Northern Ireland Public Services Ombudsman Bill – submission from the Ombudsman of Ireland

I would like to begin by welcoming the new legislation. Creating a single public service Ombudsman institution for Northern Ireland is a desirable development and the proposed legislation draws on some of the best international practice. The fact that this is Committee sponsored legislation marks an important development in the Northern Ireland context and will help to cement the relationship between the NIPSO and the Assembly, thus ensuring that the Office is fully independent from the public services in its jurisdiction. It also will enable the Assembly to provide political oversight of the implementation of recommendations as is the case in the vast majority of Parliamentary Ombudsman institutions internationally.

Own initiative powers

The proposed jurisdiction is comprehensive, and will make it easy for complainants to discover how to access independent redress. The introduction of own initiative powers will also bring the Office in line with best international practice. My own office has such powers which are used sparingly. Our first report following an own-initiative investigation was published on 27th May 2015. A copy of the report and a summary are attached for information. The ability of the Ombudsman to investigate complaints where people may be reluctant or unable to complain is highly valuable. Whereas it is easy for articulate individuals to complain, some people whether through disability or other disadvantage may find it more difficult to do so and indeed, as my own investigation discovered, some people may fear the consequences for themselves or their loved ones if they complain. In addition, a complaint about one body may suggest an issue affecting others. As an Ombudsman, I have seen examples about this, most recently, for example, the way in which local authorities dealt with a tax on second homes. It was evident to me that the problems I encountered were likely to affect most if not all authorities, and own-initiative powers make it possible to extend investigations to cover such systemic problems. The resolution reached in this case extended to all local authorities.

Ombudsmen across the world have own initiative powers, although such powers have not traditionally been available in the UK. There are many examples of excellent investigations being undertaken which complement the work of regulators and do not overlap them. The constraints proposed in the draft legislation are not typical elsewhere, and there is no evidence that their absence has led to any difficulties. I would suggest that this is an area that might be reviewed by the Committee during the scrutiny of the legislation.

Complaints Standards Authority

Ombudsmen have a unique insight into the operation of complaints mechanisms across the public sector. In some instances, this has been recognised by the development of standardised approaches to complaints handling. In Wales, the Model Complaints process has received Government backing and has been adopted by the cast majority of public service providers. There is now a proposal that new Ombudsman legislation should give the Ombudsman the power to specify complaints processes across the public sector. In Scotland, such legislation already exists and is working very effectively. The operation of the Complaints Standards Authority by the Ombudsman's Office has brought consistency and clarity to the complaints process. Members of the public know what to expect, standardised training has been developed for front line staff and statistics can now be generated for each service area. As part of the Open Government Plan in Ireland, such proposals are also due to be explored. The Committee may wish to consider whether this power should be included in Northern Ireland. The opportunity of new legislation would seem an appropriate time to introduce this change. Standard complaint handling would reduce the cost of managing complaints in the long run, allow for standardised training to be introduced across the public sector, contribute to better public services by indentifying systemic weaknesses that need to be addressed, preventing mistakes from being repeated and promote greater transparency by allowing statistics about complaints to be produced across the public service.

Reports

The ability to publish reports and digests is fundamental to the work of an Ombudsman. It is helpful to be able to lay reports before the Parliamentary Body, in your case the Assembly; to have such reports considered by a Committee; to issue public reports to draw attention to issues of public importance, and to be able to prepare other reports which are made available, usually via a website, and to summarise all reports in regular digests. While it is valuable to require the preparation of public reports where a body refuses to implement recommendations, and for such reports to be laid before the Committee to enable proper scrutiny of any such decision, my view is that the Ombudsman should have discretion as to how best to publish reports otherwise. That discretion could be subject to the proviso that all reports should be available on request unless they contain elements of personal information, e.g. in cases relating to child protection, that would make it inappropriate to do so.

Recommendations

On a related point, I am happy that recommendations are the appropriate way for a public services Ombudsman to provide redress. In practice, only a tiny minority of recommendations are not immediately accepted and I have never experienced such a rejection as an Ombudsman. It is also essential that a range of remedies, including financial redress, are available.

Title

Finally, I was a little disappointed to see the use of the title Ombudsperson. The word Ombudsman is from the original Swedish and is gender neutral. It is an internationally recognised brand associated with key values such as objectivity, fairness, free access and independence. Changing the 'man' element to person is equivalent to changing it in other gender neutral words, so we might personoevure our car or elected members might receive a persondate! I hope that you might reconsider this element of the proposals.

Conclusion

These points, though, are minor caveats set against a very warm welcome for some thoughtful and forward thinking proposals. The new NIPSO with its comprehensive coverage of public services, its independence secured through its links to the Assembly and its powers in line with best practice internationally marks a significant step forward for Northern Ireland and I welcome the proposals. I look forward to having the opportunity to discuss them with the Committee

Peter Tyndall

Ombudsman of Ireland and Information Commissioner

Oifig an Ombudsman
Office of the Ombudsman

Learning to Get Better

An investigation by the Ombudsman into how public hospitals handle complaints

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Learning to Get Better

An investigation by the Ombudsman into how public hospitals handle complaints

(under section 4 of the Ombudsman Act 1980, as amended)

Foreword

When patients or their loved ones make a complaint about hospital treatment, the one thing that is most likely to satisfy them is effective reassurance that what has happened to them will not happen to others. Most people will find complaining daunting and, having summoned up the courage to do so, it is most likely they will trust the outcome if they are treated fairly, respectfully and persuaded that their concerns have been taken seriously. If on the other hand they are dismissed without adequate explanations and appropriate apologies the trust they and those close to them want to have in the service may be destroyed.

No organisation serving the needs of the sick, can afford not to listen, and listen carefully, to the experiences of their patients and their families. This is partly a matter of recognising the rights of patients and in part a necessity for any effective running of the service. Modern healthcare has to be a genuine partnership between patients and those who provide them with the help they need. Gone, or at least going, are the days when patients were expected to be the passive recipients of the benevolence of the medical profession. They are entitled to have their views and wishes respected not only in relation to the type of treatment they are prepared to accept, but in evaluating the standard of care that is appropriate. Further, in the complex organisation that is a modern hospital service, it is quite impossible for those who lead it to have the knowledge required to fulfil their challenging duties, without taking full advantage of the experiences of their patients. As I said in the report after the public inquiry into Mid-Staffordshire NHS Foundation Trust:

A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect early warning signs that something requires correction, to address such issues and to protect others from harmful treatment.[1]

The consequences of not listening to patients can be very serious not just for the patients themselves but the reputation and survival of the services about which they have complained.

Complaints must not only be listened to, there must be an effective response. Failure to do so aggravates the grievance and suffering of the patients and others who are affected and undermines public trust. Complaints handling at the Mid-Staffordshire NHS Trust was characterised by the inadequacy and tardiness of the responses to complaints, a failure to remedy identified deficiencies or a lack of consideration of complaints by the Board.

The litany of deficiencies identified in that Trust's procedures echoed the conclusions of Dame Janet Smith in the Shipman Inquiry where she found a lack of fair procedures, a failure to investigate, or to give adequate explanations and apologies and a high level of dissatisfaction.[2] Since the Mid-Staffordshire reports there have been two comprehensive reviews of complaints handling in England and Wales, both of which have produced recommendations worthy of consideration.[3]

Therefore this report by the Ombudsman into the handling of complaints by public hospitals in the Republic of Ireland does not arrive on a blank canvas, even though there are obviously differences of context between the United Kingdom and the Republic. The findings and the conclusions rightly recognise the importance of complaints and the challenges in ensuring that the handling of them is effective, for the patient and the hospital and its staff.

I believe this report can provide a sound foundation for enhancing the ability of public hospitals to be caring, responsive and learning organisations. The emphasis on accessibility to the complaints process, an effective process, learning, and the leadership which can make these things happen is, I am sure, to be welcomed.

Sir Robert Francis QC

Chair of the Inquiry into care failings at Mid-Staffordshire NHS Foundation Trust

1 Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, February 2013, The Stationery Office, HC898-1, page 245

2 Shipman Inquiry 5th report – Safeguarding Patients: Lessons from the past – Proposals for the Future, December 2004 Cm 6394 chapter 2

3 Clywd, Hart, A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture, October 2013. House of Commons Select Committee, Complaints and Raising Concerns, 4th Report of Session 2014-2015, January 2015 HC 350

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Acronyms used in this report

FTPC	Fitness to Practise Committee
HIQA	Health Information and Quality Authority
HSCIC	Health and Social Care Information Centre
HSE	Health Service Executive
NALA	National Adult Literacy Agency
NIMS	National Incident Management System
NHS	National Health Service
NMBI	Nursing and Midwifery Board of Ireland
PPC	Preliminary Proceedings Committee

Introduction

The health service supports us at key moments in our lives. It is there when we are born, and also at the end of our lives. We rely on it to ensure that we can live life to our potential. Over the years, care has become more sophisticated and more effective.

Against this background, and the changing demographics, which are partly at least because so many of us live longer due to advances in healthcare, pressure on our health service is rising inexorably. This has been exacerbated by the very difficult financial circumstances from which we are only now starting to emerge. Inevitably, in a very busy and complex environment, mistakes will be made. Making sure that we know about them, putting things right in so far as we can for individuals, giving proper explanations of what has gone wrong, and critically, learning from complaints to minimise the chance of recurrence, is essential.

In Ireland, complaints to the Ombudsman about healthcare are considerably lower than in other comparable jurisdictions. Potentially, this means that some errors are going undetected, and opportunities to improve services are being lost. Most Ombudsman investigations are driven by individual complaints. However, in order to try to establish why complaints are not reaching my Office, this report is the product of the first "own initiative" investigation we have undertaken.

The methodology we used was different to a normal investigation. It included reaching out to members of the public and talking to a wide range of service providers and stakeholders, as well as looking at how a broad sample of hospitals were dealing with complaints. We have found good practice and some not so good. We have identified a lack of consistency in the way complaints are dealt with, and a need for best practice to be adopted across the board.

In answer to the question, why don't people complain when they are unhappy, we have identified two key issues. The first is that people don't want to complain because they fear that there will be negative repercussions for themselves or their families. The second is that they don't believe that it will make any difference.

In order to tackle this, we need to make it easier for people to complain and we need to encourage and support them in doing so. It is important also that complaint outcomes are arrived at by means of a proportionate, objective and thorough investigation of the facts. We need to create a culture in our hospitals which welcomes complaints and which demonstrates how it acts upon the lessons which they provide.

I'd like to thank all of those people who helped us with this investigation - the members of the public who shared their experiences; the regulators and representative bodies, and the staff in the hospitals. I'd like also to pay tribute to my investigation team who worked so diligently to produce it.

I particularly want to welcome the very positive engagement with the Health Service Executive (HSE) and the Department of Health. They both demonstrated their commitment to considering how the complaints process was working in practice and a willingness to seek improvement for the future.

This report is not designed to sit on shelves. It offers a clear path forward for developing a more responsive, learning service for the future. I look forward to continuing to work with the key stakeholders to ensure that the Action Plans which are put in place are ambitious, and that progress is monitored so that we can deliver a better health service for all.

Peter Tyndall
Ombudsman
May 2015

Executive Summary

This investigation by the Office of the Ombudsman looks at how public hospitals in Ireland handle complaints about their services. In particular, it looks at how well the HSE and public hospitals (including voluntary hospitals) listen to feedback and complaints and whether the HSE and public hospitals are learning from complaints to improve the services they provide.

At the outset of this investigation, this Office sought the views of members of the public who had complained about a hospital service, either as a patient or a relative and/or carer.

One of the key points that emerged from this public engagement was:

- many users of hospital services (whether patients or relatives/carers) **do not know how to make a complaint about a hospital service and are not aware of the support available** to help them to do so, including the right to escalate the complaint to this Office.

The main barriers to giving feedback or making a complaint were identified by participants as:

- **a fear of repercussions for their own or their relatives' treatment;**
- **a lack of confidence that anything would change as a result of complaining.**

This Office surveyed all public hospitals to gain a better understanding of the complaints process as it operates across the country and visited 8 randomly selected hospitals for a more in-depth study of their processes. We met with senior management from the HSE, the Department of Health, representative organisations and health sector regulators. We also received submissions from other representative organisations and patient advocacy groups.

The key findings that emerged from this investigation include:

1. Feedback should be encouraged – Members of the public reported a lack of knowledge about how to give feedback or make a complaint. The HSE and hospitals must publicise the information and supports available in order to encourage and assist people to share their experiences of hospital care and make the process more accessible for all. Complaints should be seen as a positive way of ensuring that healthcare services continually improve.

2. Learning from complaints is essential – Hospital staff reported to this Office that there was often a difficulty in getting internal feedback on the outcome of complaints. In view of this, and the belief among the focus group participants that nothing happens as a result of complaining, there is a need for a new focus on learning (and sharing the learning) from complaints. Responding effectively to complaints and learning from them is fundamental in providing a high quality service. In this regard, learning from complaints should sit alongside learning from other sources such as adverse events or "near misses".

3. There is a role for senior managers within the complaints process – Senior managers must be active and visible in promoting and reinforcing a positive complaints culture within hospitals.

4. Outcomes need to be publicised more – It is important that the HSE and hospitals highlight complaint outcomes which led to improvements and changes in procedures and tell people (the public, hospital staff and the hospitals) what these improvements are.

As a result of these findings, the Ombudsman has made a number of recommendations. These recommendations include:

- **A no "wrong door" policy should be developed** so that wherever a complaint is raised, it is the system and not the complainant that is responsible for routing it to the appropriate place to get it resolved.
- **Independent advocacy services should be sufficiently supported and signposted** within each hospital so patients and their families know where to get support if they want to raise a concern or issue.
- **A standard approach should be adopted by all hospitals in relation to the information available to the public.**
- **A standardised structure for collecting and documenting a complaint should be developed** across the hospital groups outlining the nature of the complaint, the preferred method of communication and the desired outcomes.
- **The outcome of any investigation** of a complaint together with details of any proposed changes to be made to hospital practices and procedures arising from the investigation should be conveyed in writing to the complainant with each issue in the complaint responded to.
- Each hospital group should **provide a six monthly report to the HSE** on the operation of the complaints system detailing the issues giving rise to complaints and the steps taken to resolve them and the HSE should publish an annual commentary on these six monthly reports.
- Each hospital should **develop a learning implementation plan** arising from any recommendations from a complaint which should set out the action required, the person(s) responsible for implementing the action and the timescale required.
- Each hospital group should **publicise (via the development of a casebook) complaints received and dealt with within that hospital group**. This casebook should contain brief summaries of the complaint received and how it was concluded/resolved (including examples of resulting service improvements) and should be made available to all medical, nursing and administrative staff as well as senior management.

The Ombudsman intends to ask the HSE and each of the voluntary hospitals to develop an action plan in order to monitor the implementation of these recommendations.

Chapter 1
Background

Background

The role of the Ombudsman is to consider complaints about the actions of certain public service providers which adversely affect individuals. This Office decided to undertake this investigation into how complaints are handled by public hospitals in Ireland because we were struck by the fact that, despite the high number of interactions people had with public hospitals, relatively few complained to this Office about the service they received, particularly when compared with other jurisdictions. We wanted to find out why this may be and to make sure that the complaint handling service made available to people was efficient and effective. In addition, we felt that it was vital to highlight good practice in complaint handling and outcomes and to make certain that, where things went wrong, the hospital service was:

- putting things right for the patient;
- learning from its mistakes;
- introducing procedures and practices to prevent a recurrence of the issues which gave rise to the complaint in the first instance; and,
- making sure that the lessons derived from the investigation of complaints feed into the system to benefit the users and service providers alike.

Writing in 2006[1], as the HSE was introducing its statutory complaints system, the then Ombudsman, Emily O'Reilly, wrote about her hope that the new system would become an established feature in the landscape of quality customer service and complaint handling. She acknowledged that a perfect system would not be easily achieved and that the process would have to be the subject of on-going review and change over the years as it evolved and developed. This investigation presented a unique opportunity to undertake a review of the workings of the complaints system and to consult with stakeholders to seek their opinions on the efficacy of the process.

In order for the investigation to be as comprehensive as possible, we decided that it should include

- **a survey of all acute public hospitals within the State in order to get an overview of their complaints processes,**
- **site visits/inspections of a sample of hospitals (8 in total),**
- **interviews with front line and senior hospital staff,**
- **focus groups with members of the public,**
- **consultations with interested health sector and advocacy groups and**
- **a review of a selection of complaints dealt with by the sample of hospitals visited.**

We also asked members of the public (via dedicated postal and e-mail addresses) to share their experiences, both positive and negative, of making a complaint about a public hospital. Equally, if they didn't make a formal complaint, despite being unhappy with the service they received, we asked them why.

We hope that this investigation will be of relevance and assistance to the HSE, public hospitals, the Department of Health, other regulatory bodies and this Office as we work with each other to develop the complaints handling service over the coming years. Irish and international experience shows that good complaint handling increases patient safety and improves services.

1 A report by the Ombudsman to the Health Service Executive, March 2006

Mid-Staffordshire Trust hospital scandal

The Mid-Staffordshire Trust hospital scandal concerned poor care and high mortality rates at the then Stafford Hospital, Stafford, England. In November 2010, a public inquiry opened, chaired by Sir Robert Francis QC, which examined the causes of the failings in care. Amongst the inquiry's findings was that hundreds of complaints were made about the care provided at the hospital but these complaints were not investigated or were simply ignored.

