Managing Patient and Service User Feedback within the Health Services

Your Service
Your Say

Your Service Your Say 2020

Foreword

2020 saw new challenges and changes within our health services. The impact of the coronavirus pandemic has been felt in every facet of society and by every person.

The response to the pandemic by the health services in Ireland presented significant challenges for our staff and our service users. Staff were redeployed and services were disrupted in order to divert resources to the COVID response. However, the pandemic also presented opportunities to innovate in service delivery and adopt new ways of working.

The HSE's vision for the *Your Service Your Say* process is to ensure that the fundamental right for people to voice opinions, provide comment, and to complain, is to the fore, with the focus on creating a positive environment and culture to encourage and learn from feedback.

To protect and promote this vision during COVID-19, the National Complaints Governance and Learning Team (NCGLT) commenced planning in early 2020 for a move to online delivery of its many tools and supports. The result was the release of a number of new training modules on HSELanD as well as the development of various webinars hosted on the Discovery Zone of HSELanD. This was to provide the greatest flexibility for the system to continue to access guidance and assistance when responding to feedback.

Evolving public health guidance around COVID-19 including health service delivery disruption significantly increased contacts by the public with the National Your Service Your Say Office, which saw an increase of 34% in interactions compared to 2019. Resources were diverted from NCGLT to support the function of the office and protect the right of people to relate their experience. While the system continued to respond to feedback, I recognise there were delays and I wish to thank those Service Users engaged in the Your Service Your Say process during this time for their patience and understanding.

While COVID affected NCGLT's ability to provide its full range of services and supports, we endeavoured to continue to deliver key supports and promote learning, albeit at a reduced frequency.

- NCGLT moved its Complaints Manager Governance and Learning Forum and CMS Steering Group to online platforms to continue to offer the necessary flexibility for attendees to network with colleagues and to participate in and progress developments around feedback.

- NCGLT produced an annual Anonymised Feedback Learning Casebook for 2020. The end of year casebook presented the learning gained from complaint investigations, reviews as well as the many positive experiences relayed. It is important that the voice of service users continue to feed into service development. NCGLT circulated the casebook widely throughout the HSE and published it online, enabling the sharing of good practice as well as initiatives to address and rectify issues that could be replicated in other areas.

- NCGLT ring-fenced critical support for the Complaints Management System (CMS). Data inputters across the HSE could continue to access the dedicated helpline for technical assistance and support with data queries that would aid the system to continue to record and access complaints data.

While many of the wider developments being progressed by NCGLT were impacted by COVID-19, feedback continued to be received and responded to, efforts to enhance responses to feedback were advanced and supports redesigned to meet the changing needs of staff and service users during this time.

I am pleased, therefore, to present the data on feedback received by the health services during 2020, the various solutions developed to continue to deliver support and guidance to the system and an update of the work currently in development by NCGLT.

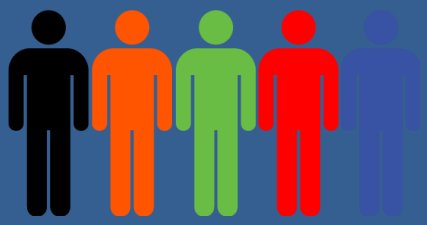
I acknowledge and appreciate the cooperation, enthusiasm and willingness of the operational system to work with NCGLT to bring developments to fruition and fully realise the potential that a positive feedback culture can deliver, both for those who work in the HSE and for those who use HSE services.

I hope that, despite COVID-19 and the pressures placed on our health services, you are encouraged by the consistent effort to improve and advance our response to your feedback, and are reassured that the HSE welcome, value and learn from your experience.

Mr Christopher Rudland
Assistant National Director
Patient and Service User Experience

2020. . .at a glance

The health services received **15,029** new complaints



COMPLAINTS MANAGEMENT SYSTEM

WE TRAINED 77 NEW INPUTTERS

Staff completing online training:

- 9632 completed Effective Complaints Handling
- 1875 completed Effective Complaints Investigation
- 786S completed YSYS Guidance for Clinical Staff

New Staff Online Training Modules

- YSYS Guidance for Clinical Staff on HSeLanD
- HSeLanD Discovery Zone webinars

WE HANDLED 73% OF COMPLAINTS WITHIN 30 WORKING DAYS OR LESS

The National Your Service Your Say Team had **17,603** client interactions

1135 Disability Complaints relating to Assessment of Need were received

the top 5 Causes for complaints relate to:

1. Safe and Effective Care
2. Access
3. Communication & Information
4. Dignity and Respect
5. Accountability

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Background

Feedback, both positive and negative, can provide unique insights into the standards of care those who use our services receive. Being in a position to capture this feedback and experience should therefore be central to how we learn and improve the quality of our services. Past UK and Irish reports into failings in care in hospitals highlighted the importance of listening to the patient voice; through patient journeys and formal complaints. Complaints can give a truer indication of the 'health' of a health system and provides an early warning alert to potential service user and patient safety issues.

The Ombudsman in his report, Learning to Get Better (2015) found that where patients and service users felt silenced by complex processes, a fear of repercussion or a perceived sense of futility surrounding complaints, the result was poorer outcomes and higher morbidity and mortality rates.

The HSE publicly committed to ensure that our feedback system would be open and responsive to the experience of our patients and service users. In particular, the HSE wanted to ensure that learning from complaints was a key feature of the complaints management process and used to drive quality and safety.

National Complaints Governance and Learning Team

The HSE established the National Complaints Governance and Learning Team to provide national leadership and strategic support for the management of the function in relation to feedback. The Team is responsible for developing the policies, systems and processes and tools to enable and encourage service users to share their experiences of HSE services and to ensure that the HSE are in a position to respond fully to these. Through its audit function, NCGLT provides assurance to the system that these measures are being implemented and are effective in alerting the organisation to poor service or potential service failures as well as highlighting trends or issues that need consideration in the context of the quality, safety and experience of services.

