

[27] See for example Federation of Ophthalmic & Dispensing Opticians, undated leaflet, *Insurance Information,* London: FODO.

[28] Europe Economics, 2010, *Risks in the Optical Profession: Final Report,* London: GOC.

[29] Association of British Dispensing Opticians, 2008, *Advice & Guidelines (Issued December 2008; updated March and July 2010),* London, ABDO (accessed July 2010 at: http://www.abdo.org.uk/adviceandguidelines.php).

[30] Department of Health, 2010 (revised edition), *The Handbook to the NHS Constitution,* London, Department of Health.

[31] See for example: NHS Scotland, 2009, *Making a complaint about the NHS*, Glasgow, HRIS; Welsh Assembly Government, 2006, *Complaints about treatment and care: a guide to making a complaint about the NHS in Wales*, Cardiff, WAG; and in Northern Ireland see: Patient and Client Council, *Making a Complaint* (www.patientclientcouncil.hscni.net).

[32] Department of Health, 2009, *Listening, responding, improving – A guide to better customer care,* London, Department of Health; and Health Rights Information Scotland, June 2009, *Making a complaint about the NHS,* Scottish Consumer Council and Scottish Executive Directorate of Health and Wellbeing.

[33] Welsh Assembly Government, 2006, *Complaints about treatment and care: a guide to making a complaint about the NHS in Wales*, Cardiff, WAG.

[34] The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (Statutory Instrument 2009 No 309).

[35] NHS Primary Care Contracting, April 2009, *General Ophthalmic Services Contract Compliance Framework*, NHSPCC (www.pcc.nhs.uk).

[36] See: *Quality in Optometry* (www.qualityinoptometry.co.uk) which includes an England Checklist and a Wales Checklist. See also Warburton T, Blakeney S and Thompson K, 2009, Quality in Optometry toolkit grows for contract compliance, *Optometry Today*, 4/12/09.

[37] Scottish Executive, 2007, *NHS 207 PCA(O)3 General Ophthalmic Services*, Edinburgh, Scottish Executive Health Department.

[38] Optical Consumer Complaints Council: Annual Report 2008 (1 January 2008 – 31 March 2009), Petersfield, OCCS.

[39] Personal communication: Richard Wilshin, OCCS Administrator, June 2010.

[40] The General Optical Council publishes standards of competence for optometrists, dispensing opticians, contact lens practice, and competencies required for entry to the optometry additional supply and supplementary prescribing specialist registers (see www.optical.org for the latest editions); and General Optical Council 2010, *Code of Conduct*, London, GOC.

[41] General Optical Council, undated leaflet, *How to complain about an optician – Information for you,* London, GOC.

[42] General Optical Council, 2010, *Accessibility of Fitness to Practise in formation consultation*, London, GOC.