The inquiry identified key themes in relation to the handling of complaints. These included the presence of barriers preventing organisations from receiving complaints, the lack of support given to complainants and the low priority given to feedback and learning from complaints. The inquiry's report was published in February 2013 and contained 290 recommendations, including recommendations for increased openness, transparency and candour throughout the healthcare system, improved support for compassionate care and stronger healthcare leadership.

"A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment" – Sir Robert Francis QC.

Overview of the public hospital system in Ireland

The Department of Health is responsible for the formulation, evaluation, and implementation of government approved health policies in Ireland. The Department plays a central role in the strategic planning of health services in consultation with the HSE.

The HSE is charged with the provision of health services to every resident in the State. It is responsible for the delivery and management of these services which are provided in hospitals, health facilities and in communities throughout the country. The services are, in the main, funded through the tax system, and the HSE is allocated an annual budget by the Department of Health to enable it to carry out its functions.

Hospital services are generally delivered by one of three different types of hospitals:-

- HSE Hospitals - these hospitals are owned, funded and operated directly by the HSE.
- Public voluntary hospitals – these are hospitals owned and run on a not for profit basis by private voluntary organisations, including religious institutions. The majority of their income comes from the State (through the HSE).
- Private hospitals, which are entirely owned, operated and funded privately. They receive no state funding. Private hospitals are not covered by the statutory complaints process and are also currently outside the remit of the Ombudsman. For these reasons, they are not included in this investigation.

Public hospital services are provided in HSE hospitals and public voluntary hospitals. They can be either "in-patient services", which require a patient to be admitted to the hospital, or "out-patient

services" where the patient visits a hospital for diagnosis, treatment or follow-up. All Irish residents are entitled to receive in-patient and out-patient services in publicly funded hospitals. A Medical Card entitles holders to receive these services free of charge. People who do not hold a Medical Card must pay charges for certain hospital services. There is a €100 charge for those who attend accident and emergency and/or out-patient departments without a referral letter from a GP. Hospital charges (for in-patients) are a flat fee of €75 per day up to a maximum of €750 in any twelve month period.

Acute hospitals diagnose, treat and care for seriously ill or injured patients. Some hospitals are also specialist in nature providing particular services, for example maternity hospitals or mental health facilities.

In 2013, information on discharges from Irish public hospitals presented by the Healthcare Pricing Office (HPO)[2] indicated that:

- over 1.55 million discharges were reported by the participating hospitals;
- day patients accounted for 64.6% of total discharges;
- in-patients accounted for 35.4% of total discharges of which 79.5% were emergency in-patients and 20.5% were elective in-patients;
- in-patients used over 3.16 million bed days;
- just over 34% of total discharges were of patients aged 65 years and older;
- Medical Card holders accounted for 57.1% of total discharges (excluding maternity);
- public patients accounted for almost 84% of total discharges (excluding maternity);
- private patients accounted for 16.3% of total discharges (excluding maternity).

A re-organisation of the country's hospitals is currently underway. This re-organisation will involve hospitals being divided into one of 7 groups, each of which will contain between six and eleven hospitals (with the exception of the Children's Hospital Group) and will include at least one major teaching hospital.

Each group will have its own management structure and the hospitals in the group will work together as a single entity to provide acute care for people within the group's geographical area. It is anticipated that healthcare staff will work across a group rather than in individual hospitals with a view to reducing duplication in areas such as human resources and finances. The general objectives of the hospital groups are to:

- achieve the highest standard of quality and uniformity in hospital care across the group;
- deliver cost effective hospital care in a timely and sustainable manner;
- encourage and support clinical and managerial leaders;
- ensure high standards of governance (both clinical and corporate) and recruit and retain high quality nurses, non consultant hospital doctors, consultants, allied health professionals and administrators in all hospitals.

2 Activity in Acute Public Hospitals in Ireland 2013 Annual Report, December 2014, Healthcare Pricing Office

The new hospital groups are:

- RCSI - Dublin North East
- Dublin Midlands
- Ireland East
- South/South West
- Saolta - West/North West
- University of Limerick
- Children's Hospital Group

A list of the hospitals in each group can be found at Appendix 1 to this report.

The statutory complaints process

The Health Act 2004

Part 9 of the Health Act 2004 (which came into effect on 1 January 2007) established the existing statutory complaints system within public hospitals in Ireland. Under Part 9 of the Act, any person seeking or receiving hospital services either from a HSE hospital, or another service provider acting on behalf of the HSE, (such as a public voluntary hospital) has a statutory right to make a complaint if they consider that the actions of the hospital, or service provider, in delivering that service, did not accord with fair and sound administrative practice and they were adversely affected as a result. There is a twelve month time limit for making a complaint, running from the date of the action complained of, although there is also discretion to waive this requirement.

The Health Act 2004 (Complaints) Regulations 2006 provided for the establishment of a statutory complaints process to enable people to make complaints to the HSE and service providers (including public voluntary hospitals) acting on its behalf. The Regulations required the establishment of procedures for the investigation of complaints and the appointment of Complaints and Review Officers.

The requirements to be complied with by persons making a complaint were also set out in the Regulations along with an obligation on the HSE and service providers to:

- keep records in relation to the processing of complaints received;
- make available full information on the complaints process and advice on all matters relevant to making a complaint or seeking a review; and
- provide assistance to a person (or identify another person who could provide such assistance) making a complaint, requesting a review or referring the complaint to this Office (or the Ombudsman for Children, where appropriate).

Having completed the investigation of a complaint, Complaints Officers are required to make a finding as to whether a complaint is upheld or not and, on the basis of that finding, to make any recommendations which they consider fair and reasonable having regard to all the facts and circumstances of the complaint. The HSE or service provider, where it is within its remit and appropriate to do so, is required to take steps to give effect to any such recommendation made.

According to the HSE, 3,897 complaints against HSE-run hospitals were recorded in 2013. In addition, 5,573 complaints were recorded by the voluntary hospitals and agencies. Since 2013, complaints are broken down into categories in line with the eight principles of the National Healthcare Charter – access, dignity and respect, safe and effective care, communication and information, participation, privacy, improving health and accountability.

Where a complainant is dissatisfied with the recommendation of the Complaints Officer, he/she can apply to the HSE for a review of the case or can escalate the complaint to this Office (or the Ombudsman for Children where appropriate). In cases where the complainant applies for a review, the HSE or service provider is required to assign a Review Officer to review the recommendation made, where appropriate. Review Officers can either uphold, change, or vary any recommendation made by the Complaints Officer. Following this, the HSE or service provider, where it is within remit and appropriate to do so, is required to take steps to give effect to any such recommendation(s) made. According to the HSE, 124 requests for reviews were received by the HSE in 2013 relating to hospital services. In that same year (2013), this Office received 92 complaints about hospital services[3].

HSE policy - Your Service Your Say

The HSE's Your Service Your Say procedure gives effect to the legislation and outlines how users of any HSE service can make a complaint about the service they receive. While the Health Act 2004 provides that a service provider may establish its own procedures for dealing with complaints as long as they are of a comparable standard to the procedures established by the HSE, in practice all hospitals, including public voluntary hospitals, operate the Your Service Your Say procedure.

There are five stages in the process:

Stage 1

A person wishing to make a complaint can

- complete a form and either place it in the feedback/comment boxes provided or post the completed form to the hospital Complaints Officer;
- speak with a member of the hospital staff, service manager or the hospital Complaints Officer;
- ring, fax or send a letter (or email) to the hospital Complaints Officer or e-mail yoursay@hse.ie

Stage 2

- A written complaint should be acknowledged by a Complaints Officer in writing within five working days.

Stage 3

- A staff member/service manager should attempt to resolve the complaint locally; or
- a Complaints Officer will look into the issues raised in the complaint.

3 In 2014, the number of recorded complaints about hospitals (excluding mental health facilities) received by this Office increased to 262 - perhaps at least partly as a result of publicity generated by this investigation. By comparison, in the reporting year 2013-2014, the Public Services Ombudsman for Wales received 759 complaints about the NHS.

Stage 4

- The Complaints Officer will investigate the complaint within 30 working days;
- if it takes longer to look into all the issues raised in the complaint the Complaints Officer should notify the complainant within 30 working days and should give him/her an update on what is happening every 20 working days after that.

Stage 5

- Where a complainant is dissatisfied with the conduct of the investigation or the recommendation of the Complaints Officer, he/she can apply for a review of the case or can escalate the complaint to this Office (or the Ombudsman for Children, where appropriate).

Under the Your Service Your Say procedure, the HSE can offer appropriate and reasonable redress where it has been established that a measurable loss, detriment or disadvantage was suffered or sustained by the complainant. Redress can include (amongst other options) an apology, an explanation, admission of fault and a recommendation/undertaking to make a change to a relevant policy or procedure.

Your Service Your Say is not the only complaints or investigation process currently operated by the HSE. For example, some serious complaints (such as allegations of abuse) are managed under a separate HSE policy known as Trust in Care. While the HSE has in recent years attempted to standardise as far as possible the numerous policies (at least 13) associated with the investigation of complaints and incidents, so far this has not been achieved.

The role of the Ombudsman

The role of the Ombudsman, in examining a complaint, is to consider whether or not a person has been adversely affected by improper, unfair or unreasonable actions or inaction on the part of a public service provider. If this is found to have occurred, the Ombudsman will examine whether or not the public body has taken appropriate steps to remedy the adverse affect. In addition, the Ombudsman tries to ensure that public bodies deal with individuals properly, fairly and impartially.

The Ombudsman cannot examine complaints which relate to persons acting on behalf of the HSE and which, in his opinion, relate solely to the exercise of clinical judgement in the diagnosis or care or treatment of a patient. However, the Ombudsman can examine the administrative actions of healthcare professionals and administrators, taken in the course of clinical work, which do not involve clinical judgements.

Examples of issues that this Office can examine include:

- delay in providing a service
- failing to follow approved administrative procedures, protocols or reasonable rules
- poor communication
- failing to get informed consent to a procedure
- keeping poor records
- careless or rude behaviour
- failing to respect a person's privacy and dignity
- giving slow or unsatisfactory responses to letters
- failing to provide reasonable assistance and guidance

- failing to deal properly with a complaint and to provide information on any rights of appeal or review

Other channels for complaints – the Protected Disclosures Act 2014

The Protected Disclosures Act 2014 provides legal safeguards for people who want to report serious concerns about standards of safety and quality within the health and social care services. Such disclosures will qualify as "protected" if certain criteria (as laid down in the Act) are met. Disclosures can be made by health service employees or members of the public to the HSE or a number of regulatory bodies including the Health Information and Quality Authority (HIQA) and the Mental Health Commission.

The role of Regulators

Regulators have responsibility for protecting the quality and safety of hospital health services. Regulators can regulate different aspects, for example, they can be responsible for health professionals or for health service quality.

The professional regulators include:

The Medical Council

The Medical Council can investigate complaints about individual doctors in relation to a number of issues including professional misconduct and poor professional performance. It can examine matters relating to clinical judgement. The legal framework for the Medical Council's complaint procedures is set out in the Medical Practitioners Act 2007.

The Nursing and Midwifery Board of Ireland (NMBI)

Complaints against nurses or midwives can be made to the NMBI. As with the Medical Council, there are a number of grounds for making a complaint including professional misconduct, poor professional performance or non-compliance with a code of professional conduct. It can also examine matters relating to clinical judgement. The legal framework for the NMBI's complaint procedures is set out in the Nurses and Midwives Act 2011.

The role of the Medical Council and the NMBI is discussed in greater detail in Chapter 5 of this report.

CORU

CORU is Ireland's multi-profession health regulator and was established under the Health and Social Care Professionals Act 2005, as amended. It includes the Health and Social Care Professionals Council and 12 registration boards. Its role is to protect the public by promoting high standards of professional conduct, education, training and competence through statutory registration and regulation of health and social care professionals. CORU can investigate complaints about registered health or social care professionals failing to meet the agreed professional standards. Where a complaint is upheld, the Health and Social Care Professionals Council of CORU may impose sanctions which can include censure, the attachment of conditions to or the cancellation, or suspension of, a member's registration. The professions regulated include dieticians, occupational therapists, physiotherapists, radiographers and social workers.

System regulators include:

HIQA

HIQA is the independent body established in May 2007 with responsibility for ensuring continuous improvement in Ireland's health and social care services. It is concerned with developing standards, monitoring compliance with standards and carrying out investigations where there are reasonable grounds to do so.

HIQA does not have a remit to address individual complaints or incidents in relation to healthcare services provided by or on behalf of the HSE. However, it is open to receiving information about matters which could indicate a risk to the health and welfare of service users – this information is used to inform ongoing monitoring programmes. In very serious cases, HIQA may initiate or be asked by the Minister for Health to carry out an investigation into the safety, quality and standard of healthcare services, if there is a clear risk to service users.

The Mental Health Commission

The Mental Health Commission is an independent statutory body, established in April 2002 under the Mental Health Act 2001. Its main functions are to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of patients who are involuntarily admitted to approved centres providing mental health services. The Mental Health Commission does not investigate individual complaints but can use information from complaints to inform inspections.

As part of the Mental Health Commission, the Office of the Inspector of Mental Health Services is made up of the Inspector of Mental Health Services and a multi-disciplinary team of Assistant Inspectors. The functions of the Inspector include visiting and inspecting every approved centre at least once each year and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate.

In 2014, the Mental Health Commission published a report of the Inspector of Mental Health Services. This report showed that in 2013, only 66% of approved centres were fully compliant with the legal requirements in respect of complaints procedures, as set out in Article 31 of the Mental Health Act 2001 (Approved Centres) Regulations 2006. One of the report's other findings was that the quality of recording of complaints was poor in many approved centres.

"A reason that people do not complain might be that the procedure they have to go through would make most people ill"

Submission from member of the public

Chapter 2
What the public told us

What the public told us
Submissions from members of the public

As outlined in Chapter 1 of this report, this Office invited members of the public to share their experiences of the hospital complaints system.

87 submissions were received from members of the public. 37 of the submissions received were from people who had been patients in a public hospital. The remainder of the submissions (50) were received from advocates/carers and/or relatives (only 1 of these was from an advocate not related to the patient).

Overall, the general trend from all of the submissions received is that **the complaints process is not easy to navigate, that it is difficult to get to talk to or meet with a Complaints Officer and patients/relatives are not always notified of the right of review to the HSE or this Office.**

- Many of the patients said they did not make a complaint as they feared the repercussions for their ongoing care and treatment.
- Some of the relatives who told us they did not make a complaint were also fearful of the repercussions for their loved ones (who remained in the care of the hospital concerned) if they made a complaint.
- A small number had relatives who work for the HSE and were fearful of negative repercussions for them and their careers if they pursued a complaint.
- There was a clear feeling expressed that nothing would change as a result of complaining and that the time spent complaining would be better spent with their relatives.
- 41 respondents made formal complaints to the hospital concerned. Another respondent told us that he wanted to make a formal complaint but was not given any information on how to do so.
- A number of respondents sent e-mails or made telephone calls to the hospital concerned in an attempt to make a complaint but did not receive any acknowledgement of the complaint or any call back from the hospital. In three cases, the respondents told us that they were promised further contact from the hospital but no contact was made.
- A small number of complaints were made informally at ward level, and in one of those cases, the staff nurse told the patient she would pass his complaint to the doctor and the doctor would make contact. He told us that he is still waiting for the doctor to make contact.
- Six of the cases submitted to us had not yet completed the complaints process, even though the 30 days timeframe for a response (as required under Your Service Your Say) had passed. In those cases, no progress updates had been provided by the hospitals concerned.
- One relative said that she had made a formal complaint to the hospital but the family subsequently wanted to withdraw this complaint to spend the time caring for their relative in peace before he passed away. She received a response from the hospital to tell her that, even if she did not want to pursue the formal complaint, the hospital would carry out an internal review of the patient's care and contact her again. The family never heard about the outcome of the internal review.

- Another respondent said that she wrote to the Chief Executive of the hospital concerned detailing her experiences. While she and her husband were called to a meeting with the Chief Executive, she said that the Chief Executive did not answer any of her issues but simply let her tell her story. After the meeting, she received a letter which again, in her view, did not address the issues but thanked her for the meeting and wished her a speedy recovery.
- On a more positive note, one person who contacted us said she made her complaint to her Consultant who directed her to contact the Nursing Manager. Within 24 hours, the Nursing Manager had contacted the patient and listened to her concerns. She said she would address the issues with the relevant staff member involved in the care. The patient was not advised of her right of review but she was nonetheless happy with the way her complaint was handled by both the Consultant and the Nursing Manager and did not feel it was necessary to escalate it to the HSE or this Office.
- A number of respondents were not told of their rights to escalate their complaints to the HSE and/or this Office. (In a small number of cases, the respondents were not even aware of the existence of an Ombudsman).

"If making complaints became constructive criticism rather than a stick to beat people with, we actually might get somewhere to make things easier"

Submission from member of the public

HIQA Red C Poll 2010

In July 2010, HIQA carried out a public opinion poll ahead of its consultation process on the draft National Standards for Safer Better Healthcare. The poll asked members of the public for their opinions on important areas of quality and safety in healthcare. The results of the poll provided interesting information on the standard of healthcare received by respondents and on making complaints about the services provided. On the question of whether respondents ever felt that the healthcare they received was below what they might expect, 43% said that they had. However, only one third of those who had a negative experience went on to make a complaint.

Those who experienced services below expectation or who had made a complaint were asked what supports would help in making complaints about the standard of healthcare. In this regard:

- **82%** said that it was important that staff were open to complaints when they arise;
- **68%** said that no one took responsibility for service levels in healthcare;
- **68%** said that it was difficult to know who to complain to; and
- **34%** said that they felt too intimidated to make a complaint.