NCGLT sits within National Quality Assurance and Verification and is closely aligned to the other functions within QAV. Together, these ensure adherence to national standards and policy and the implementation of evidence-based best practice through audit and the appropriate management of risk, and in using service user experience, be it through the Your Service Your Say process, the incident management framework or the appeals service, drive quality improvements within the organisation.

Part One: Data on Complaints recorded in the Health Services 2020 (Community Services, Statutory Hospitals, Voluntary Hospitals and Voluntary Agencies)

1.0 Introduction

In order to provide the best possible care to those who use our services we must listen to and act on the views, concerns and experiences of patients, service users and other concerned individuals. Our priority is to ensure that patients and service users are engaged, enabled and empowered to be at the centre of service delivery.

This report is based on data collected through Complaints Officers who made regular returns, to either, regional Consumer Affairs offices or to the National Complaints Governance and Learning Team. Data relating to Statutory HSE services is primarily taken from the Complaints Management System. The remainder of statutory services data and much of voluntary hospitals and agencies data is taken from data sheets returned directly by these services to the HSE.

This annual collection of 2020 is a count of Stage 2 complaints recorded and examined by Complaints Officers in both the HSE and Voluntary Health Services which receive funding from the HSE in the Republic of Ireland.

1.1 Key Findings

In 2020, there were 15029 complaints received by the health services.

Of these, 5396 formal complaints were recorded as received and examined by Complaint Officers under the *Health Act 2004* and the *Disability Act 2005* in the Health Service Executive. Of the total number of complaints received, 277 were excluded from investigation under the Your Service Your Say complaints process, or withdrawn. Of the remaining 5,117 complaints, 2,916 or 57% were dealt with ≤30 working days (Part 9: Health Act, 2004, and Part 3: Disabilities Act, 2005). There were 1135 complaints relating to Assessment of Need of which 28% were dealt with by a Complaints Officer within 30 working days.

There were 9,633 complaints recorded and examined by Complaints Officers in Voluntary Hospitals and Agencies. Of the total number of complaints received, 9,285 were investigated. The other 348 were either excluded or withdrawn. Of those investigated 8,116 or 87% were addressed by a complaints officer either informally or through formal investigation within 30 working days.

1.2 Overall Findings

- There were **15,029** new complaints recorded.
- The top 5 causes of complaints contained an issue relating to the following classification:
    1. Safe & Effective Care
    2. Access
    3. Communication and Information
    4. Dignity and Respect
    5. Accountability

1.3 Variance from 2019

Summary Table of Variance

Summary Table of Variance	2020	2019	%Change
HSE Statutory Hospitals	**3013**	**3595**	-16%
Voluntary Hospitals within Hospital Groups	**5317**	**7142**	-26%
HSE Community Healthcare Organisations	**917**	**1011**	-9%
HSE Assessment of Need	**1135**	**1244**	-9%
HSE National Ambulance Service	**138**	**88**	57%
PCRS	**193**	**-**	
Other Voluntary Hospitals and Agencies	**4316**	**5018**	-14%
Total	**15029**	**18098**	**-17%**

Table 1: Summary of % Variance Complaints recorded 2019 to 2020

1.4 Breakdown of Recorded 2020

Complaints (Excluding Voluntary Hospitals and Agencies

HSE: Excluding Voluntary Hospitals and Agencies - Complaints under Part 3 of the Disabilities Act 2005	Total
HSE: Community Healthcare Organisations	917
HSE: Statutory Hospitals	3013
HSE: National Ambulance Service	138
HSE: Primary Care Reimbursement Fund	193
Complaints under Part 2 of the Disabilities Act 2005 (Assessment of Need)	1135
Total	**5396**

Table 2: Complaints (Excluding Voluntary Hospitals and Agencies and Complaints under Part 2 of the Disabilities Act 2005)

Complaints received to Voluntary Services

Complaints received to Voluntary Services	Total
HSE Voluntary Hospitals	5317
Other Voluntary Hospitals and Agencies	4316
Total Complaints received to Voluntary Services	9633

Table 3: Complaints received to Voluntary Services

Total Complaints Received

Total Complaints received 2020	Total
Total Complaints received to the HSE	5396
Total Complaints received to Voluntary Services	9633
Total Complaints received 2020	**15029**