Respondents were then asked how beneficial, in their view, would each of the following supports be in making it easier for people to make a complaint about substandard healthcare. The following were considered to be beneficial:

- Polite and approachable staff **(96%)**
- Certainty that treatment would not be negatively affected by making a complaint **(93%)**
- Having information on the complaints process **(93%)**
- Understanding how complaints are managed **(91%)**

Focus Groups

Focus groups (involving 16 participants in all) were held as part of this investigation. These focus groups were made up of members of the public who made a submission regarding this investigation and a small number of people who had complained to this Office in the past. While the focus groups were a relatively small sample, it nevertheless gave us an opportunity to explore some of the issues raised through the public submissions in greater detail.

The participants included people who:

- had considered making a complaint to the hospital but did not;
- made a complaint informally to the hospital;
- made a complaint to the hospital Complaints Officer but did not pursue the matter further after that;
- made a complaint to the hospital Complaints Officer and subsequently requested a review of the matter from either the HSE or this Office.

Key findings of the focus groups

The key findings of the focus groups were:

- the two main barriers to not making a formal complaint were fear of **possible negative repercussions** and the **feeling that it would be pointless;**
- the main motivations in making a formal complaint were to protect someone else from suffering, a desire for service improvement and a wish to get the hospital to acknowledge it was wrong;
- at the time of their complaint (i.e. when they first made the complaint), just over four-fifths of the participants were aware that they could complain formally to the hospital (i.e. involving the Complaints Officer), considerably fewer were aware of the option of escalating their complaint to the HSE or this Office;
- the overwhelming majority of participants who had made complaints were relatives or carers, two had made complaints as a patient;
- there was wide variation in participants' perception of the awareness of hospital staff of their own complaints processes, some participants felt that hospital staff clearly understood the complaints process whilst others felt that they clearly did not;
- the overwhelming view, (of almost two-thirds of the focus group participants), was that the response of hospital staff to a complaint was "defensive";
- the overriding sentiment amongst the vast majority of participants was immense dissatisfaction with the extent, quality and consistency of information they were given about how to complain. More than two thirds stated that they had received "very little information/not very clear information" or "no information";
- in the end, almost three-quarter of participants escalated their complaint beyond the local hospital complaints process;
- focus group participants indicated that "someone else" (i.e. an entity outside the hospital complaints process) had been the most helpful in terms of making a complaint. The 'someone else' were colleagues, friends, family (who provided practical and emotional support) and the internet (for information on the process);
- two-fifths of participants considered that hospital administrative staff (including the Complaints Officer) were the least helpful during the complaints process;
- three-quarters of participants reported that they had not felt listened to/believed when they brought their complaint to the attention of hospital staff. Well over half specified that they had felt dismissed;
- the two main reasons focus group participants gave for withdrawing/discontinuing the complaint were that the process was too stressful or "something else" i.e. they felt like a nuisance or were afraid of negative repercussions;

- of the three participants who pursued their complaint to a conclusion, one indicated that they were satisfied; another stated that they were not very satisfied; whilst the third reported that they were not at all satisfied; and,
- of the nine participants who indicated that they were dissatisfied with the outcome of their complaint, the majority (5 participants) indicated that they were advised of the option to have this Office look at the complaint if they were dissatisfied. However, over two-fifths (4 participants) indicated that they had not been advised of this option.

Some of these key findings are explored in greater detail as follows:

Biggest barriers to making a formal complaint

Participants identified several barriers to making a complaint. However, two specific barriers were cited much more frequently than all the others. These were:

- The **fear of possible negative repercussions** from making a formal complaint was a barrier for half of the participants (8 participants) - for example, one participant indicated that before a complaint had been made, hospital staff had been flexible about visiting times. However, after the complaint had been lodged, hospital staff insisted that the carer/relative adhered absolutely to official visiting times. Another participant explained that their relative was adamant they did not want a complaint made because they believed they had witnessed how other patients had been verbally abused following a complaint being made.
- The feeling that seeking to raise a complaint and get a resolution was **pointless** was a barrier for almost a half of participants (7 participants). As they saw it, professional allegiance interferes with objectivity; and patients and carers/relatives could be worse off in terms of how they were treated – in short, it was simply "not worth the effort".

The motivation behind making a formal complaint

- The primary motivation for making a formal complaint was **protective** i.e. to protect someone else from suffering (12 participants).
- The second most frequently cited motivation (11 participants) was for **acknowledgement** i.e. to get the hospital to acknowledge it was wrong.
- The third most frequently cited motivation related to a desire for **service improvement** i.e. to bring about positive change (10 participants).

Amount of information provided by hospitals about making a complaint

Participants appeared to receive different amounts of information to assist them to make a complaint, the clarity of which also differed:

- The experience of over two thirds (11 participants) appeared to be negative. They said that they had received "very little information / not very clear information" or "no information". Almost one third (5 participants) indicated that they had received "no information" or that the information was "not at all clear".

- Close to one fifth (3 participants) indicated that they received "some information/some of which was clear";
- However, just over one in 10 (2 participants) stated that they had received "lots of information/ very clear".

Response of the hospital to the complaint

Participants reported a variety of responses from hospital staff to their complaint:

- The overwhelming view, of almost two-thirds of focus group participants (10), was that the response of hospital staff was **"defensive"**;
- Close to one fifth (3 participants) experienced the response of hospital staff as "not very helpful" or "not at all helpful";
- Again, close to one fifth (3 participants) experienced the response of hospital staff as "helpful";
- No one said that the response of hospital staff was "very helpful".

Reasons given for withdrawing/discontinuing a complaint

The two main reasons focus group participants gave for withdrawing/discontinuing the complaint were:

- The process was too stressful (4 participants);
- "Something else" (4 participants). The "something else" was:
  - **Feeling like a nuisance;** and,
  - **Fear.**

Confidence in the hospital complaints system

- More than two thirds of focus group participants (10) described their confidence in the hospital complaints system as "non-existent".
- A further 13% (2 participants) described it as "poor".
- Two participants indicated that they had a "fair" degree of confidence in the hospital complaints system.
- One participant rated their confidence in the hospital complaints system as "good".
- No one described their degree of confidence in the hospital complaints system as "excellent".

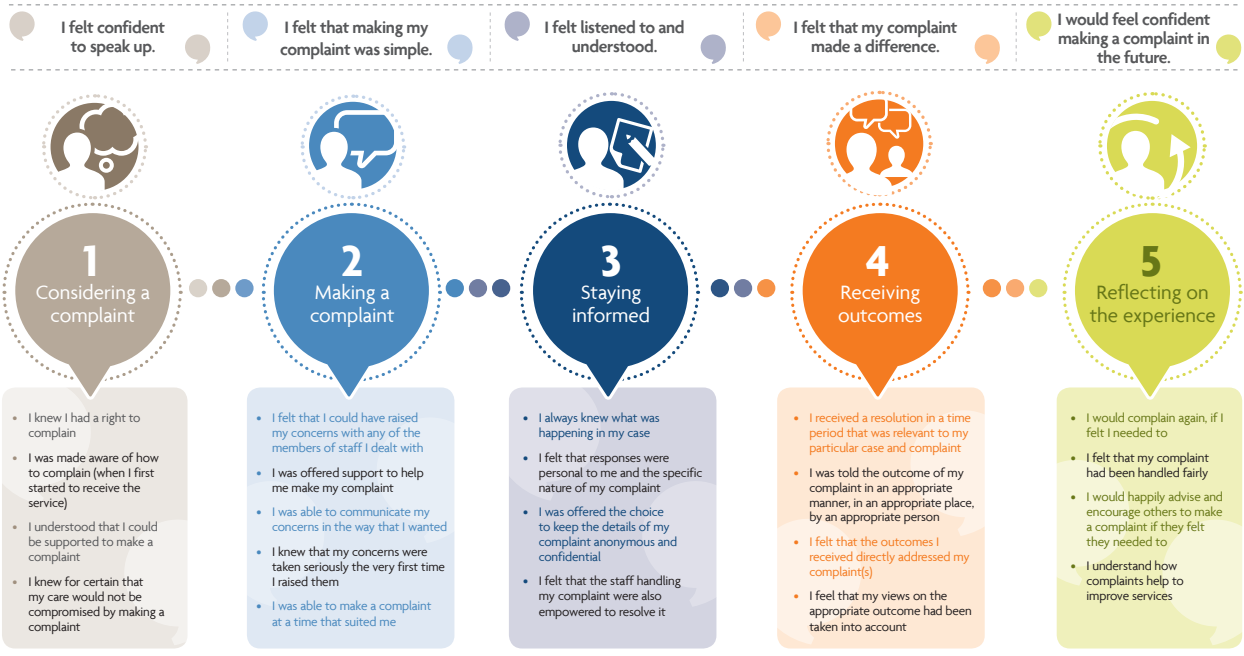
Healthcomplaints.ie

Healthcomplaints.ie is a website developed by a group of organisations chaired by the Office of the Ombudsman. The Medical Council, the Citizens Information Board, the Irish Patients Association, the HSE, HIQA and other regulators were involved in its development.

It provides information on how to make a complaint or give feedback about health and social care services in Ireland and provides links to complaints procedures for specific organisations. It has been developed as a one-stop information site for all those who use health and social care services as well as for their families, carers and advocates.

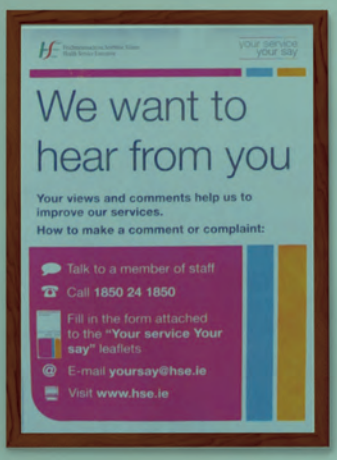
This is an example of what 'good' may look like from a user perspective when making a complaint about a hospital service. It is taken from a report by the United Kingdom's Parliamentary and Health Service Ombudsman, Local Government Ombudsman (LGO) and Healthwatch England called *My expectations for raising concerns and complaints* and is reproduced here with their permission.

A user-led vision for raising concerns and complaints



Chapter 3

What the hospital complaints system told us



What the hospital complaints system told us

As part of our investigation, we visited eight public hospitals throughout the country. Six of these hospitals were general hospitals, one was a maternity hospital and another was a mental health facility.

Access

The visits to the selected hospitals found that, in most cases, the complaints procedures are accessible, clearly written and fairly well signposted. The documented processes and procedures adhere to statutory regulations (and in particular Part 9 of the Health Act 2004) and resemble (in writing at least) best practice. In seven of the eight hospitals visited, there is a designated Complaints Officer who is the named contact for those wishing to make a complaint. In all the hospitals, information on how to complain is available at or close to the hospital reception and, in some cases, also scattered throughout the hospital. Comment boxes are also visible in six of the hospitals visited (although not always close to the complaint information leaflets and forms and in one case the key to a comment box had been mislaid some time ago). However, in looking beyond the written and standard processes, some issues emerged.

Accessibility of Complaints Officers

A point of human contact is a valuable source of information and assistance in making a complaint. While, in some hospitals, the Complaints Officers are situated in accessible locations and complainants are able to drop in to discuss their complaint, in others the Complaints Officers are not always available on site to meet potential complainants. In one case, the Complaints Officer is located in a separate building some minutes walk from the main hospital.

For those Complaints Officers who are located on site, facilities are not always adequate or sensitive to the needs of the service. For example in one hospital visited, the designated Complaints Officer, while based at the far end of the hospital, routinely met with complainants in the hospital reception in full view of many other patients and visitors. In that hospital, no facilities close by are earmarked for meeting complainants.

Bright spot

Complaints Officer located beside reception

It is important that patients and their families / carers should know who to go to with questions or concerns. While in many cases this can be a member of staff on ward level, the Complaints Officer should also be clearly visible and accessible to everyone in the hospital.

In **Portiuncula Hospital**, Ballinasloe the Complaints Officer has an office located right behind the main reception and is clearly visible to all those entering and leaving the hospital. Those wishing to raise a concern or make a complaint therefore have a visible and easily accessible place to do so without having to travel through or (in some cases) outside the hospital building.

Complaint information – hospitals

As part of the investigation, this Office issued a questionnaire to each public hospital (including maternity hospitals and mental health facilities) regarding how its complaint handling service was advertised (Appendix 2). All hospitals (a total of 56 in all) responded to the questionnaire with most indicating that they comply with the provisions of the Your Service Your Say complaints procedure.

We asked each of the hospitals how it made patients and their families aware of its complaint system. (The hospitals were allowed to select each option that applied to them):

Notices/Posters on hospital premises	51
Information leaflets (usually Your Service Your Say)	48
Hospital/HSE website	37
Admission/Discharge documentation/booklets	36
Directly from staff	11
Other (e.g. TV display, local exhibitions)	3

Many of the hospitals supplied samples of notices, posters and information leaflets, some in a variety of languages, which they use to promote Your Service Your Say. Some hospitals also provided examples of their 'Welcome Packs' or patient information booklets which included information on how to make a complaint.

49 of the hospitals surveyed stated that they have complaint forms within the hospital. Many use the Your Service Your Say complaint form. Some hospitals stated that patients and families can make complaints by letter, by e-mail or in person. 51 hospitals said complaints could be made online (although it is not currently possible to complete the Your Service Your Say form online).

We asked how patients and their families can access complaint forms:

On display in the reception area/waiting areas	36
On wards	26
From HSE website	7
Staff	7
Near the Complaints Officer's office	5
Comment boxes throughout hospitals	4

40 hospitals surveyed stated that they have a Patients' Charter. These hospitals make the Patients' Charter available to patients and their families in the following ways:

On hospital premises/displayed in public areas	38
Information booklets	12
Through website	11
Comment Card/Surveys	3
Staff information sessions	3

Correspondence to complainant	2
Written into complaints policy	1

45 of the hospitals surveyed stated that they have criteria or guidelines on how to recognise a complaint. However, two hospitals indicated that staff at all levels were not made aware of the existence and workings of the hospital's complaints system and patients' rights.

We then asked hospitals how they make their staff aware of the complaints system:

Complaints policy	15
General staff training	15
Staff induction training	9
Staff meetings	7
Documentation on information management system (e.g.: QPulse)	5
Complaint form/Patients' Charter /Your Service Your Say leaflets and posters	5
Complaint sessions/Discussion on complaint reports	4
Staff newsletter	1
Monthly hospital board meetings	1

Under the Ombudsman Act 1980, as amended, organisations such as public hospitals must provide information to people on their rights of appeal or review, including the right to complain to this Office. It is also useful to include the contact details for this Office. Before bringing a complaint to the Ombudsman the person is expected to have tried to resolve their complaint with the hospital.

53 of the hospitals surveyed stated that they make patients and their families aware of their right to complain to this Office. (Following receipt of the questionnaire others indicated that they will now comply). These hospitals stated that they make patients or their relatives aware of the right to complain to this Office in the following ways:

In a letter to the complainant following completion of complaint examination	40
In a letter acknowledging the complaint	11
Your Service Your Say leaflet	6
Complaints policy	6
Verbally to complainant/in person	4
Through the website	4

Complaint information - websites

Hospital websites can be a useful tool for providing information about the complaints process. All of the public voluntary hospitals have their own website. For those hospitals operated by the HSE, an internet presence usually means a page on the HSE website.

As stated earlier in this chapter, 51 of the hospitals surveyed said that it is possible to make a complaint online. We therefore conducted a spot check of all hospital / HSE websites as part of this investigation. The aim of this was to ascertain whether hospitals present information on how to make a complaint in a sufficiently clear and obvious way.

At the time the websites were checked, approximately 30 of the hospitals did not have their own websites, but relied on pages within the HSE's website. Within the HSE's own website, there are varying degrees of information available for each of the hospitals. For example, 14 hospitals on the HSE website do not make any mention of the complaints procedures, do not provide any information about a named person responsible for complaints in the hospital or any details of what the complaints policy is in that hospital. By contrast, one hospital has two direct links for e-mails on its site, one for comments/suggestions about the site and the other for the Complaints Officer within the hospital.

Some hospitals give details on their websites of who the complainant is to contact to make a complaint (usually a job title or department instead of a named person) and seven others link complainants to the HSE's Your Service Your Say. One hospital group (comprising both voluntary and HSE-run hospitals) has a "Send Feedback" link which provides various options for making a complaint/comment/feedback about any of the hospitals in the group. However, some of the information is incorrect and, in particular, it does not clearly state that you can either seek a review by the HSE or refer the matter to the Ombudsman. Three other hospital websites on the HSE page have "Patient Information Leaflets" or "Patient Service User Leaflets" which contain limited information about making a complaint and is aimed at patients rather than their families or carers.

In relation to those hospitals (21 in all) that have their own websites, all of these have information about the complaints process on their sites. Some can be found under the "About Us" tab, some under the tab marked "Patient Information" or "Patient & Visitor" while others have direct links to "Feedback" facilities. 12 of these hospitals provide direct links to either e-mail addresses or comment boxes for people to make their complaints and/or comments online. Of those who did not provide direct links, information was provided in other formats. As stated earlier, the Your Service Your Say complaint form cannot currently be completed online.

14 hospitals did not advise patients of their right to have the complaint examined by this Office, while five hospitals mentioned the review process in some form, but in all 5 cases referred to it as an "appeal" system. One hospital offered an "appeal" to either the Ombudsman or the HSE Appeals Office in Donegal which is not the appropriate forum for an internal HSE review about hospital care. Another hospital did not mention the complaints policy, the HSE or the Ombudsman but simply offered a link to the website 'healthcomplaints.ie' to those wishing to provide "feedback".

Information can also be given to patients and service users before they make a complaint as a way of encouraging feedback. In many hospitals visited, this is provided at the point of admission and/or hospital receptions areas / waiting rooms – mainly through the Your Service Your Say posters. While few hospitals have produced their own patient information booklets, those that had, (including a small number of HSE hospitals) had produced quite detailed and helpful booklets.

Bright spot

Outreach (Health Fair)

It is important that all users of hospital services are aware of their right to complain and are given information on how to complain.

The Patient Community and Advisory Council of **Tallaght Hospital** is a community-based group which contributes to understanding the experience of patients and families using the hospital services. An example of this is that, once a year, the hospital takes part in an outreach Health Fair. This Health Fair is held in a community hall and all members of the local community are invited to attend. The event is advertised in the local media. It is staffed by hospital staff including Clinical Nurse Managers and explains about supports available to people in the hospital and how to make a complaint, etc. Complaints can be accepted by the staff during the Health Fair although complainants can also make a more "formal" complaint at a later date.

Making a complaint

All the hospitals surveyed said that they provide information on the complaints process to complainants and, in some cases at least, provide both an estimate of the date by which a response should issue and the contact details of the Complaints Officer responsible.

Most hospitals surveyed as part of this investigation use the Your Service Your Say complaint form. Some, though by no means all, of the hospitals have also designed their own in-house complaint form. However, in using these forms, patients are not prevented from submitting their complaint in free form, whether by letter, e-mail, etc. In one hospital, the in-house complaint form is no longer used as it was felt that complainants preferred to communicate in their own format (whether in addition to or instead of the complaint form).

In addition, some Complaints Officers call to wards to meet complainants who are still in-patients in the hospital in order to take a complaint, to discuss their complaint and, if possible, resolve it. None of the hospitals visited as part of this investigation have therefore an unduly formal approach to accessing the complaints process, e.g.: no hospital required complainants to put their complaint in writing.

Guaranteeing access

When asked about whether there were any measures in place with respect to complaints from potentially vulnerable groups, the single most common response from hospitals focused on the provision of interpretation and translation. All hospitals appear to have arrangements in place to offer an interpretation service when required (although it is noted that few hospitals provide complaint information and forms in other languages apart from English). However, few of the hospitals appear to have considered other access issues that may arise, such as literacy and disability issues. For example, none of the hospitals had information leaflets available in Braille. On a positive note, however, the majority of hospitals visited (who had patient information leaflets) had consulted with the National Adult Literacy Agency (NALA) in producing their literature, posters, etc. In one hospital, NALA had also provided an afternoon of training which staff involved in complaints handling were able to attend.

The Disability Act 2005 places significant obligations on public bodies (including hospitals) to make their buildings and services accessible to people with disabilities. This obligation therefore would include making a complaints process fully accessible. The appointment of an Access Officer is also a legal obligation under the Disability Act. An Access Officer provides or arranges for and co-ordinates the provision of assistance and guidance to persons with a disability in accessing its services. However, when asked, half of the hospitals visited did not have a designated Access Officer, although in at least one case, this has since been rectified.

According to the HSE, 125 Access Officers attended training sessions organised by the HSE by January 2015. Of those trained, only 27 were from acute hospitals (representing 24 hospitals in total). Access Officers from a further thirteen acute hospitals were due to attend training by the middle of April 2015. We understand that the HSE has written to all hospitals and other HSE facilities reminding them of their obligations under the Disability Act and the importance of an Access Officer being appointed and appropriately trained. In January 2015 the HSE and the National Disability Authority launched the *National Guidelines in Accessible Health and Social Care Services*. These guidelines aim to give practical advice to all health and social care staff on how they can provide accessible services to patients and clients with a disability.

Only one hospital visited had implemented a separate advocacy service by allowing volunteers to work as advocates for patients. However, while they provide an excellent service, this role is currently limited to getting patient feedback – they are not at present in a position to assist with complaints although they may discuss them with the ward manager.

Process

Timescales

Your Service Your Say provides that Complaints Officers should examine a complaint within 30 working days of acknowledging the complaint. All hospitals are aware of this requirement and strive to meet it (with varying degrees of success). While one hospital says that it meets this deadline in 100% of cases, other hospitals admitted that they only meet the deadline in fewer than 70% of cases[4]. The majority of hospitals, however, reported challenges in meeting the timeframes for responding due to the complexity of complaints and the need to involve other people within the hospital.

Your Service Your Say also provides that a complaint must be made within 12 months of the date of the action giving rise to the complaint or within 12 months of the date when they first became aware of the action. However, this deadline can be waived if the Complaints Officer is of the opinion that there are special circumstances which make it appropriate to do so.

All hospitals visited do not appear to regularly enforce the timeline of 12 months and operate a flexible approach to accepting complaints outside that deadline, recognising that people who may be recovering from illness or bereavement may need a little more time. In fact, some hospitals were looking at complaints relating to actions that occurred many years ago. While this may present evidential problems, the flexible approach adopted by the hospitals should nevertheless be welcomed.

4 The HSE Service Plan for 2015 expects to meet this target in 75% of cases. The project outturn for 2014 is 69%.

Clinical judgement

As discussed elsewhere in this report, matters relating to clinical judgement are currently excluded from the statutory complaints process. However, the hospitals visited nevertheless still examine complaints that relate solely to clinical judgement, albeit outside the statutory complaints process. In most cases, the matter is assigned for "review" to a senior clinician and the complainant is provided with a response to their complaint. However, it was noticed that, as they are considered to fall outside the complaints process, further review options are not signposted in many of these cases.

Clinical judgement

Under Part 9 of the Health Act 2004, issues relating to clinical judgement (that is judgments made by clinicians relating to diagnosis or decisions about treatment) cannot be dealt with under the statutory complaints process. Clinical judgement is also excluded from the Ombudsman's remit by virtue of Part II of the First Schedule to the Ombudsman Act 1980, as amended. Where a complainant is unhappy with a matter relating to clinical judgement, it may be open to him or her to go to the appropriate professional regulator (the Medical Council, the NMBI, etc.). However, the threshold for considering a complaint about professional practice is often much higher than the threshold an Ombudsman would have for considering a complaint.

In the UK, clinical judgement was originally excluded from the remit of the Health Service Ombudsman. That was changed in 1996 when the Ombudsman was given the authority to investigate all aspects of NHS care and treatment, including clinical judgement. At present in England, Wales, Scotland and Northern Ireland, the Ombudsmen can investigate such complaints and does so without encroaching on the area of jurisdiction of the professional regulatory bodies. The two processes sit alongside each other to provide a single, joined-up approach to investigating healthcare complaints.

In reality, few complaints relate solely to clinical judgement but instead contain issues of a clinical nature which involve administration issues such as communication. These complaints can be examined under the statutory complaints process and by this Office.

This Office has recently made a formal submission to the Department of Public Expenditure and Reform seeking to extend its jurisdiction to matters relating to clinical judgement. We are also liaising with the Department of Health in this regard.

Status and Role of Complaints Officers

From our examination of hospital structures (including the hospitals visited as part of this investigation), Complaints Officers do not often form part of the senior management team within the hospital. Instead, their grade varies from PA to the Chief Executive to Grade 8 level (below functional officer grade, e.g.: Assistant Director of Nursing level). The overwhelming majority of Complaints Officers report to a more senior member of staff.

The most effective way of ensuring responsiveness within the complaints process is through visible senior management engagement and support. The Complaints Officer's relationship with the Chief Executive also varies. Some Complaints Officers surveyed work directly to the Chief Executive /

General Manager and enjoy high levels of access. Others report at lower levels within the governance or risk structure of the hospital.

When complaints have to compete with a range of other work, there is always a risk that they are not given adequate priority. One of the most striking results of the survey to all hospitals and the subsequent visits was that, while all hospitals except one have a designated Complaints Officer, only one Complaints Officer is working full-time on handling complaints. The time spent on other work varies from hospital to hospital (from on average 30% of their working time to 55% of their time) while the nature of that other work varies from other patient services work to General Manager of the hospital.

Training in complaints handling also varies from mandatory training, to ad hoc sessions, to no training at all. In over half of the hospitals visited, the designated Complaints Officer had not received specialised training. In some cases, the training received by Complaints Officers had been provided by the HSE following the introduction of Your Service Your Say in 2007 and has not been updated since.

In this regard, just two of the hospitals visited offer a module on complaints as part of induction training for all new hospital staff. In one hospital, all staff were invited to customer care training in 2014, however, as the hospital pointed out, it was difficult to get staff released to attend and even then statutory or mandatory clinical training (such as the recent Ebola preparations) would have to take precedence. In addition, while there is phased implementation of the HSE Open Disclosure policy in all hospitals following its launch in November 2013, actual training on the policy has begun to be rolled out in only some of the hospitals.

Bright spot

Complaints process as part of induction training

While the business of dealing with complaints is mainly seen as the responsibility of the Complaints Officers, all staff have a role in being able to respond to concerns or expressions of dissatisfaction. They should also have a good understanding of how the complaints process operates within the hospital.

In the **Mater Hospital** a module on the complaints process is a standing slot (on a monthly basis) for the corporate induction programme for all new staff regardless of discipline or grade. This module lasts approximately one hour and serves to both introduce the hospital complaints policy and explain the process and pathways for complaints.

Early resolution

It was clear from the site visits that all hospitals encourage informal early resolution of complaints. This can have many advantages and can often stop a complaint escalating to the more formal complaints process. However, only two of the hospitals interviewed actually document and record these interactions in any organised way.

Bright spot

Recording verbal complaints

When things go wrong or when a patient or their family is unhappy with the care being provided, an immediate response and action at ward level to put things right can prevent a complaint escalating through the formal process.

In the **Coombe Hospital**, staff are encouraged to document these complaints and have developed a form (a "verbal complaint form") to do so. These forms are available on the wards and allow staff to record the issue complained of and the action taken to resolve it. The verbal or informal complaints are therefore dealt with in a similar way to any other complaint made while recording these complaints ensures that trends and learning can be identified and shared.

Case management systems

All hospitals visited operate some form of case management information system in order to track and record complaints. Ideally, a management information system should capture the information the hospital needs and its use should be compulsory for every staff member who is involved in complaints.

One of the hospitals visited is currently taking part in a pilot project for the roll-out of the National Incident Management System (NIMS). NIMS is the national web-based system hosted by the State Claims Agency for the reporting of incidents associated with clinical activities in all services funded or wholly managed by the HSE. Any adverse event or "near miss" directly related to service user treatment or care which has or could have resulted in an adverse outcome must be reported to the State Claims Agency's Clinical Indemnity Scheme via NIMS. The system's clinical incident reporting feature is designed to support sharing of learning from near misses and serious adverse clinical events, at local and national levels. It is understood that the system includes a complaints module although this has yet to become operational. It is hoped that its use should help to improve reporting and management of incidents. Implementation of the system has so far been confined to a small number of voluntary hospitals but we understand that the HSE aims to have it implemented across the hospital groups in the coming months.

However, at present, the systems used by the hospitals range from manual hard copy registers to office software such as Excel to more complex purpose-built systems. In the case of the purpose-built systems (such as Q-Pulse) there is also a wide variation in how and by whom it is used. In two hospitals visited, it has been adopted throughout the hospital and is used to circulate hospital policies and circulars as well as complaint information. However, in most cases, it is used solely for tracking and recording complaints. Unfortunately, even in these cases, some Complaints Officers admitted that they do not have time to update the system in a timely way.

A number of years ago, the HSE developed a template to act as a checklist when handling and dealing with complaints. Although it is our understanding that this template was circulated to all hospitals, we saw evidence of it being used in only one hospital to any degree.

Bright spot
Complaint checklist

When a hospital has a complaints procedure in place that can involve several steps, it is important that each of the steps is identified and actioned. These steps and those responsible for each step can be noted on a complaints checklist.

Our Lady of Lourdes Hospital, **Drogheda** has one such checklist in use for all formal complaints. It is used by the staff when setting up complaint files and contains detailed information about the steps to be taken for dealing with complaints. It outlines the types of complaints that fall into each category. For example category 1 complaints relate to non clinical issues such as car parking or other facilities; category 2 is used when the complaint relates to a number of areas, such as treatment, care, staff behaviour, invoices, etc. and category 3 type complaints relate to clinical issues. The checklist has prompts about ensuring the plan is completed and provides that a review date can be added to the list.

Response

Responding to the complaint

Part of this investigation included examining a number of randomly selected completed complaint files (6 from each hospital visited) to determine whether complaints are well-handled in a way that matches good practice. We found that, for most hospitals, the standard of response to the complainant was relatively clear, addressed the key issues raised and was often empathetic. This type of response can be a major step in resolving an issue. Apologies were freely given in most cases as an acknowledgement of the patient's experiences (even if the complaint was deemed to be unsubstantiated). There was little evidence, however, that the hospitals took steps to ascertain whether the complainants were satisfied with the response and the outcome.

In at least one hospital visited, many of the complaints are responded to (and resolved) through face to face meetings with the Chief Executive or a senior clinician. Such meetings are often an effective way to resolve complaints to the satisfaction of the complainant. Another hospital often uses telephone calls to the complainant as a way of responding. However, in closing the complaints in this manner, there is little evidence as to whether the hospital concerned provides details to the complainant as to the next step to take if he or she is unhappy with the outcome of the complaint.

We found that in at least one hospital, the final response to complainants often includes a reaffirmation of the right to complain and expressly states the organisation's commitment to that right and to learn from it. However, unfortunately, with many of the hospitals visited, there was little or no evidence that the complainant (or indeed hospital staff) was kept informed as to how his or her complaint was acted on and whether any changes or improvements were made to the service as a result.

Redress

All of the hospitals visited as part of this investigation appear willing to offer an apology as appropriate. In three of these hospitals, an apology is offered to the complainant as a matter of course as an acknowledgement that their experience engaging with the hospital service was not as they would have wished. However, just as few complainants are kept informed as to whether any changes were made as a result of their complaint, few hospitals could provide us with examples of improvement and/or changes to hospital practice and procedure as appropriate redress offered. No hospital offers financial compensation as a method of redress although some charges may be waived in certain circumstances (e.g.: the charge for attending A&E if the service was deemed to be less than satisfactory upon examination). Unfortunately, two of the hospitals visited do not keep any information on the types of redress offered to complainants.

Leadership

Role of Senior Management

This investigation found that the level of senior management involvement within the complaints process varies significantly between hospitals. In one hospital, the Chief Executive is very involved in the complaints process – her PA acts as the first point of contact for complainants while she signs the final response letters to complainants. She also sits on the hospital's complaints review group along with other members of the hospital's senior management. In another hospital, the General Manager is routinely copied in on all responses. However, unfortunately, the investigation also found that other senior managers are not involved in the complaints process to any significant degree and instead delegate it to the Complaints Officer (and in one case, the various business units within the hospital) without a feedback loop being in place.

Notwithstanding this, however, all hospitals have some form of reporting structure (to the hospital Board) in respect of complaints. These reports primarily focus on the numbers of complaints received and the broad subject matter of those complaints, rather than on complaint outcomes or particular issues raised. However, two hospitals provided examples of a different focus on complaints. One hospital visited provides a very detailed report to its Board every six months on the complaints received and some of the stories behind them, while another hospital starts each Board meeting with a complaint or compliment ("a patient's story").

As part of the examination of randomly selected hospital complaint files, the number of complaints involving the input of members of the senior management teams was also looked at. With just few exceptions, there was little evidence on file that senior management were copied on the complaint response or were even aware of the complaint's existence. In saying that, there were a few examples of complaints being escalated to the appropriate management committee or a particular issue (such as waiting lists) being brought directly to the attention of senior management by the Complaints Officer.

Each hospital also submitted monthly reports to the HSE on the complaints received using a standard template. The template seeks to source information on the number of complaints received and the main themes of these complaints. Unfortunately, there is little scope within this template to report on emerging complaint issues (or indeed outcomes) or to look beyond the numbers to the narrative behind it. It is also not clear as to what actions, if any, result, from these reports.

Bright spot
Complaints Report

Regular and detailed reporting to management is vital if management are to be fully aware and engaged in the complaints process.

Twice a year, **Cork University Hospital** produces a "Complaints Report" for senior management. This report contains very detailed statistics on the number of complaints received under both the eight principles of the National Healthcare Charter and further sub-categories developed by the hospital itself. It also looks beyond the figures to provide further information on some of the complaints received (including direct comment from the complainants). An action plan is included as part of these biannual reports with an identified lead for each action and a timeframe for completion.

Clinical accountability

Clinical accountability is a vital part of the complaints process. In three of the hospitals visited, the Clinical Director is very involved in the complaints process. This includes responding directly to and meeting with complainants and providing assistance if and when the Complaints Officer has difficulties in obtaining a response from the relevant clinicians. In these hospitals, the Clinical Director is also involved in implementing any recommendations resulting from a complaint which would impact on clinical care. Other Clinical Directors that we met or spoke to during the course of this investigation are not as directly involved in the hospital complaints process although they are aware of the process and are involved in resolving complaints within their own particular area. The Directors of Nursing we spoke to also have some involvement in the complaints process. For example, in one hospital we visited, the Complaints Officer reported directly to the Director of Nursing.