Table 4: Total Complaints received 2020

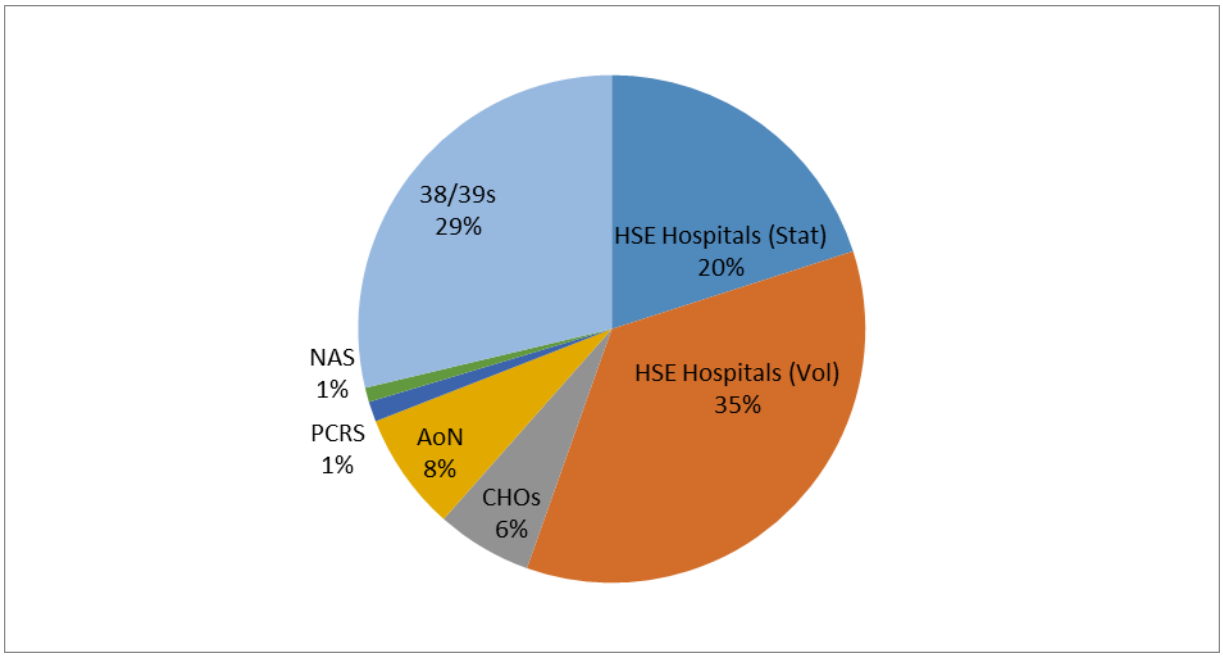


Figure 1: Breakdown of Complaints Recorded 2020

1.5 Complaints resolved by COs ≤30 working days

Complaints Officers are encouraged to resolve complaints informally if possible. However, if informal resolution is not possible then a formal investigative process must commence.

Complaints Officers should attempt to complete the formal investigation within 30 working days.

Our KPI target is 75% and for 2020, 73% of complaints were dealt with within 30 days or less.

Currently this KPI is calculated as follows:

- The numerator is the number of complaints investigated *under Your Service Your Say* and reported as addressed within 30 working.
- The denominator is the total number of Complaints recorded as received by the organisation less withdrawn, anonymous or otherwise exempt complaints.

1.6 Hospital Groups (Statutory and Voluntary)

University Limerick Hospitals Group

University Limerick Hospitals Group Statutory Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Croom Hospital	12	1	11	6	**55%**	5
Ennis Hospital	21	0	21	14	**67%**	7
Nenagh Hospital	18	0	18	12	**67%**	6
University Hospital Limerick	465	12	453	276	**61%**	177
University Maternity Hospital Limerick	99	5	94	55	**59%**	39

Table 5: ULHG Reported Complaints 2020 (Statutory)

University Limerick Hospitals Group Voluntary Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
St John's Hospital	10	0	10	10	**100%**	0

University Limerick Hospitals Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
ULH Statutory Hospitals	615	1	9	8	278	93	227	60%
ULH Voluntary Hospitals	10	0	0	0	8	2	0	100%

Table 6: ULHG Reported Complaints 2020

South/South West Hospital Group

South/South West Hospital Group Statutory Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Bantry General Hospital	1	0	1	0	**0%**	1
Cork University Hospital	110	6	104	43	**41%**	61
Cork University Maternity Hospital	152	2	150	64	**43%**	86
Mallow General Hospital (NIL)	2	2	0	0	**0%**	0
South Tipperary General Hospital	14	0	14	0	**0%**	14
University Hospital Waterford & Kilcreene	30	4	26	6	**23%**	20
University Hospital Kerry	4	3	1	0	**0%**	1

Table 7: SSWHG Reported Complaints 2020 (Statutory)

South/South West Hospital Group Voluntary Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Mercy University Hospital	101	11	90	75	**83%**	15
South Infirmary Victoria University Hospital	83	4	79	58	**89%**	21

Table 8: SSWHG Reported Complaints 2020 (Voluntary)

South/South West Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
SSWHG Statutory Hospitals	313	3	14	0	39	74	183	38%
SSWHG Voluntary Hospitals	184	5	9	1	70	63	36	79%

Table 95: SSWHG Reported Complaints 2020

Saolta Hospital Group (Statutory)

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
University Hospital Galway	284	2	282	215	76%	67
Merlin Park University Hospital	45	0	45	41	91%	4
Sligo Regional Hospital	160	0	160	160	100%	0
Letterkenny General Hospital	97	3	94	59	63%	35
Mayo General Hospital	171	0	171	0	0%	171
Portiuncula Hospital	81	1	80	67	84%	13
Roscommon County Hospital	3	0	3	3	100%	0

Table 106: Saolta Reported Complaints 2020

Saolta Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
Saolta Statutory Hospitals	841	1	5	0	198	347	290	65%

Table 11: Saolta Reported Complaints 2020

RCSI Hospital Group

RCSI Hospital Group Statutory Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Cavan & Monaghan General Hospitals	83	18	65	65	100%	0
Connolly Hospital	107	19	88	73	83%	15
Our Lady of Lourdes Hospital, Drogheda & Louth	195	15	180	158	88%	22

Table 12: RCSI Reported Complaints 2020 (Statutory)

RCSI Hospital Group Voluntary Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Beaumont Hospital	435	40	395	377	95%	18
Rotunda	118	1	117	115	98%	2

Table 13: RCSI Reported Complaints 2020 (Voluntary)

RCSI Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
RCSI Statutory Hospitals	385	17	35	0	37	259	37	89%
RCSI Voluntary Hospitals	553	7	34	0	8	484	20	96%

Table 14: RCSI Reported Complaints 2020

Ireland East Hospital Group

Ireland East Hospital Group Statutory Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Midland Regional Hospital Mullingar	191	17	174	102	**59%**	72
Our Lady's Hospital, Navan	38	0	38	18	**47%**	20
St. Columcille's Hospital	21	0	21	5	**24%**	16
St Luke's General Hospital, Kilkenny	112	0	112	88	**79%**	24
Wexford General Hospital	159	0	159	74	**47%**	85

Table 15: IEHG Reported Complaints 2020 (Statutory)

Ireland East Hospital Group Voluntary Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Cappagh National Orthopaedic Hospital	36	3	33	30	**91%**	3
Mater Misericordiae University Hospital	1225	15	1210	1077	**89%**	133
National Maternity Hospital (Vol)	127	21	106	97	**92%**	9
St Michael's Hospital, Dun Laoghaire	36	1	35	32	**91%**	3
St Vincent's University Hospital	619	2	617	593	**96%**	24
Royal Victoria Eye and Ear Hospital	113	0	113	91	**81%**	22

Table 167: IEHG Reported Complaints 2020 (Voluntary)

Ireland East Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
IEHG Statutory Hospitals	521	0	3	14	46	241	217	57%
IEHG Voluntary Hospitals	2156	15	27	0	1572	348	194	91%