Learning

Highlighting improvements

Many of the hospitals gave concrete and detailed examples of improvements that have been made as a result of a complaint received. However, as mentioned earlier, it is not always clear whether the complainant or indeed the hospital staff are aware of these changes and the reasons behind them. The majority of the frontline staff interviewed as part of this investigation (regardless of the hospital) referred to the level of feedback as an area which could be improved.

We also found little evidence that hospitals publicised (either within or outside the hospital) learning or any changes to policy or processes that have been made as a result of complaints. Making the outcomes known can promote public confidence in the value of complaining while also reassuring service users that it can indeed make a difference. However, it would appear that at least some of the hospitals are beginning to recognise this. For example, while one hospital gave an example of providing information on complaints (and changes brought about as a result) in their staff newsletter, another hospital displays "You said, We did" posters in public areas within the hospital to highlight what has been done as a result of complaints made.

Bright spot

Service improvement as a result of a complaint

Complaints can be a vital source of information as to how the service is working and in prompting and identifying improvements. An example of how a complaint was used positively to improve the service was provided by **University Hospital Limerick**.

Family members are normally asked to launder the clothes of a patient. Arising from a complaint from a family member about having to handle very soiled clothing, the hospital introduced bags that are given to family members which disintegrate in the wash. Hospital staff now use these bags to store soiled clothing and inform families of their special use - that it is not necessary to take the clothing out of the bags before washing.

Sharing the learning

Acute hospitals experience similar challenges. However, all the hospitals informed us that there is no opportunity for Complaints Officers to regularly participate in multi-site forums to share ideas and/or experience. There is therefore no way of capturing inter-hospital learning from complaints in any formal way.

Many of the hospitals acknowledged this and admitted that it is something that could be developed more. At the moment, most of the knowledge sharing between hospitals appears to focus on clinical risk issues only. As one hospital succinctly put it, as the system currently stands, every hospital must make the same mistake themselves.

Many of the hospitals also acknowledged that there is often an issue with the implementation of recommendations. Some the hospitals have now begun to address this. In one hospital, a Complaints Management Team has been established to look at if and how recommendations are being implemented. Another hospital has implemented a ratings system (RAG) to monitor the progress of recommendations – (R = nothing done yet, A = behind schedule but in progress while G = delivered), while another hospital has appointed a Service Quality and Improvement Manager. One of her tasks will be to ensure that recommendations arising as a result of complaints are implemented throughout the hospital.

"Remember : the majority of patients do not complain with a view to financial rewards – they simply do not want anyone else going through the same experience"

Portiuncula Hospital training presentation

Chapter 4

What the HSE and the Department of Health told us

What the HSE and the Department of Health told us

The HSE

Acute Hospitals Division

The Acute Hospitals Division in the HSE is responsible for the re-organisation of acute hospitals within the HSE into seven hospital groups (including the Children's Hospital Group). As mentioned in Chapter 1 of this report, each group will contain between six and eleven hospitals, at least one of which will be a major teaching hospital. The hospitals in each group will work together as a single entity to provide acute care for people in the catchment area, with management structures being put in place at group level. This re-organisation represents the first step in the transition process which is intended to lead to the establishment of a national system of independent hospital trusts in Ireland.

In our discussions, the Acute Hospitals Division expressed the following views:

Access

- there will be one Complaints Officer/Complaints Office for each group to ensure a standardised approach to the processing of complaints;
- training in complaint handling and the development of communications skills for all hospital staff are key to the efficient and effective working of complaint investigation systems;

Response

- standard patient satisfaction surveys will be carried out nationwide which will contribute to the development of performance indicators for hospital groups;
- it would be preferable if there was a statutory obligation on healthcare professionals and administrators to provide full information when mistakes are made to encourage and support confidence in the Open Disclosure process;

Process

- the new hospital groups arrangement will help standardise practices and procedures within the HSE hospital system;
- the groups will help contribute to the eradication of inefficiencies within the HSE hospital system;
- the groups will be able to form partnerships with local organisations and stakeholders to enable them to provide a more comprehensive service to the catchment population;
- the new structures will reflect the group configuration rather than the individual hospital;

Leadership

- upward feedback will provide, from a variety of sources, the information required to give a broad view as to how individual hospitals are performing;

Learning

- information on complaints, compliments and adverse incidents is vital to an understanding of how the hospital system is performing;
- there is a need to develop a knowledge management system which will lead to the provision of a comprehensive database on all issues relating to the investigation of complaints and resolutions achieved;
- the hospital group system will facilitate the promotion of learning on a broader and deeper level;
- a comprehensive, balanced and workable complaints system will encourage buy-in from hospital staff and will ensure that complaints are seen as valuable sources of learning and essential components of an improving service.

Quality and Patient Safety Division

The Quality and Patient Safety Division of the HSE has overall responsibility for the development of policy and procedures to ensure that high quality safe services are designed and delivered to patients and clients.

In our discussions, the Quality and Patient Safety Division expressed the following views:

Access

- most people are familiar with Your Service Your Say and use the service to make complaints;
- a knowledge of the local hospital context is important in the examination of complaints;
- it is desirable for hospitals to be open and creative when trying to resolve issues;
- a National Advocacy Unit has been established which is responsible for ensuring that the involvement of service users is central to how health care services are designed, delivered and evaluated.

Response

- complainants are offered meetings with hospital staff, both clinical and administrative, to assist in the resolution of complaints;

Process

- good patient advice and liaison services can help in resolving problems quickly and at a local level;
- while potentially there might appear to be a conflict between a hospital based patient advocacy arrangement and the complaint handling process, both have an important role to play as they are resources aimed at achieving resolutions;
- the focus of the complaints process should be on making things better and promoting learning;
- complaints relating to clinical judgement issues are excluded from the HSE complaints process but, in practice, clinicians can and often do look at the issues involved;

Leadership

- training of staff in complaint handling has been prioritised and escalation of complaints can be avoided by the person nearest the complaint being involved in its resolution;
- listening to the needs of service users will lead to the development of positive action plans;
- positive action plans promote the culture of welcoming and valuing complaints and facilitate users of the complaints process in giving their view in a constructive way without fear;
- reports on complaints are valuable but more frequent reporting is desirable;
- a standardised approach to recording of complaints is desirable - for example, QPulse, the management information system used by some hospitals is available but usage is uneven across the service;

Learning

- reviews, properly carried out, are important because they enable the hospital to have a second look at issues giving rise to complaints;
- complaints provide important information in relation to the quality of hospital services provided and patient safety;
- compliments are equally important in identifying positive aspects of hospital care;
- a thematic breakdown of complaints received will help identify trends.

Since this investigation began, there has been a further re-organisation of functions within the HSE. According to the HSE, following a review of quality and patient safety activities undertaken in 2014, it has put in place enhanced arrangements for quality improvement and patient safety – the Quality and Patient Safety Enhancement Programme. A new division within the HSE is being established with responsibility for Quality Assurance, National Safety Incident Management, Healthcare Audit and Corporate Risk Management. It is intended that this new division will be responsible for providing overall national leadership for the HSE's complaints management system and processes.

Compliments

Compliments or positive feedback are part of the same spectrum as complaints and a continuation of the dialogue between patients and their families and the hospitals that treated them. It is about taking the opportunity to express appreciation, to let staff know what they are doing well and to inspire staff to continue to perform well. The Your Service Your Say process makes provision for both compliments and complaints. In 2013 there were 4,019 compliments recorded by the HSE (compared with 6,823 complaints relating to HSE-run services), while there were 9,110 compliments recorded by voluntary hospitals and agencies (compared with 5,573 complaints). However, the focus of this process is still very much on complaints.

Most of the hospitals visited admitted that, while compliments are very important, more could be done to bring them to the attention of staff and to use them as a valuable learning tool. One hospital has begun to log compliments on the case management system in the same way as complaints are logged.

The Department of Health

As mentioned earlier in this report, the Health Act 2004 (Complaints) Regulations 2006, which were introduced by the Department of Health, made provision for people to make a complaint about the HSE and service providers. We met with representatives of the Department to discuss issues relating to the operation of the complaints process from when the Regulations came into force in January 2007. During the course of the meeting with Departmental officials the following issues on the operation of the existing hospital complaints system were noted and discussed:

Access

- the question of including the area of clinical judgement within the complaints process is under consideration at the moment;
- the need to have an accessible and easily navigable complaints process was a priority with the Department;

Response

- no particular division within the Department has responsibility for overseeing the operation of the complaints process;
- the Department acknowledged that, under the Regulations, assistance must be provided to persons making a complaint or seeking a review but that it does not specifically monitor arrangements for this;

Process

- the Department was of the view that the time limits set out in the Regulations for dealing with complaints were not always complied with;
- there were no immediate plans in place to undertake a review of the operation of the Regulations but review of the different aspects which form part of the overall regulation of health care is on the agenda of the Department's Management Advisory Committee (MAC);
- details obtained by the Department on complaints is restricted to individual cases or statistical information;
- the Department is aware that the practicality of continuing with the review element of the complaints process is being re-assessed by the HSE at the moment;

Leadership

- the proposed establishment of the Patient Safety Agency is under review in the context of the strategic reform of the health service;
- the Department is tending towards the view that improving the present arrangements for patient safety is preferable to the establishment of a new agency;
- the Department supports the further development of the Open Disclosure policy within the hospital service;
- a statutory duty of candour will likely be incorporated in the proposed Health Information Bill;

Learning

- the Department recognised the importance for wider service improvement of capturing the learning from complaints and the need for improvements in this area, including through implementation of the National Incident Management System (NIMS).

Open Disclosure

Open Disclosure has been part of the regulatory framework for a number of years. For example, HIQA's *National Standards for Safer Better Healthcare* require that service providers fully and openly inform service users as soon as possible after an adverse event has occurred or becomes known and continue to provide information and support as needed. Doctors are also obliged to disclose adverse events to patients under the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*.

In its publication, *Open Disclosure: National Guidelines – Communicating with service users and their families following adverse events in healthcare,* the HSE describes Open Disclosure as *"an open, consistent approach to communicating with service users when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the service user informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event".*

According to the guidelines, the following incidents should be disclosed to patients – an incident/adverse event resulting in harm, a suspected (not yet confirmed) adverse event, a no harm (no injury) event and a "near miss" event (to be assessed on a case by case basis). In addition, where there is a risk or potential for future harm, the guidelines advise that the event should be discussed with the patient. The guidelines state that an expression of regret or saying sorry for a patient's experience is not an admission of liability.

There is currently no legislation in place to assist the Open Disclosure process (or as it is known in some jurisdictions a statutory duty of candour). However, the Department of Health has indicated that it supports the further development of the practice of Open Disclosure within the health service and the Health Information Bill will likely include provisions in this regard.

Chapter 5
What others told us

What others told us

Advocacy Groups

As part of this investigation, we invited a number of patient advocacy groups to complete a short survey on their experiences of the HSE and hospital complaints process.

All nine groups which responded were aware of the HSE and hospital complaints process. Three advocacy groups had made a complaint on their own behalf or on behalf of a client, while two others had provided feedback in relation to a service. Five of the advocacy bodies who responded had provided advice or information to clients on the HSE and/or hospital complaints process. One organisation involved in disability services advised that it provided information on the complaints process to all of their service users as a matter of course as they regularly have to attend hospitals. Another organisation said that it provides advice and information on a weekly basis.

The majority of advocacy groups (80% of those who responded) were of the opinion that the HSE and/or voluntary hospitals did not provide sufficient advice and information on all relevant aspects of the complaints process. One organisation said that there is a different process within each hospital with no recognised individuals and no job title that is easily recognised by patients and/or their families.

When asked to rank aspects of the complaints process in order of importance, 60% of those who responded ranked early resolution of the complaint as the most important aspect. This was followed by an explanation of the process and redress provided. Perhaps surprisingly, learning from complaints was ranked as the least important aspect of the complaints process. Finally, 75% of those who responded were not aware of any changes made as a result of a complaint made.

We also met with one of the main patient advocacy organisations. According to this organisation, the most frustrating thing about complaints to hospitals is that it is difficult for patients or relatives to navigate the complaints systems. It is particularly frustrating that some matters cannot be examined under the statutory complaints process, such as clinical judgement, while there may be a requirement to go to another regulatory body such as the Medical Council with aspects of the complaint. The organisation does not have a presence within the hospital structure and their services are not notified to patients who want to make a complaint or who are in need of advocacy. Information about this group is usually obtained using the internet or by word of mouth.

In its experience of the current complaints system, there is no facility for sharing learning from complaints throughout the country and this causes similar mistakes to be made in different hospitals. In order for the complaints process to work better for the patient, the advocacy organisation was of the view that the Ombudsman (or some other regulatory body) should have overall responsibility for complaints and that all issues - clinical, nursing and/or administrative - should be examined by the one organisation. In its opinion, clinicians should be statutorily obliged to admit liability if they make a mistake without that admission automatically leading to litigation.

Advocacy

Once someone has decided to make a complaint, navigating the complaints system is not always straightforward. Some complainants may, for many reasons, need assistance in making and documenting a complaint. There are advocacy services within Ireland which can provide very valuable assistance in this regard. For example, the National Advocacy Service under the aegis of the Citizens Information Board provides an independent advocacy service for people with disabilities.

Patient advocates can perform a very valuable function for both patients and hospitals by solving small problems before they become large ones and by helping patients feel that they are being treated fairly and with respect by the hospital. Also, investing resources at the time of complaint to ensure that the complaint accurately reflects the problem can save time during the process and is more likely to achieve an effective result.

In parts of the United Kingdom, the advocacy service operates outside the NHS and supports people who are making a complaint or thinking about making a complaint. For example, in Wales, the Complaints Advocacy Service provides free independent advice and advocacy to individuals who do not feel comfortable making a complaint by themselves or who need support at some point during the complaints process.

Health sector interest groups

We also wrote to a number of health sector interest groups (including professional bodies, medical/nursing schools and representative organisations) seeking their views and experience of the existing complaints system. The responses received highlighted the following issues:

Access

- a good complaints policy should be easy to access, timely, clear, user friendly, responsive and should also facilitate open communication;
- it can be difficult for individuals to find out about making a formal complaint;
- a flow chart showing what to do and what will happen would provide clear information on what the complaints process entails;
- the lack of advocacy and supports for patients is a real concern which needs to be addressed;

"It is designed to wear you down....You get a letter...It's a gap filler.... And then another month....You need determination to pursue it.... And at the end you get nothing"

Member of the Public (Focus Group)

Process

- the specified timeframes for dealing with complaints are not always manageable;
- the success or otherwise of a complaint is largely dependent on who receives the complaint in the first instance;
- mandatory training is urgently required to bring positive change to the complaints handling process;
- personnel involved in the examination of complaints need training, education and mentoring in order to ensure the process is fair, objective and ethical;
- hospital staff may feel threatened by the complaints process;
- support systems should be available to those making a complaint and to those who are the subject of a complaint;
- the Open Disclosure policy should be an integral element in hospital staff training programmes;
- financial constraints inhibit the effective operation of a complaints handling system;

Response

- the provision of feedback on the outcome of the investigation of a complaint is essential;
- recommendations that require additional funding have traditionally not been implemented;

Leadership

- the example set by more experienced work colleagues is key to the establishment of best practice in welcoming and handling complaints;
- it is important that senior hospital management are proactively engaged in the complaints process;
- the development of a duty of candour culture should be embedded in clinical practice for all healthcare workers;

Learning

- the complaints process should place emphasis on the concept of service improvement and learning from mistakes;
- there should be a move away from the 'blame' culture to a more open culture where complaints and adverse reports are embraced and openly discussed as a learning opportunity;
- there is currently no standard way of gathering feedback from complaints and learning from those complaints which potentially has a detrimental impact on patient safety;
- feedback and follow through is very important if learning is to be achieved from the issues raised;
- standard practice should be that an agreed circular should issue in respect of the matter which gave rise to the complaint and its outcome;
- a comprehensive and robust complaints process empowers the public in providing feedback and provides a learning mechanism which will inform service improvements.

Health Sector Regulators

During the course of the investigation, this Office met with a number of health sector regulatory bodies. Two of these bodies, the Medical Council and the NMBI (formerly known as An Bord Altranais), are empowered to investigate complaints against hospital medical staff.

As explained in Chapter 1, the Medical Council is the statutory registration authority for doctors in Ireland. At present there are approximately 18,000 doctors registered with the Council. The Medical Council receives approximately 400 complaints a year about doctors. The overwhelming majority of these complaints were from members of the public – in fact, in 2013, only one of the complaints received by the Medical Council was from the HSE as the employer of the doctor concerned. This is quite different to the international situation where complaints or notifications to the professional regulator frequently come from healthcare employers or others acting in the public interest (for example, another healthcare professional)[5].

The Medical Council's Preliminary Proceedings Committee (PPC) is responsible for looking at these complaints. The PPC examines complaints that are made about doctors on a number of grounds including professional misconduct and poor professional performance. If the PPC believes that there is a case to take further action, it may refer the complaint to the Council's Fitness to Practise Committee (FTPC). If the FTPC upholds the complaint, the Medical Council can impose sanctions including:

- Advising, admonishing or censuring the doctor in writing;
- Censuring the doctor in writing and imposing a fine of up to €5,000;
- Attaching conditions to a doctor's registration;
- Transferring a doctor's registration to another division of the register;
- Suspending a doctor's registration for a specified period;
- Cancelling a doctor's registration;
- Prohibiting a doctor from applying for restoration to the register for a specified period.

In February 2015, the Supreme Court delivered its judgment in *Corbally v The Medical Council & Ors*[6]. Central to this judgment is a consideration of what is meant by the concept of poor professional judgment in the context of a complaint to the regulator. The Court held that the action complained of must meet a threshold of seriousness to justify a finding of poor professional performance and that *"only conduct which represents a serious falling short of the expected standards of the profession could justify a finding by the professional colleagues of a doctor of poor professional performance on his part, having regard, in particular to the gravity of the mere ventilation of such an allegation and the potential gravity of the consequences of the upholding of such an allegation"*.

The Medical Council is currently drafting a report based on a mixed method (qualitative and quantitative) review of complaints for the period 2008-2012. As part of this work, trends and themes in complaints are being analysed in order to draw conclusions for promoting patient safety and supporting good professional practice amongst doctors.

5 For example, in 2012 the General Medical Council (United Kingdom) received 2,003 enquiries from people acting on behalf of a public organisation. An enquiry is information received from a single source that may raise concerns about the fitness to practise of a doctor.

6 [2015] IESC 9

The NMBI is the statutory body that sets the standards for the education, registration and professional conduct of nurses and midwives. The Board is responsible for considering complaints against nurses and midwives. There are 63,000 registered nurses in Ireland and over 200 complaints were received last year. The NMBI operates similar procedures to the Medical Council in relation to complaints against individual practitioners. If the FTPC of the NMBI upholds the complaint, sanctions can include the cancellation or suspension of the nurse's or midwife's registration from the register of nurses and midwives, the attachment of conditions to the registration, written censure, imposition of a fine of up to €2,000 and/or restrictions on the practice of nursing or midwifery.

The role of HIQA is to promote quality, safety and improvements in the provision of health and personal social services for the benefit of the health and welfare of the public. As mentioned in Chapter 1 of this report, HIQA cannot investigate individual complaints or incidents. However, HIQA reviews all the information it receives from the public about healthcare service providers as it may indicate non-compliance with the national standards and regulations (as developed by HIQA) and whether that non-compliance poses a risk to the health and welfare of service users. This information is used to inform ongoing monitoring programmes.

HIQA has developed its *National Standards for Safer Better Healthcare* as part of its statutory role to set and monitor compliance with standards for the quality and safety of health and social care services in Ireland. Standard 1.8 requires that

"Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process."

According to HIQA, a service which meets this standard should have the following features:

- Complaints procedures that are clear, transparent, open and accessible to service users and take account of legislation, relevant regulations, national guidelines and best available evidence;
- Complaints procedures that ensure as timely a response as possible, taking account of the requirement to fully address the issues raised by the complainant;
- Complaints procedures that identify the expectations of service users making complaints and ensure that these expectations are taken into account and addressed throughout the process;
- A coordinated response to service users who make a complaint, including when their care is shared between healthcare professionals or transferred from one service provider to another;
- A supportive environment for service users that encourages them to provide feedback, raise concerns or make complaints verbally or in writing in a culture of openness and partnership;
- Support for a culture in which service users' care is not negatively affected as a result of them having made a complaint or expressed a concern;
- Structured arrangements to ensure that service users who make a complaint are facilitated to access support services, such as independent advocacy services.

Each of the three regulatory bodies provided valuable insight into complaints processes in connection with the examination of issues arising from their role. They also made comments which reflected on the complaints process generally as follows:

Access

- patient advocacy groups play a vital role and are important to complainants trying to navigate the complaints process. Inclusion of a list of advocacy groups in complaint information is therefore desirable;
- to work properly, complaints systems need to be transparent from the point of view of both the patient and hospital staff;
- it is vital that information on how to make a complaint is provided to all health service users;
- anonymous complaints have value and should be encouraged;
- user-friendly complaint forms should be developed;
- healthcomplaints.ie is a positive development in the complaints process;

Process

- high turnover of hospital staff inhibits smooth running of the complaints process;
- mediation can play a role in helping to resolve a complaint but needs to be further developed;
- given the number of interactions a patient may experience in a hospital, the number of complaints is quite low;
- Open Disclosure is beginning to play an important part in complaints examination;
- good communication within the process is important;
- complaints relating to clinical judgement are not appropriate for investigation under the existing complaints system;

Response

- many complaints are resolved quickly at ward level in hospitals;
- the standard of note-keeping needs to be improved;
- delays in the completion of the investigation of a complaint are common and can undermine confidence in the process;
- complainants need to be persistent in pursuing a complaint;

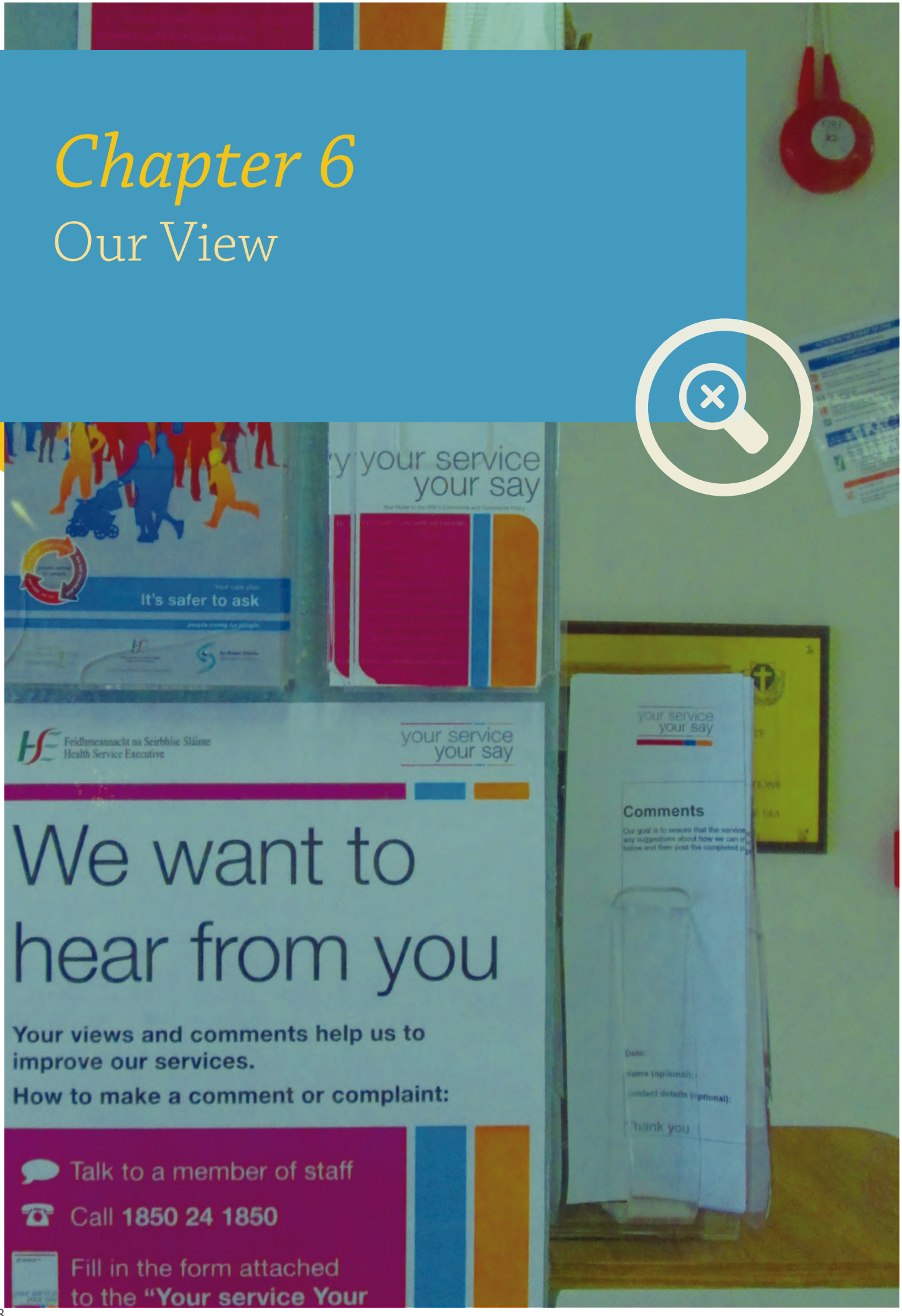
Leadership

- hospital managers can come under pressure from senior clinical hospital staff in relation to whether a complaint has merit;
- a lot of issues which give rise to a complaint are the result of human error – if these are managed properly, there should not be a recurrence;

Learning

- a lot of complaints are the result of recurring issues – lessons are not being learned;
- there is an opportunity for healthcare organisations, in responding to individual complaints, to identify trends and patterns and to determine whether there is a need to respond to concerns about individual clinicians;
- outcomes arising from complaints which have been properly examined should be the subject of feedback within the hospital and the wider hospital service.

Chapter 6
Our View



Our View

Access

One of the main hallmarks of a good complaints system is that it should be easy to find out how to make a complaint and simple and convenient to then do so. After all, no matter how efficiently or effectively designed a complaints process is, it will make little or no difference if the environment and culture discourages people from making a complaint in the first place.

A significant proportion of the public who made submissions to us and/or attended our focus groups did not appear to be aware of how the process worked or what to expect when they made a complaint. This was not a surprising finding – for example a survey conducted by the Mental Health Commission in 2012 found that 53% of respondents were not aware of hospital complaints processes[7]. However, while not surprising, it is nonetheless disappointing as it is vital in any hospital complaints process that patients and their families have clarity both as to how to make a complaint and how their complaint will be handled.

It is also of concern that many of the respondents to this investigation mentioned that they were not aware of the existence of this Office or their right to escalate their complaint to the Ombudsman. Anyone who complains to a hospital should know that they have a right to bring that complaint to the Ombudsman if they are not happy with the outcome of their complaint. It is also important that they are reminded of this information at the time they may wish to take their complaint further.

Most of the hospitals surveyed use the Your Service Your Say leaflets and documentation when highlighting their complaints processes. Signage and posters/leaflets setting out the hospital's commitment to welcoming all types of feedback (including complaints) are visible in hospitals throughout the country. In the hospitals visited as part of this investigation, all have signage displayed in prominent public areas, although in some cases it is limited to one or two areas. All the hospitals visited also use colourful original (not photocopied) documentation which helps to make it stand out against the hospital walls and other signage.

However, there is little evidence that the materials displayed are reviewed to ensure that the information is still correct. In addition, not all hospitals provide easy opportunities for members of the public to give feedback. For example, only a minority of hospitals visited have comment boxes close to the relevant signage and leaflets, despite the fact that these comment boxes allow for a complaint to be made without the patient or relative possibly feeling intimidated by making the complaint directly to a member of staff of the hospital. It is also disappointing that few hospitals have produced their own patient information handbook with guidance on how to make a complaint.

Many hospitals told this Office (through the survey and visits) that there is information on their complaints process available online – despite the fact that it is currently not possible to complete the Your Service Your Say form online. The internet is an increasingly valuable source of information and so this is to be welcomed. However, as discussed in Chapter 3 of this report, not all hospitals have a significant web presence. In addition, the internet has its limitations. Where a problem is immediate, a hard copy brochure containing information about the complaints process might be the best source of information.

7 Your views of Mental Health Inpatient Services : Inpatient Survey, Mental Health Commission, 2012

Information provided on the hospital and HSE websites is also far from uniform and in some cases is incomplete or incorrect. It is also striking that few hospitals actually use the term "complaint" when providing information on the complaints process which can only add to the confusion of those wishing to make a complaint.

It is important to bear in mind that not everyone has equal access to the internet. For example, in 2014 the CSO reported that 51% of people aged between 60 and 74 have never used the internet[8]. Literacy or disability issues may also mean that this format is effectively useless to them unless there are appropriate supports. However, as mentioned earlier, few hospitals have produced a paper version of a patient information handbook (or indeed at all).

A good complaints system needs to be easily accessible to all sectors of the community. Information alone is not always enough to enable navigation of the system. Supports need to be in place to assist complainants in this. In this regard, it is clear that patient advocacy groups (whether within the hospital or outside) can play a very important role. However, in order to play such a role, advocates must be seen as independent and appropriately resourced and trained so that patients and their families can feel confident in turning to them with their concerns. While it was envisaged that the planned Patient Safety Agency would be an independent supportive resource for patients and their families, we understand from discussions with the Department of Health and the HSE that plans for this agency are currently being reviewed.

Many of the designated Complaints Officers within hospitals are also called Patient Advocates or Patient Liaison Officers. When the function of patient advocacy and complaints management is combined (as in the case of most hospitals visited), there is a potential for a conflict of interest. The people responsible for supporting and advising complainants are also employed by the organisation against which they are making their complaint and may even be deciding on the merits of the complaint. However, perhaps surprisingly, none of the Complaints Officers interviewed as part of this investigation (who also held the title of Patient Advocate) saw this as a potential conflict.

Potentially vulnerable people are often more likely to have an issue with a health provider but may be less able to address that issue through a complex complaints system. Complaints systems need to be tailored, responsive and flexible enough to deal with the needs of all members of our community, including disadvantaged or vulnerable groups. However, while all hospitals are apparently willing to accept a complaint from a third party on behalf of someone else, there is little evidence of efforts to encourage feedback from groups that have particular issues when engaging with health services or are "seldom heard".

All hospitals surveyed have interpreting facilities in place when required. This is to be welcomed. However, while most of the hospitals have consulted with NALA or other literacy groups when developing their information leaflets, there is little evidence that the hospitals have fully considered other access issues such as those concerning people with disabilities.

While most hospitals have sought to ensure that their buildings and services are physically accessible, only half of the hospitals visited had an Access Officer in place at the time of the visit. Access Officers can play a vital role in ensuring that complainants with disabilities have the appropriate avenues and supports required for lodging a complaint. Furthermore, it is a statutory requirement under the Disability Act 2005.

8 Central Statistics Office, 2014 - See http://www.cso.ie/multiquicktables/quickTables.aspx?id=ica05

The public submissions and focus groups also highlighted the fact that many people are reluctant to make a complaint in any event and indeed, in many cases, never reach the stage of making a formal complaint. Again, this is in line with previous surveys on this issue – for example, the HIQA Red C Poll mentioned in Chapter 2 of this report. The two significant barriers to making a complaint, as identified in this investigation, are the fear of repercussions for themselves or their relatives and the feeling that it is a waste of time. In particular, fear was highlighted as a major concern for many people and a consistent theme across all the consultations.

Patients and their families/carers should be made to feel confident and safe about making a complaint. However, it is disappointing that few hospitals have made concerted efforts to support complainants when making complaints and to reassure them of the importance of their feedback. For example, only one hospital visited acknowledges this in their response to complainants and highlights the importance and value of making a complaint. Likewise, while the Your Service Your Say procedure makes it clear that complainants should not be made to feel afraid of any negative repercussions after making a complaint, this assurance is not contained in the HSE's basic information leaflets on the process.

Process

Making a complaint about issues relating to hospital practices, treatment and procedures can be a daunting and sometimes bewildering experience for a patient and/or their family. For the potential complainant there will often be other priorities including dealing with bereavement or looking after their own health or that of a loved one. Furthermore, a complaint may involve issues about which the complainant is unfamiliar and often may involve a number of issues, not all of which may fall within the remit and the competency of the statutory complaints process.

The exclusion of clinical judgement from the statutory complaints process (and indeed from the remit of the Ombudsman) provides a clear example of how difficulties can arise in this respect. At present, the only way to make a complaint involving clinical judgement is through the professional regulatory bodies. It is the role of the fitness to practise or similar committee of the regulators, to consider complaints against a registered practitioner to see if there is evidence of professional misconduct or whether he/she is unfit to practice medicine. This situation, from the perspective of the average complainant, can appear very confusing. In addition, the threshold for professional bodies looking at the behaviour of its members is very high and following the recent Supreme Court judgment in *Corbally v The Medical Council & Ors* (as discussed earlier in this report) it is likely to become even higher. While the Medical Council has pointed out that there are alternatives to a Fitness to Practise inquiry (such as professional competence schemes or mediation), it is nevertheless still possible that many complaints involving clinical issues may not be considered to come within the ambit of the regulatory bodies. Therefore, there is a risk that some complaints might not be considered at all under the present arrangements.

Where such a complaint can be made, it should be the complaints process rather than the complainant which has responsibility for routing the complaint (with the consent of the complainant) to the appropriate body to be resolved. Ombudsman Offices in other jurisdictions (for example in Scotland and Wales) have, in partnership with service providers, contributed towards the development of simplified and standardised complaint handling practice across the public sector, regardless of the nature of the complaint. This ensures that complaints can be investigated in a balanced and consistent

manner across the public service and that complaints are directed to the appropriate organisation. In other words, there should be no "wrong door" for complaints so that regardless of where somebody makes a complaint, they can be certain that the complaint will be listened to and examined by the organisation best placed to address the issue raised.

It would appear that none of the hospitals visited as part of this investigation adopt an overly formal approach when accepting a complaint. This is also to be welcomed. However, it is nevertheless desirable for Complaints Officers (and indeed other staff) to adopt some form of structure when accepting a complaint so that it is clear what information to collect when taking a complaint (regardless of the nature of the complaint). It should be possible for Complaints Officers to agree the nature of the complaint with the complainant from the outset, the preferred method of communication (if appropriate) and the desired outcomes.

All hospitals aim to abide by the timeframes provided for under Your Service Your Say – that is 30 days to respond. By undertaking to act on a complaint within a certain time, a hospital is making a statement that complaints are treated seriously and will be handled in a certain way. It has other advantages too, for example, deadlines can help when chasing clinical staff for responses and managing the expectations of complainants.