Table 17: IEHG Reported Complaints 2020

Dublin Midlands Hospital Group

Dublin Midlands Hospital Group Statutory Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Midlands Regional Hospital Portlaoise	65	2	63	28	44%	15
Midlands Regional Hospital, Tullamore	190	0	190	166	87%	24
Naas General Hospital	83	0	83	68	825	15

Table 18: DMHG Reported Complaints 2020 (Statutory)

Dublin Midlands Hospital Group Voluntary Hospitals

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Tallaght University Hospital (Vol)	1055	0	1055	925	88%	130
The Coombe	127	0	127	115	91%	12
St. Luke's Radiation Oncology Network	4	0	4	0	0%	4
St. James's Hospital	524	0	524	221	42%	303

Table 19: DMHG Reported Complaints 2020 (Voluntary)

Dublin Midlands Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
DMHG Statutory Hospitals	338	0	2	0	158	104	74	78%
DMHG Voluntary Hospitals	1710	0	0	0	592	669	449	74%

Table 20: DMHG Reported Complaints 2020

Children's Health Ireland Group (Voluntary)

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO	Resolved >30 working days by CO
Our Lady's Children's Hospital, Crumlin	392	0	392	262	67%	130
Children's University Hospital Temple Street	252	1	251	215	86%	36
Tallaght University Hospital	60	0	60	45	75%	25

Table 218: CHI Reported Complaints 2020

Children's Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
CHG Voluntary Hospitals	704	0	1	0	103	419	181	74%

Table 22: CHI Reported Complaints 2020

All HSE Statutory and Voluntary Hospitals

All Statutory and Voluntary Hospitals	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO
Total	8330	422	7908	6204	78%

Table 23: All HSE Statutory and Voluntary Hospitals Reported Complaints 2020

Other Voluntary Hospitals and Agencies

Hospital	Complaints received 2020	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO
Other Voluntary Hospitals and Agencies	4316	249	4067	3778	93%

Table 24: Other Voluntary Hospitals Reported Complaints 2020

1.7 Community Healthcare Organisations

Complaints Reported by each CHO

Complaints Received/Resolved under the Health Act: CHOs

Community Healthcare Organisation (CHO)	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
CHO 1	122	0	0	0	12	15	95	22%
CHO 2	141	23	9	3	28	47	31	71%
CHO 3	66	0	3	0	21	22	20	68%
CHO 4	78	0	6	0	14	28	30	58%
CHO 5	31	0	0	0	23	3	5	84%
CHO 6	29	0	0	0	1	2	26	10%
CHO 7	222	1	9	0	84	101	27	87%
CHO 8	116	3	2	0	23	40	48	57%
CHO 9	101	1	2	0	40	29	29	70%

Table 25: CHOs Complaints resolved 2020

Complaints Received/Resolved relating to Assessment of Need Nationally (Disabilities) (across all CHOs) under the Disability Act.

Assessment of Need Nationally (across all CHOs)	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	1135	46	31	0	0	300	784	28%

Table 26: AoN Complaints resolved 2020

1.8 Category of Complaint

Note: Many complaints contain multiple issues and therefore fall under more than one category

Category of Complaints for all services

Category	HSE Statutory Hospitals and Community Services	Voluntary hospitals and agencies	Total 2020
Access	2318	2521	4839
Dignity and respect	635	1477	2112
Safe and effective care	1797	3274	5071
Communication and information	989	2396	3385
Participation	33	253	286
Privacy	55	213	268
Improving health	52	184	236
Accountability	235	490	725
Clinical judgement	193	211	404
Vexatious complaints	4	82	86
Nursing homes / residential care for older people (65 and over)	8	27	35
Nursing homes / residential care (aged 64 and under)	0	23	23
Pre-school inspection services	0	7	7
Trust in care	6	91	97
Children first	10	35	45
Safeguarding vulnerable persons (new 2016)	1	356	357
Total Issues	**6336**	**11640**	**17976**

Table 27: Complaints broken down by category NOTE: Explanation of Categories is available in Appendices

1.8.1 Complaints by Issues (per Hospital Group)

University Limerick Hospitals Group Statutory Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Croom Hospital	1	1	8	3	0	0	0	1
Ennis Hospital	3	1	20	2	0	0	0	1
Nenagh Hospital	2	0	4	9	0	0	0	2
University Hospital Limerick	154	53	267	85	3	7	12	35
University Maternity Hospital Limerick	41	15	41	24	0	1	8	3
Total Issues	**201**	**70**	**340**	**123**	**3**	**8**	**20**	**42**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Croom Hospital	0	0	0	0	0	0	0	0
Ennis Hospital	0	0	0	0	0	0	0	0
Nenagh Hospital	0	0	0	0	0	0	0	0
University Hospital Limerick	0	0	0	0	0	0	0	0
University Maternity Hospital Limerick	0	0	0	0	0	0	0	0
Total Issues	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 28: Complaints broken down by category University Limerick Hospitals Group Statutory Hospitals

University Limerick Hospitals Group Voluntary Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
St John's Hospital	0	0	0	2	0	0	0	0
Total Issues	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
St John's Hospital	0	0	0	0	0	0	0	0
Total Issues	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 29: Complaints broken down by category University Limerick Hospitals Group Voluntary Hospitals

South/South West Hospital Group Statutory Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Bantry General Hospital	0	1	1	0	0	0	0	0
Cork University Hospital	8	10	61	28	1	1	0	1
Cork University Maternity Hospital	72	9	47	27	0	1	3	2
Mallow General Hospital	0	0	0	2	0	0	0	0
South Tipperary General Hospital	3	21	6	14	0	1	1	0
University Hospital Waterford & Kilcreene	21	10	95	55	1	4	1	27
University Hospital Kerry	12	16	25	18	0	0	0	4
Total Issues	**116**	**67**	**235**	**144**	**2**	**7**	**5**	**34**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Bantry General Hospital	1	0	0	0	0	0	0	0
Cork University Hospital	0	0	0	0	0	0	0	0
Cork University Maternity Hospital	0	0	0	0	0	0	0	0
Mallow General Hospital	0	0	0	0	0	0	0	0
South Tipperary General Hospital	0	0	0	0	0	0	0	0
University Hospital Waterford & Kilcreene	0	0	0	0	0	0	0	0
University Hospital Kerry	0	0	0	0	0	0	0	0
Total Issues	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 30: Complaints broken down by category South/South West Hospital Group Statutory Hospitals

South/South West Hospital Group Voluntary Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Mercy University Hospital	10	15	31	43	0	0	0	2
South Infirmary Victoria University Hospital	24	2	21	18	0	0	0	3
Total Issues	**34**	**17**	**52**	**61**	**0**	**0**	**0**	**5**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Mercy University Hospital	0	0	0	0	0	0	0	0
South Infirmary Victoria University Hospital	3	0	0	0	0	0	0	0
Total Issues	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 319: Complaints broken down by category South/South West Hospital Group Voluntary Hospitals

Saolta Hospital Group Statutory Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
University Hospital Galway	63	26	83	74	2	2	3	13
Merlin Park University Hospital	24	8	7	18	0	0	0	1
Sligo Regional Hospital	55	30	40	24	0	5	0	0
Letterkenny General Hospital	39	3	45	10	0	0	0	0
Mayo General Hospital	28	24	79	26	0	1	2	17
Portiuncula Hospital	14	11	25	20	2	0	0	9
Roscommon County Hospital	0	0	0	0	0	0	0	0
Total Issues	**223**	**102**	**279**	**172**	**4**	**8**	**5**	**40**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
University Hospital Galway	0	0	0	0	0	0	0	0
Merlin Park University Hospital	0	0	0	0	0	0	0	0
Sligo Regional Hospital	2	0	2	0	0	1	0	1
Letterkenny General Hospital	0	0	0	0	0	0	0	0
Mayo General Hospital	1	0	0	0	0	0	0	0
Portiuncula Hospital	0	0	0	0	0	0	0	0
Roscommon County Hospital	0	0	0	0	0	0	0	0
Total Issues	**3**	**0**	**2**	**0**	**0**	**1**	**0**	**1**

Table 32: Complaints broken down by category Saolta Hospital Group Statutory Hospitals

RCSI Hospital Group Statutory Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Cavan & Monaghan General Hospitals	17	23	50	31	0	1	0	5
Connolly Hospital Blanchardstown	19	12	81	37	0	3	0	6
Our Lady of Lourdes Hospital, Drogheda & Louth	30	73	65	15	0	2	0	5
Total Issues	**66**	**108**	**196**	**83**	**0**	**6**	**0**	**16**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Cavan & Monaghan General Hospitals	47	0	0	0	0	0	0	0
Connolly Hospital Blanchardstown	33	0	0	0	0	0	0	0
Our Lady of Lourdes Hospital, Drogheda & Louth	1	0	0	0	0	3	0	0
Total Issues	**81**	**0**	**0**	**0**	**0**	**3**	**0**	**0**

Table 33: Complaints broken down by category RCSI Hospital Group Statutory Hospitals

RCSI Hospital Group Voluntary Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Beaumont Hospital	87	32	243	61	0	3	0	50
Rotunda	92	32	158	203	7	6	7	6
RCSI Voluntary Hospitals Total Issues	**179**	**64**	**401**	**264**	**7**	**9**	**7**	**56**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Beaumont Hospital	2	0	0	0	0	0	0	0
Rotunda	57	0	0	0	0	0	0	0
Total Issues	**59**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 34: Complaints broken down by category RCSI Hospital Group Voluntary Hospitals

Ireland East Hospital Group Statutory Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Midland Regional Hospital Mullingar	52	25	85	28	0	0	5	4
St Luke's General Hospital, Kilkenny	18	1	48	32	0	6	2	22
St. Columcille's Hospital	4	4	5	2	0	1	0	0
Our Lady's Hospital, Navan	9	4	17	8	0	0	0	0
Wexford General Hospital	68	30	53	80	10	7	4	17
Total Issues	**151**	**64**	**208**	**150**	**10**	**14**	**11**	**43**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Midland Regional Hospital Mullingar	0	0	0	0	0	0	0	0
St Luke's General Hospital, Kilkenny	39	0	0	0	0	0	0	0
St. Columcille's Hospital	0	2	0	0	0	0	0	0
Our Lady's Hospital, Navan	0	0	0	0	0	0	0	0
Wexford General Hospital	50	2	0	0	0	1	2	0
Total Issues	**89**	**4**	**0**	**0**	**0**	**1**	**2**	**0**

Table 35: Complaints broken down by category Ireland East Hospital Group Statutory Hospitals

Ireland East Hospital Group Voluntary Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Cappagh National Orthopaedic Hospital	16	3	24	26	0	0	1	2
Mater Misericordiae University Hospital	151	89	326	248	14	5	7	59
National Maternity Hospital	23	23	61	72	4	1	5	1
St Michael's Hospital, Dun Laoghaire (V)	15	4	9	11	0	0	0	2
St Vincent's University Hospital	4	6	58	34	0	5	0	5
Royal Victoria Eye and Hospital	27	17	20	48	0	0	0	0
Total Issues	**236**	**142**	**498**	**439**	**18**	**6**	**13**	**69**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Cappagh National Orthopaedic Hospital	9	0	0	0	0	0	0	0
Mater Misericordiae University Hospital	21	2	0	1	0	2	0	1
National Maternity Hospital	3	0	0	0	0	0	0	0
St Michael's Hospital, Dun Laoghaire (V)	4	0	0	0	0	0	0	0
St Vincent's University Hospital	58	38	0	0	0	0	0	0
Royal Victoria Eye and Hospital	1	0	0	0	0	0	0	0
Total Issues	**96**	**40**	**0**	**1**	**0**	**2**	**0**	**1**

Table 36: Complaints broken down by category Ireland East Hospital Group Voluntary Hospitals