Timescales should be realistic, achievable and monitored. Complainants should also be kept informed about the progress of their complaint at every stage of the process, particularly if any delays arise. It should be appreciated that some complaints are more complex than others and the standard timeframe may not be appropriate in these cases. In addition, while dealing with complaints in a timely manner is an important measure as to how well complaints are handled, it is not the only one. The quality of the final response is usually more important.

As this investigation has highlighted, not all Complaints Officers occupy a senior position within the hospital. They are also invariably involved in a wide variety of other tasks along with their complaint duties. Complaints Officers are the lynchpin of the complaints process and have a wide range of responsibilities in terms of administration and handling of complaints, providing help and advice to people wishing to make a complaint and supporting staff involved in handling complaints.

Complaints Officers should therefore have the authority and time to deal with complaints effectively. They should have access to the information required to process a complaint (including timely reports from the relevant clinicians and other hospital staff), have the necessary time and resources to carry out their role (including access to private rooms and other suitable facilities to meet a complainant, if necessary), be able to provide remedies themselves or at least have access to other staff (including those at a senior level) who can provide a remedy, have appropriate training in complaint handling and have their value to the organisation clearly recognised through the attention and support the hospital management team gives to their work.

All hospitals visited recognised the importance of early resolution of complaints. This is good practice as it is an important component of any good complaints process that complainants should not find themselves involved in a formal complaints system straightaway (unless they wish to be). Only two hospitals had any mechanisms in place to record these "early" complaints. This is despite the fact that these complaints (and the actions taken to resolve them) can be very important for learning and service quality improvement. The recording of such complaints also helps to identify patterns and volumes of complaints which, in turn, may reveal underlying systemic weaknesses. In addition, it can

emphasise to frontline staff that it is important and a part of their job to address concerns wherever possible. Unfortunately, however, it would appear that frontline staff are not always provided with the training to respond to these concerns and complaints in a constructive manner (including training in communication skills, customer service and complaints handling). Staff need the confidence, knowledge and authority to deal with issues as they arise.

It is clear from this investigation that more can be done to make the complaints process much more open and collaborative (both from the complainants' perspective and hospital staff). In doing so, complaints should be seen not as negative developments or attacks but instead can be welcomed as opportunities for learning and improvement. It is important that neither complainants nor hospital staff feel removed from the process but instead should be kept informed throughout the process and receive appropriate feedback as and when it arises. Staff who are the subject of a complaint should also be supported through the process and should not be put on the defensive about the complaint being made.

Many of the hospitals surveyed have begun to implement Open Disclosure policies. Some organisations who made submissions to this investigation also made reference to Open Disclosure policies and a possible future statutory duty of candour. Open Disclosure is not about apportioning blame or even an apology but promotes a culture of openness and accountability. It should never be feared but instead should be embraced as not only an opportunity to strengthen the relationship of trust between the hospital and the patient but also as a great opportunity to learn.

This Office's findings in relation to the hospital complaints process would appear to correspond with our many years experience of considering complaints about hospitals. In our experience, very long delays before a final response is issued can define the process in many cases and unfortunately, when this response does issue, it often fails to address all or most of the issues raised by the complainant. In addition, the Complaints Officer often does not have the authority to deal with a complaint effectively on their own or even challenge the views of the hospital staff involved, particularly when the hospital staff concerned are senior clinicians or managers within the hospital. Instead, we have found that their role is often confined to repeating verbatim the views of that clinician, which only adds to the distress of the complainant.

Response

As discussed earlier, one of the main barriers to making a complaint would appear to be the pre-conception that it won't make a difference. Perception as to whether "justice" has been done following a complaint may be influenced by a variety of factors including the response of the hospital concerned (including perhaps whether there has been full and open disclosure) and how the hospital communicates on how they are going to prevent a recurrence of the events that led to the complaint. A lack of empathy in communication can also lead to an adverse reaction from the complainant.

Often the best response to a complaint is a better explanation of the action taken and, where applicable, reassurance that lessons will be learned. In this way, a complainant might receive a real demonstration that their complaint has been used to shape learning or improvement and was therefore not made in vain. From our examination of hospital complaint files (discussed in greater detail in Chapter 3), it would appear the some of the hospitals do indeed try to include some acknowledgement of learning. However, it would also seem from the submissions received (and indeed

our examination of the hospital files and past experience of examining complaints in this Office) that, in many cases, those involved (both the complainants and hospital staff) do not, at the end of the process, know what was done to ensure that the action complained of does not happen again and, in cases where this information was available, whether it worked.

The hospital's response to a complaint is a key indicator of how seriously the hospital has taken the complaint in the first place. A good response should directly address all of the key issues raised in clear and understandable language, offer a personalised apology and redress (where appropriate) and offer reassurance that steps have been, or will be taken, to prevent a recurrence. A good response should also outline what those steps are. A follow up letter confirming that the action has been taken and proved effective is also good practice.

In some instances, hospitals offer face to face meetings with the complainant to talk through the response in detail. Sometimes a hospital also chooses to close a case over the telephone. Telephone calls may be appropriate in some cases and are certainly a good way of judging the complainant's satisfaction with the hospital's response. However, there is a risk that, by relying on telephone calls, complainants may not have an opportunity to fully consider a detailed explanation (as may be provided in a written response) and may even feel hard done by in terms of how they were dealt with, particularly if there had been a formal complaints process up until then. In these cases, a brief "follow-up" letter or e-mail may also be appropriate and provide details of any further routes to take (e.g. to this Office) should the complainant wish to escalate the complaint.

A good complaints process should offer a range of timely and appropriate remedies to individuals who have a justified complaint. In any given situation, it is important that the HSE or service provider be able to outline any action taken as a result of the complaint and be willing and able to offer suitable redress which meets the needs of the particular complainant and allows for improvements in the service as a whole. While this investigation has found that many hospitals are willing to provide an apology for any hurt, distress or inconvenience caused, few hospitals appear to be willing to consider other forms of redress or even have a redress policy.

Leadership

For a complaints process to be effective, senior hospital management should encourage a culture of openness to accepting and learning from complaints. Hospital management should be active in promoting and reinforcing a positive complaints culture within the hospital. It was noted through our survey and visits that few hospitals incorporate training on the complaints process in induction training for hospital staff. It was also noted that few hospitals discuss complaints at staff meetings.

Management must also be active and visible in requesting and analysing regular reporting of complaint information, therefore integrating reporting into business improvement. In this regard, management should also be active in incorporating information from other sources such as from NIMS or under the Protected Disclosures Act. Increasingly, hospitals are reporting on the number of complaints received to a variety of management committees and, as discussed in Chapter 3, some very interesting and welcome initiatives have developed in this area to allow for feedback, compliments and complaints to be reported back beyond mere headline figures in order to offer a more complete "patient story".

However, it is clear that, in a majority of hospitals, senior management still have a small to no role in the processing of complaints and, for the most part, are often unaware of particular issues and resolutions. Merely receiving (often numerical) information on complaints in isolation and without the narrative behind it can minimise both the understanding of the true nature of complaints and opportunities for specific focus on improvements or the allocation of resources in the most appropriate areas.

As well as reporting to senior hospital management, each hospital is also obliged to provide data to the HSE (as part of their service level agreements) on the number of complaints received. However, it remains unclear as to what happens to this data when it is received by the HSE and subsequently the Department of Health. Greater clarity going forward as to the true value of the monthly reporting and how best to make use of it going forward would therefore be welcomed.

It is also disappointing to note that this information is not published and available outside the HSE and/or the Department of Health apart from through aggregate figures in the Annual Report. This is in contrast to the situation in the United Kingdom where, in order to promote greater transparency within the health service, it is now mandatory for all NHS organisations to supply information on the number and types of written complaints received. This information is collated and then published by the Health and Social Care Information Centre (HSCIC)[9].

In addition, overall responsibility for complaints handling within the HSE is currently in a state of transition although it is noted that the newly-established National Quality Assurance and Verification Division has, as one of its key objectives, the strengthening of complaint handling across the health service. It is currently not possible to identify the appropriate responsible division or unit within the Department of Health. In order to improve overall direction and leadership within the Department on this issue, there would be clear benefits from one unit taking responsibility for complaints handling in order to help avoid potentially serious systemic issues within the overall hospital complaints process going unnoticed and unsolved. In this regard, it is noted that, in response to this investigation, the Secretary General of the Department of Health has undertaken to look at the current assignment of responsibility for complaints.

Learning

Complaints are a valuable source of information about how well a service is doing. One key objective of a good complaints process is that there should be long-term learning across the hospital sector. All of the groups who responded to the consultation (and many of the hospitals) were in broad agreement that an efficient and effective complaints handling process was essential to the provision of a high standard of hospital care services and in promoting learning. Unfortunately, however, it would appear that information from complaints is still being underexploited as a learning resource.

It is clear that there is a necessity to learn and improve as a result of complaints. There must also be a focus on implementing the recommendations and making meaningful improvements as a result. Such a focus on organisational learning would be a vital way of hospitals encouraging a culture of good complaint handling with all feedback (both compliments and complaints) being seen as a positive agent for the organisation. Hospitals need to encourage and assist all staff in understanding and using feedback as necessary information to support ongoing improvements to services.

9 For example, the HSCIC published a report entitled *Data on Written Complaints in the NHS 2013-2014* in August 2014.

It is clear that the recommendations and learning arising from complaints is as important as any other aspect of the complaints process. It is therefore very disappointing that few hospitals have procedures in place to monitor the implementation of recommendations. Instead it remains the case that once the response to the complaint has issued, any follow-up tends to be forgotten about. This must be addressed as a matter of priority.

There is also, as yet, no fully integrated standardised management information system within the public hospital sector. This is despite that fact that there is already precedent for similar systems within the sector –as discussed earlier, the reporting system NIMS is designed to support sharing of learning from adverse events and "near misses" at both local and national levels. While one management information system (Q-Pulse) appears to have been adopted by many hospitals, there is a marked variance in the level of engagement with the system across the hospitals. Non-engagement with the management information system has the potential to lead to a discrepancy in information on the actual activity in managing complaints and the recorded data. It also makes it almost impossible to aggregate or link important data from other sources of learning, such as serious incident reviews or litigation.

It is also disappointing to note that there are few opportunities for hospitals to share learning with other hospitals, despite the fact that they must receive many similar complaints on the same issues and themes. The lack of a network or forum to share experience amongst hospitals and Complaints Officers means that essentially each hospital is learning on their own. The HSE has advised this Office that the new hospital structures as previously outlined (the hospital groups), will allow for a more centralised complaints process within the group structure and more formal reporting with the Acute Hospital Division. It is therefore to be hoped that the new hospital structures will provide for greater opportunities for communication and sharing between hospitals, within the new hospital groups and across the hospital groups.

"There is a different process within each hospital, no standardised mechanism of complaint, no recognised individuals in many hospitals, no job title that is easily recognised by patients / family members"

Advocacy Group

Chapter 7
Conclusion and Recommendations

Conclusion and Recommendations

It is clear that there is a visible commitment to good complaints processes in many hospitals throughout the country. However, the ability to deliver on this commitment remains a challenge in many instances. Frameworks for complaint handling are not enough on their own to ensure that there is an appropriate consideration of and outcome to a complaint. Systems must be designed and implemented to address the needs of both the complainant and the service at every stage – from making it easy to make a complaint in the first place to implementing any learning that has arisen as a result.

In view of this, and arising from this investigation, the Ombudsman makes the following recommendations:

Access

1. Multiple methods of making a complaint should be available and easily understood, both during and after treatment. These should include comment boxes within hospital wards (if not already in place). A fully accessible online version of Your Service Your Say should be developed to allow complainants to make a complaint online.

2. The HSE should undertake a review of Your Service Your Say with a view to making sure that service users have greater clarity, guidance and information on how the complaints system works.

3. A standard approach should be adopted by all hospitals in relation to the information available to the public when viewing their website, particularly those hospitals availing of the HSE website – hospital details on this site should all contain the same information and the same links for ease of reference.

4. Complaints Officers should be provided with appropriate and accessible facilities within each hospital to meet complainants.

5. Independent advocacy services should be sufficiently supported and signposted within each hospital so patients and their families know where to get support if they want to raise a concern or issue.

6. Each hospital should actively develop and encourage volunteer advocates with the hospital who can help support patients who wish to express a concern or make a complaint.

7. A no "wrong door" policy should be developed so that wherever a complaint is raised, it is the system and not the complainant that is responsible for routing it to the appropriate place to get it resolved.

8. Regulators and the Ombudsman should work more closely together to co-ordinate access for patients to the complaints system. In this regard, the online platform healthcomplaints.ie should be extended to provide a better publicised point of information and access for complainants.

9. Each hospital group should develop a process to allow for the consideration of anonymous complaints.

10. Each hospital should appoint an Access Officer (as statutorily required under the Disability Act 2005) who should attend all necessary training as provided by the HSE.

11. A detailed complaints policy statement should be displayed in public areas within all hospitals, on the hospital website, and in, or near, the Complaints Officer's office. Induction and other training for staff should include a reference to the policy. Staff should also be periodically reminded of the provisions of the policy.

12. Each hospital that has not yet done so, should include a reference to this Office:

- In any letter or correspondence notifying the patient/family of the outcome of the complaint to the hospital;
- On websites, booklets and information leaflets where the hospital refers to their complaints system;
- Verbally if explaining how to make a complaint to a patient or their family.

Process

13. The HSE should introduce a standard approach to implementing Your Service Your Say across the public health service. This should include standard forms, standard guidance for patients and staff, standard categorisation of complaints and standard reporting to give certainty to complainants and to allow for comparison on complaint handling, subjects and outcomes between hospitals and hospital groups.

14. Addressing concerns at ward level should be a main focus for each hospital. All hospital staff should be provided with the appropriate training to allow them to deal with issues as they arise.

15. Consideration should be given on a wider front to amending the statutory complaints process (and the remit of the Ombudsman) to allow for the inclusion of clinical judgement as a subject about which a complaint can be made.

16. Each hospital group should have a Complaints Officer to take overall responsibility for the complaints process and co-ordinate the work of complaints staff in each hospital in the group.

17. A standardised process and template for recording and documenting complaints at ward level should be embedded via a standardised system across the hospital groups.

18. A standardised structure and template for collecting and documenting a complaint should be developed across the hospital groups outlining the nature of the complaint, preferred method of communication and desired outcomes.

19. A standardised information system for the recording of complaints, comments and compliments should be developed across the hospital groups.

20. Each hospital group should implement mandatory training on complaints handling for all Complaints Officers and other staff involved in the complaints process.

21. Each hospital group should provide an induction module for all new hospital staff on the hospital complaints process and its underlying statutory framework.

22. Each hospital group should implement a bi-monthly audit of the complaints dealt with within the group in order to assess the quality of the process, including the response.

23. Each hospital group should develop a facility to allow for independent (i.e. outside the HSE) investigation of complaints where the complaint received is of sufficient seriousness and where appropriate.

24. The HSE and the hospital groups should take steps to ensure that all complaints are thoroughly, properly and objectively investigated and comprehensively responded to.

25. Each hospital group should develop an Open Disclosure training programme in line with the HSE National Guidelines and make it available to all staff.

26. The Department of Health should undertake a full review of the Health Act 2004 (Complaints) Regulations 2006. This Office looks forward to working with the Department in this regard.

Response

27. The outcome of any investigation of a complaint together with details of any proposed changes to be made to hospital practices and procedures arising from the investigation should be conveyed in writing to the complainant with each issue in the complaint responded to.

28. Each hospital group should develop a standardised policy on redress.

Leadership

29. Each hospital group should redevelop standardised reporting on complaints with greater attention paid to the narrative contained within complaints data so that senior management can identify recurring themes / issues and take action where appropriate.

30. Each hospital group should provide a six monthly report to the HSE on the operation of the complaints system detailing the numbers received, issues giving rise to complaints, the steps taken to resolve them and the outcomes.

31. The HSE should publish an annual commentary on these six monthly reports alongside detailed statistical data (using the reports published in the United Kingdom by the HSCIC as a model)

32. Each hospital group should appoint a senior member of staff to assume an active and visible leadership role in the complaints process with key involvement in education, training and reporting arrangements.

33. Senior managers in each hospital should foster and encourage positive attitudes towards complaints to ensure that each hospital is open to feedback and is responsive to complaints.