Dublin Midlands Hospital Group Statutory Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Midlands Regional Hospital Portlaoise	16	5	75	30	5	5	0	11
Midlands Regional Hospital, Tullamore	35	7	71	57	0	1	2	33
Naas General Hospital	15	7	20	38	0	1	0	4
Total Issues	**66**	**19**	**166**	**125**	**5**	**7**	**2**	**48**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Midlands Regional Hospital Portlaoise	0	0	0	0	0	0	0	0
Midlands Regional Hospital, Tullamore	0	0	0	0	0	0	0	0
Naas General Hospital	2	0	1	0	0	0	0	0
Total Issues	**2**	**0**	**1**	**0**	**0**	**0**	**0**	**0**

Table 3710: Complaints broken down by category Dublin Midlands Hospital Group Statutory Hospitals

Dublin Midlands Hospital Group Voluntary Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
The Adelaide & Meath Hospital, Dublin	330	97	350	307	14	14	9	25
The Coombe Women & Infant University Hospital	30	2	22	62	1	1	4	5
St. Luke's Radiation Oncology Network	0	0	1	1	0	0	0	0
St. James's Hospital	135	86	302	222	14	5	6	57
Total Issues	**495**	**185**	**675**	**592**	**29**	**20**	**19**	**87**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
The Adelaide & Meath Hospital, Dublin	0	0	0	0	0	0	0	0
The Coombe Women & Infant University Hospital	0	0	0	0	0	0	0	0
St. Luke's Radiation Oncology Network	0	0	0	0	0	0	0	0
St. James's Hospital	12	2	0	1	0	2	0	1
Total Issues	**12**	**2**	**0**	**1**	**0**	**2**	**0**	**1**

Table 38: Complaints broken down by category Dublin Midlands Hospital Group Voluntary Hospitals

Children's Health Ireland Group Voluntary Hospitals: Issues

Hospital	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Our Lady's Children's Hospital, Crumlin	199	36	242	248	13	4	19	39
Children's University Hospital Temple Street	90	10	11	45	0	8	5	20
Tallaght University Hospital	19	2	16	19	2	1	0	4
Total Issues	**308**	**48**	**269**	**312**	**15**	**13**	**24**	**63**

Hospital	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Our Lady's Children's Hospital, Crumlin	0	0	0	0	0	0	0	0
Children's University Hospital Temple Street	1	0	0	0	0	0	0	0
Tallaght University Hospital	0	0	0	0	0	0	0	0
Total Issues	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 39: Complaints broken down by category Children's' Health Ireland Group

1.8.2 Complaints by Issues (CHOs)

Community Healthcare Organisations (CHOs)

Community Health Organisation	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
CHO 1	25	10	13	22	2	0	1	0
CHO 2	69	8	15	20	0	0	0	1
CHO 3	29	29	1	6	0	0	0	1
CHO 4	24	19	21	27	2	0	2	1
CHO 5	15	8	6	2	0	0	0	0
CHO 6	4	7	18	3	0	1	0	1
CHO 7	98	16	80	33	3	1	1	2
CHO 8	49	17	32	38	1	1	5	6
CHO 9	41	30	31	19	1	1	0	0
Total	**354**	**144**	**217**	**170**	**9**	**4**	**9**	**12**

Community Health Organisation	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
CHO 1	1	0	1	0	0	1	0	0
CHO 2	0	0	0	0	0	0	0	0
CHO 3	0	0	0	0	0	0	0	0
CHO 4	0	0	3	0	0	0	0	0
CHO 5	0	0	0	0	0	0	0	0
CHO 6	0	0	0	0	0	0	0	0
CHO 7	9	0	0	0	0	0	0	0
CHO 8	2	0	1	0	0	0	0	0
CHO 9	5	0	0	0	0	0	8	0
Total	**17**	**0**	**5**	**0**	**0**	**1**	**8**	**0**

Table 40: Complaints broken down by category for Community Healthcare Organisations 2020

Part Two: The National Complaints Governance and Learning Team

2.0 Introduction

To deliver on the HSE's commitment to strengthen and enhance the response to feedback and to ensure a focus on learning, a unit within National Quality Assurance and Verification was set up to provide national leadership and governance.

The National Complaints Governance and Learning Team (NCGLT) is tasked with developing the systems and supports to deliver on the HSE's commitment to provide an enhanced service user feedback process that is accessible, flexible and responsive as well as the mechanisms that enable the narrative and data from feedback to drive learning and quality improvement.

The NCGLT team includes the National Your Service Your Say Office based in Millennium Park in Naas. This is a national frontline service offering a dedicated contact point for assisting service users and their families to provide feedback to the HSE.

The NCGLT team also includes the National Disability Complaints Service dealing with Assessment of Need Complaints. This service is co-located in Millennium Park, Naas and in Limerick.

2.1 Complaints Governance

2.1.1 Complaints Managers

To provide visible leadership, and ensure governance, in the area of feedback (comments, compliments and complaints) at a local level, and as recommended within the Ombudsman's Learning to Get Better report, the appointment of Complaints Managers, within Community Healthcare Organisations, Hospital Groups and National Services was supported and accordingly mandated by the HSE.

Complaints Managers are involved in education, training and reporting arrangements around Your Service Your Say. They ensure that the HSE's feedback policy is implemented and that the system is functioning in line with policy with key staff, including clinicians, supported to understand how complaints are handled. They provide assurance, through casebooks, that learning is being captured and shared as well as reporting to local and national management on the effectiveness of the process.

Complaints Managers are responsible for assigning Review Officers to complaints following request for a review.

NCGLT, as part of its governance function, continue to promote appointments to this mandated role within Community Healthcare Organisations, Hospital Groups and National Services.

To support Complaints Managers in the execution of their role, NCGLT also facilitate the hosting of the National Complaints Governance and Learning Forum. Attendance of Complaints Managers at this Forum is mandated by the HSE.

2.1.2 *National Complaints Managers Governance and Learning Forum*

The National Complaints Managers Governance and Learning Forum has been running for the past 6 years, having been established in 2016. The Forum, which meets quarterly, offers a valuable opportunity for shared learning, problem solving, discussion around issues, expert input into specialist topics as well as an arena for exploring areas for development to ensure the continuous evolvement of our feedback processes.

Key messages from the Forum, including matters identified or arising, are shared by Complaints Managers with their respective Senior Management Teams at Community Healthcare Organisation, Hospital Group and National Service level for consideration and action as appropriate.

The Forum offers Complaints Mangers an opportunity to relate their experience of responding to and managing feedback from an operational perspective and flag issues for further discussion. Members also have the chance to network with peers and build informal as well as more formal connections that will support them in their role.

While the Complaints Managers Governance and Learning Forum normally convenes quarterly, in 2020, as a result of the HSE response to COVID-19 and public health advice, the Forum was only held twice, in March and December.

March Forum

The March Forum, which was held pre-COVID restrictions, was the only face-to-face meeting for Complaints Managers in 2020.

Case studies are an integral part of the learning platform that is fostered and facilitated at the Forum and NCGLT would like to thank Ms Nicola Gregg and Ms Sarah Walshe, South Dublin, Kildare and West Wicklow Community Healthcare for sharing an interesting case that spanned both the hospital and community setting.

Case Study – Presented by South Dublin, Kildare and West Wicklow Community Healthcare
Feedback Category: *Safe and Effective Care / Medication*

Key issue related to a visitor to Ireland who accessed care in an acute setting and was provided with a prescription. However, the medication was not prescribed using an EU prescription form, which a visitor to Ireland utilising the European Health Insurance Card requires. The visitor tried to contact a GP as well as an out of hours GP service in an effort to have the medication prescribed on the correct form in order for a pharmacy to dispense. No avenues successfully resulted in the prescribing of the medication on the correct EU prescription form.

Eventually, after much effort, the visitor was able to organise an emergency one-week supply of the medication. However, the issue remained that the visitor could not get anyone to write up the medication on the appropriate form.

This complaint generated much discussion at the Forum, and the case was relayed to both acute and PCRS services for learning and follow up action.

Forums also feature presentations on specialist topics as requested by members. In March, NCGLT were delighted to welcome Cassandra Ferguson, HSE Health & Safety Advisor, HSE Workplace Health and Wellbeing Unit, who presented on the topic of **Resilience and Stress Management**.

Specialist Topic Presentation: Resilience and Stress Management
The presentation defined what stress is and what can give rise to stress including that created in the workplace. The symptoms of stress were also outlined.

With regards to workplace stress, the presentation set out the organisational responsibility and explained the workplace stress flowchart to assist in responding to stress. The presentation went through how to conduct a risk assessment and then highlighted the various risk reduction/control measures that could be used to reduce workplace stress.

The presentation also covered the various supports available for further information and assistance.

In a departure from previous Forums, the March forum included a Complaints Manager Workshop. The workshop represented a timely review of the function and format of the Forum as well as an examination of the role and responsibilities of a Complaints Manager, how well these are being executed and where further support may be required from both a local and national perspective.

The exercise was embraced by Complaints Managers and NCGLT would like to thank members for their meaningful engagement throughout the workshop.

December Forum
The final Forum for 2020 was held in December. As a result of COVID and public health restrictions it was not possible to hold this as a face-to-face meeting. Instead, the Forum was held online.

In advance of the December Forum NCGLT issued out a brief questionnaire to Complaints Managers to gauge how the response to COVID by their service (CHO, Hospital Group, National Service) was impacting on their role and the management of feedback including the challenges presenting and ongoing issues.

As the December Forum was the final forum for 2020 and the first opportunity that Complaints Managers had to come together since the start of the emergency response to COVID, there was very high participation.

Mr Patrick Lynch, National Director Quality Assurance and Verification addressed Forum members. He acknowledged the considerable impact on individuals, teams and work during 2020. He drew attention to the results of the Complaints Manager survey which reflected the situation during the year and acknowledged positive developments such as an increase in compliments.

He also highlighted the need to continually invest in complaints and the importance of the delegated roles within the complaints function, including the Complaints Manager role and the need for same to be a dedicated full time position.

The representative of the Office of the Ombudsman, Ms Geraldine McCormack, also thanked the HSE for the work done during a difficult year.

Mr Chris Rudland, Assistant National Director, NCGLT and Chair of the Forum thanked Complaints Managers for completing the questionnaire and recognised that the main issues impacting on complaints management was the redeployment of Complaints Officers and CMS support staff along with general staff absences, clinical staff availability and service delivery pressures.

From a learning perspective, he acknowledged that due to COVID, only an end of year casebook would be published.

The survey also indicated that measures to support Complaints Officers such as a Complaints Officer Forum was needed for peer support and mentoring and he agreed that this should be a priority for 2021.

The Forum continued with presentations on updates regarding various development work and supports.

The Forum finished with an overview of the results from the Complaints Managers Workshop that was held in the March Forum. The feedback will be used to further develop the value and benefit of the Complaints Manager Forum for members as well as inform supportive measures for the role of the Complaints Manager than can be actioned at national level.

Note: All minutes from the National Complaints Managers Governance and Learning Forum are available on www.hse.ie/yoursay

The National Complaints Managers Governance and Learning Forum also has representatives from Consumer Affairs, the Office of the Ombudsman Ombudsman and, on occasion, the Ombudsman for Children, national advocacy groups and service users.

NCGLT would like to thank Ms Rosalie Smith Lynch who is the nominated representative for Consumer Affairs at the Forum. Consumer Affairs provides training, support and advice to Complaints Officers on complaint investigations. Consumer Affairs is also the key contact for the Office of the Ombudsman for any external review by that office. As the Consumer Affairs representative, Ms Smith Lynch contributes practical operational advice to Complaints Managers and feeds back the experience of Complaints Officers relevant to the issues being raised

NCGLT would also like to give a special thanks to Ms Geraldine McCormack from the Office of the Ombudsman. As a member of and contributor to the Forum, Ms McCormack keeps members updated on developments within the Office of the Ombudsman, assists the HSE in furthering progress in the area of feedback and compliance with the recommendations set out in Learning to Get Better while addressing any practical issues arising at the operational level.

Attendance

The Forum is scheduled on a quarterly basis and attendance is mandatory. For those who send apologies a nominated representative can be sent in their stead.