Learning

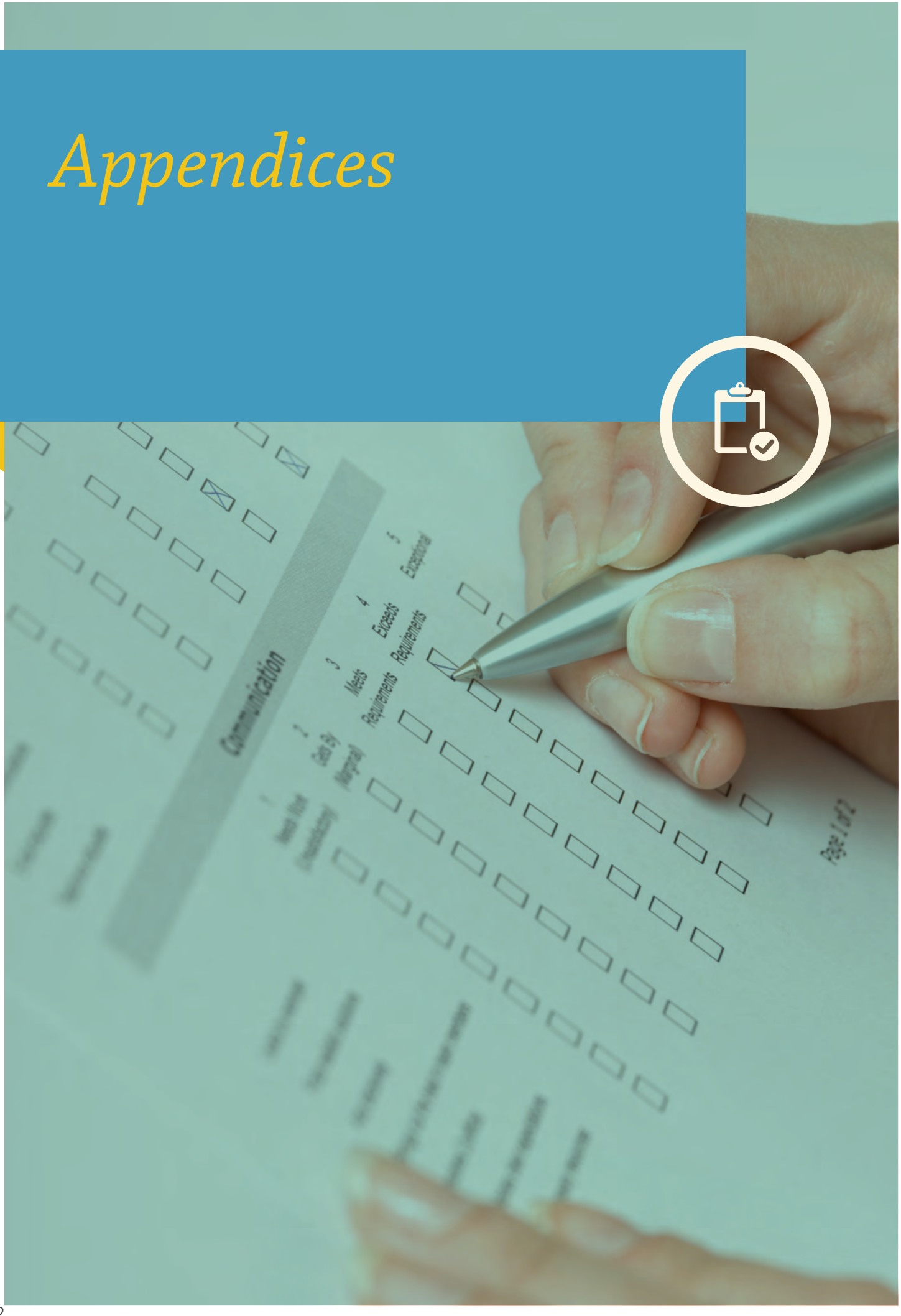
34. Each hospital group should develop a standardised learning implementation plan arising from any recommendations from a complaint which should set out the action required, the person(s) responsible for implementing the action and the timescale required.

35. Each hospital group should put in place arrangements (both within and across the hospital groups) for sharing good practice on complaint handling. This should include a formal network of Complaints Officers to ensure that learning and best practice is shared throughout the public hospital sector.

36. Each hospital group should publicise (via the development of a casebook) complaints received and dealt with within that hospital group. This casebook should contain brief summaries of the complaint received and how it was concluded/resolved (including examples of resulting service improvements) and should be made available to all medical, nursing and administrative staff as well as senior management. This could usefully form part of a larger digest incorporating all information on adverse incidents whether arising from complaints, whistle blowing or litigation to ensure that there is a comprehensive approach to learning from mistakes.

The Ombudsman intends to ask the HSE and each of the hospital groups to develop an action plan in order to monitor the implementation of these recommendations.

Appendices



Appendix 1

Hospital Groups

RCSI - Dublin North East
Beaumont Hospital
Our Lady of Lourdes Hospital, Drogheda
Connolly Hospital
Cavan General Hospital
Rotunda Hospital
Louth County Hospital
Monaghan Hospital. (Academic Partner: RCSI).

Dublin Midlands
St James's Hospital
The Adelaide & Meath Hospital, Dublin, including the National Children's Hospital (Tallaght Hospital)
Midlands Regional Hospital, Tullamore
Naas General Hospital
Midlands Regional Hospital Portlaoise
The Coombe Women & Infant University Hospital. (Academic Partner: TCD).

Ireland East
Mater Misericordiae University Hospital
St Vincent's University Hospital
Midland Regional Hospital Mullingar
St Luke's General Hospital, Kilkenny
Wexford General Hospital
National Maternity Hospital
Our Lady's Hospital, Navan
St Columcille's Hospital
St Michael's Hospital, Dun Laoghaire
Cappagh National Orthopaedic Hospital
Royal Victoria Eye and Ear Hospital. (Academic Partner: UCD).

South/South West
Cork University Hospital/CUMH
Waterford Regional Hospital
Kerry General Hospital
Mercy University Hospital
South Tipperary General Hospital
South Infirmary Victoria University Hospital
Bantry General Hospital
Mallow General Hospital
Lourdes Orthopaedic Hospital, Kilcreene. (Academic Partner: UCC).

Saolta - West/North West University Hospital Galway and Merlin Park University Hospital Sligo Regional Hospital Letterkenny General Hospital Mayo General Hospital Portiuncula Hospital Roscommon County Hospital. (Academic Partner: NUIG).
University of Limerick Mid-Western Regional Hospital, Limerick Ennis General Hospital Nenagh General Hospital St John's Hospital Limerick Mid-Western Regional Maternity Hospital Mid- Western Regional Orthopaedic. (Academic Partner: UL).
Children's Hospital Group Our Lady's Children's Hospital – Crumlin Children's University Hospital Temple Street and the paediatric service in AMNCH – Tallaght. (Academic Partner: All Universities)

Appendix 2

Questionnaire which issued to all public hospitals

Complaint Handling in Acute Hospitals

Name of hospital:

1. **How are patients and their families made aware of your hospital complaints system?**

- by means of information leaflets*? Yes ☐ No ☐
- via hospital website? Yes ☐ No ☐
- through information contained in notices/posters located in public hospital premises e.g. reception areas/wards/outpatient departments*? Yes ☐ No ☐
- through information contained in documentation provided to patients in connection with their admission/discharge from the hospital*? Yes ☐ No ☐
- Other sources (please give details)

**if your hospital produces an information leaflet or notices/posters, please enclose copies with your reply to this questionnaire.*

2. **Do you have a complaint form available within your hospital?**
   Yes ☐ No ☐

   If yes, please enclose a copy with your reply to this questionnaire

3. **How do patients and their families access these forms?**

4. **Can complaints be made online?** Yes ☐ No ☐

5. **What languages and formats are the complaint forms available in?**

6. **Does your hospital have a Complaints Officer?** Yes ☐ No ☐

7. **If yes, is the Complaints Officer engaged solely with the processing of complaints?**
Yes ☐ No ☐

8. **If the Complaints Officer is engaged in other duties, please describe these other duties and the proportion of time spent on these duties**

9. **Is the Complaints Officer easily accessible to patients and their families?** Yes ☐ No ☐

Please describe.

10. **Does your hospital have criteria or guidelines on how to recognise a complaint?**
Yes ☐ No ☐

If yes, please describe.

11. **Are staff at all levels in your hospital made aware of the existence and workings of the hospitals complaints system and patient rights?** Yes ☐ No ☐

    If yes, please provide details (including any supporting documentation or other evidence) as to how staff are made aware of your hospital complaints system and patient rights.

12. **Does your hospital have a Patients Charter?** Yes ☐ No ☐

    If yes, please provide a copy of your Patients Charter with your reply.

13. **If yes, how are patients and their families made aware of the Charter*?**

    *Please provide any supporting documentation or other evidence as to your approach in making them aware.

14. **Do you make patients and/or their families aware of their right to go to the Office of the Ombudsman or pursue other avenues of review?** Yes ☐ No ☐

    If yes, please describe how and when you do this*

* Please provide any supporting documentation or other evidence of your approach.

Signed :

Dated :

Oifig an Ombudsman
Office of the Ombudsman

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18 Lower Leeson Street, Dublin 2

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Learning to Get Better

Executive Summary and Recommendations

An investigation by the Ombudsman into how public hospitals handle complaints

Oifig an Ombudsman
Office of the Ombudsman

Executive Summary

This investigation by the Office of the Ombudsman looks at how public hospitals in Ireland handle complaints about their services. In particular, it looks at how well the HSE and public hospitals (including voluntary hospitals) listen to feedback and complaints and whether the HSE and public hospitals are learning from complaints to improve the services they provide.

At the outset of this investigation, this Office sought the views of members of the public who had complained about a hospital service, either as a patient or a relative and/or carer.

One of the key points that emerged from this public engagement was:

- many users of hospital services (whether patients or relatives/carers) **do not know how to make a complaint about a hospital service and are not aware of the support available** to help them to do so, including the right to escalate the complaint to this Office.

The main barriers to giving feedback or making a complaint were identified by participants as:

- **a fear of repercussions for their own or their relatives' treatment;**
- **a lack of confidence that anything would change as a result of complaining.**

This Office surveyed all public hospitals to gain a better understanding of the complaints process as it operates across the country and visited 8 randomly selected hospitals for a more in-depth study of their processes. We met with senior management from the HSE, the Department of Health, representative organisations and health sector regulators. We also received submissions from other representative organisations and patient advocacy groups.

The key findings that emerged from this investigation include:

1. Feedback should be encouraged – Members of the public reported a lack of knowledge about how to give feedback or make a complaint. The HSE and hospitals must publicise the information and supports available in order to encourage and assist people to share their experiences of hospital care and make the process more accessible for all. Complaints should be seen as a positive way of ensuring that healthcare services continually improve.

2. Learning from complaints is essential – Hospital staff reported to this Office that there was often a difficulty in getting internal feedback on the outcome of complaints. In view of this, and the belief among the focus group participants that nothing happens as a result of complaining, there is a need for a new focus on learning (and sharing the learning) from complaints. Responding effectively to complaints and learning from them is essential to providing a high quality service. In this regard, learning from complaints should sit alongside learning from other sources such as adverse events or "near misses".

3. There is a role for senior managers within the complaints process – Senior managers must be active and visible in promoting and reinforcing a positive complaints culture within hospitals.

4. Outcomes need to be publicised more – It is important that the HSE and hospitals highlight complaint outcomes which led to improvements and changes in procedures and inform people (the public, hospital staff and the hospitals) what these improvements are.

As a result of these findings, the Ombudsman has made a number of recommendations. These recommendations include:

- **A no "wrong door" policy should be developed** so that wherever a complaint is raised, it is the system and not the complainant that is responsible for routing it to the appropriate place to get it resolved.
- **Independent advocacy services should be sufficiently supported and signposted** within each hospital so patients and their families know where to get support if they want to raise a concern or issue.
- **A standard approach should be adopted by all hospitals in relation to the information available to the public.**
- **A standardised structure for collecting and documenting a complaint should be developed** across the hospital groups outlining the nature of the complaint, the preferred method of communication and desired outcomes.
- **The outcome of any investigation** of a complaint together with details of any proposed changes to be made to hospital practices and procedures arising from the investigation **should be conveyed in writing to the complainant** with each issue in the complaint responded to.
- Each hospital group should **provide a six monthly report to the HSE** on the operation of the complaints system detailing the issues giving rise to complaints and the steps taken to resolve them and the HSE should publish an annual commentary on these six monthly reports.
- Each hospital should **develop a learning implementation plan** arising from any recommendations from a complaint which should set out the action required, the person(s) responsible for implementing the action and the timescale required.
- Each hospital group should **publicise (via the development of a casebook) complaints received and dealt with within that hospital group.** This casebook should contain brief summaries of the complaint received and how it was concluded/resolved (including examples of resulting service improvements) and should be made available to all medical, nursing and administrative staff as well as senior management.

The Ombudsman intends to ask the HSE and each of the voluntary hospitals to develop an action plan in order to monitor the implementation of these recommendations.

Recommendations in full

Access

1. Multiple methods of making a complaint should be available and easily understood, both during and after treatment. These should include comment boxes within hospital wards (if not already in place). A fully accessible online version of Your Service Your Say should be developed to allow complainants to make a complaint online.

2. The HSE should undertake a review of Your Service Your Say with a view to making sure that service users have greater clarity, guidance and information on how the complaints system works.

3. A standard approach should be adopted by all hospitals in relation to the information available to the public when viewing their website, particularly those hospitals availing of the HSE website – hospital details on this site should all contain the same information and the same links for ease of reference.

4. Complaints Officers should be provided with appropriate and accessible facilities within each hospital to meet complainants.

5. Independent advocacy services should be sufficiently supported and signposted within each hospital so patients and their families know where to get support if they want to raise a concern or issue.

6. Each hospital should actively develop and encourage volunteer advocates with the hospital who can help support patients who wish to express a concern or make a complaint.

7. A no "wrong door" policy should be developed so that wherever a complaint is raised, it is the system and not the complainant that is responsible for routing it to the appropriate place to get it resolved.

8. Regulators and the Ombudsman should work more closely together to co-ordinate access for patients to the complaints system. In this regard, the online platform healthcomplaints.ie should be extended to provide a better publicised point of information and access for complainants.

9. Each hospital group should develop a process to allow for the consideration of anonymous complaints.

10. Each hospital should appoint an Access Officer (as statutorily required under the Disability Act 2005) who should attend all necessary training as provided by the HSE.

11. A detailed complaints policy statement should be displayed in public areas within all hospitals, on the hospital website, and in, or near, the Complaints Officer's office. Induction and other training for staff should include a reference to the policy. Staff should also be periodically reminded of the provisions of the policy.

12. Each hospital that has not yet done so, should include a reference to this Office:

- In **any** letter or correspondence notifying the patient/family of the outcome of the complaint to the hospital;
- On websites, booklets and information leaflets where the hospital refers to their complaints system;
- Verbally if explaining how to make a complaint to a patient or their family.

Process

13. The HSE should introduce a standard approach to implementing Your Service Your Say across the public health service. This should include standard forms, standard guidance for patients and staff, standard categorisation of complaints and standard reporting to give certainty to complainants and to allow for comparison on complaint handling, subjects and outcomes between hospitals and hospital groups.

14. Addressing concerns at ward level should be a main focus for each hospital. All hospital staff should be provided with the appropriate training to allow them to deal with issues as they arise.

15. Consideration should be given on a wider front to amending the statutory complaints process (and the remit of the Ombudsman) to allow for the inclusion of clinical judgement as a subject about which a complaint can be made.

16. Each hospital group should have a Complaints Officer to take overall responsibility for the complaints process and co-ordinate the work of complaints staff in each hospital in the group.

17. A standardised process and template for recording and documenting complaints at ward level should be embedded via a standardised system across the hospital groups.

18. A standardised structure and template for collecting and documenting a complaint should be developed across the hospital groups outlining the nature of the complaint, preferred method of communication and desired outcomes.

19. A standardised information system for the recording of complaints, comments and compliments should be developed across the hospital groups.

20. Each hospital group should implement mandatory training on complaints handling for all Complaints Officers and other staff involved in the complaints process.

21. Each hospital group should provide an induction module for all new hospital staff on the hospital complaints process and its underlying statutory framework.

22. Each hospital group should implement a bi-monthly audit of the complaints dealt with within the group in order to assess the quality of the process, including the response.

23. Each hospital group should develop a facility to allow for independent (i.e. outside the HSE) investigation of complaints where the complaint received is of sufficient seriousness and where appropriate.

24. The HSE and the hospital groups should take steps to ensure that all complaints are thoroughly, properly and objectively investigated and comprehensively responded to.

25. Each hospital group should develop an Open Disclosure training programme in line with the HSE National Guidelines and make it available to all staff.

26. The Department of Health should undertake a full review of the Health Act 2004 (Complaints) Regulations 2006. This Office looks forward to working with the Department in this regard.

Response

27. The outcome of any investigation of a complaint together with details of any proposed changes to be made to hospital practices and procedures arising from the investigation should be conveyed in writing to the complainant with each issue in the complaint responded to.

28. Each hospital group should develop a standardised policy on redress.

Leadership

29. Each hospital group should redevelop standardised reporting on complaints with greater attention paid to the narrative contained within complaints data so that senior management can identify recurring themes / issues and take action where appropriate.

30. Each hospital group should provide a six monthly report to the HSE on the operation of the complaints system detailing the numbers received, issues giving rise to complaints, the steps taken to resolve them and the outcomes.

31. The HSE should publish an annual commentary on these six monthly reports alongside detailed statistical data (using the reports published in the United Kingdom by the HSCIC as a model)

32. Each hospital group should appoint a senior member of staff to assume an active and visible leadership role in the complaints process with key involvement in education, training and reporting arrangements.

33. Senior managers in each hospital should foster and encourage positive attitudes towards complaints to ensure that each hospital is open to feedback and is responsive to complaints.

Learning

34. Each hospital group should develop a standardised learning implementation plan arising from any recommendations from a complaint which should set out the action required, the person(s) responsible for implementing the action and the timescale required.

35. Each hospital group should put in place arrangements (both within and across the hospital groups) for sharing good practice on complaint handling. This should include a formal network of Complaints Officers to ensure that learning and best practice is shared throughout the public hospital sector.

36. Each hospital group should publicise (via the development of a casebook) complaints received and dealt with within that hospital group. This casebook should contain brief summaries of the complaint received and how it was concluded/resolved (including examples of resulting service improvements) and should be made available to all medical, nursing and administrative staff as well as senior management. This could usefully form part of a larger digest incorporating all information on adverse incidents whether arising from complaints, whistle blowing or litigation to ensure that there is a comprehensive approach to learning from mistakes.

The Ombudsman intends to ask the HSE and each of the voluntary hospitals to develop an action plan in order to monitor the implementation of these recommendations.

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