Below is a table setting out attendance for the March and December Forums for 2020 noting that the June and September Forum did not proceed as a result of COVID.

2020 Complaints Managers Governance and Learning Forum Attendance

KEY: Attended | No Show | Issued Apologies | **AM** Affiliate Member – will attend if requested

Area	2020 Forum Dates				Summary Attendance	
	02/03/2020	08/06/2020 Cancelled	21/09/2020 Cancelled	14/12/2020	Total Attended	% Attended
Hospital Groups						
Ireland East Hospital Group	Yes			Yes	2	100%
South / South West Hospital Group	No			Yes	1	50%
Dublin Midlands Hospital Group	Apologies			Yes	1	50%
Children's Health Ireland	Yes			Yes	2	100%
Saolta University Healthcare Group	Yes			Yes	2	100%
RCSI Hospital Group	Apologies			Yes	1	50%
UL Hospitals Group	Yes			Yes	2	100%
Community Healthcare Organisations						
CHO Area 1	Yes			Yes	2	100%
Community Healthcare West	Apologies			Yes	1	50%
Mid West Community Healthcare	Yes			Apologies	1	50%
Cork Kerry Community Healthcare	Yes			Yes	2	100%
South East Community Healthcare	Yes			Yes	2	100%
Community Healthcare East	Yes			Yes	2	100%
Dublin South Kildare & West Wicklow Community Healthcare	Yes			Yes	2	100%
Midlands Louth Meath Community Healthcare	Yes			No	1	50%
Dublin North City and County Community Healthcare	Apologies			Yes	1	50%
National Services						
Internal Audit	AM			AM		
Communications	No			No	0	0%
Mental Health	No			No	0	0%
Health & Well Being	No			No	0	0%
National Ambulance Service	Apologies			Yes	1	50%
Acute Hospitals	No			Apologies	0	0%
Primary Care	Apologies			Apologies	0	0%
Social Care						
Public Health* *new for Q4 2020*	N/A			Yes		
Other Attendees						
Office of the Ombudsman	Yes			Yes	2	100%
Ombudsman for Children's Office	AM			AM		
Consumer Affairs	Yes			Yes	2	100%

Table 41: Attendance at the Complaints Managers Governance and Learning Forum 2020

2.1.3 *Complaints Officers and Review Officers*

'*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*'.

Learning to Get Better, Ombudsman (2015)

The report further recommended that '*Complaints Officers should have the authority and time to deal with complaints effectively'.*

The same equally applies to the role of the Review Officer.

In the HSE, Complaints Officers and Review Officers are delegated into their role and act independently and with the authority of the Chief Officer of a Community Healthcare Organisation, Chief Executive Officer of a Hospital Group or National Director of a National Division in the investigation of a complaint.

To ensure good governance over the delegation of Complaints Officers and Review Officers and in support of the recommendations set out in Learning to Get Better, NCGLT developed guidance regarding delegation.

This Guidance updates the delegation process ensuring that each person assigned as a Complaints Officer or Review Officer is formally delegated into this role and undergoes training, highlighting the independent nature of the function and the authority it carries. The revised process also calls for such delegations to be reviewed every three years.

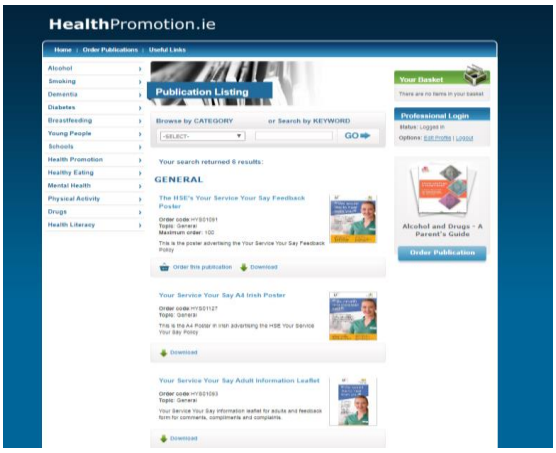
Delegation Orders including Appointment Revocation Notifications are to be held by Complaint Managers with a copy issued to the local Consumer Affairs Office, the National Complaints Governance and Learning Team, and the National Delegations Office. These offices should also be notified by a Complaints Officer and/or Review Officers should they leave or change their post for any reason.

Currently there are 784 delegated Complaints officers and 260 delegated Review officers.

The revised Delegation Forms and Guidance are available on www.hse.ie/yoursay

2.2 Your Service Your Say Materials

All published materials are available to order from www.healthpromotion.ie



To order materials from this site, click on 'Order Publications' from the top menu. You will then need to complete the 'Professional Login' area or register as a professional, if you have not done so previously. You can then enter *Your Service Your Say* into the 'Search by keyword' area and all materials available to order will be listed. Select the quantity needed and enter in your delivery details.

Materials available to order from the site include:

- Your Service Your Say Adult Information Leaflet
- Your Service Your Say Children's Information Leaflet
- Your Service Your Say A3 and A4 English Poster
- Your Service Your Say A3 and A4 Irish Poster
- Your Service Your Say Feedback Box Stickers

Materials available to download are:

- Your Service Your Say Policy Document

Feedback boxes are not available to order from the site. These should be sourced locally.

Posters

In addition to the above materials, NCGLT have developed a suite of posters.

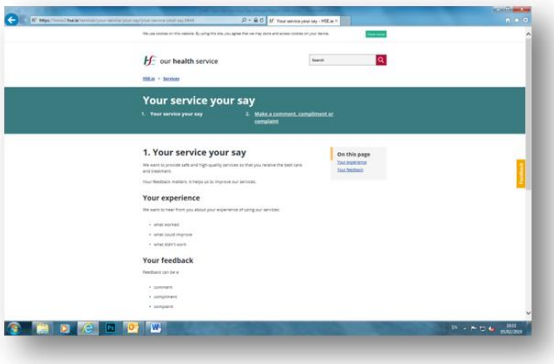
The following posters are now available:

- **Assessing a Complaint**
  Designed to assist staff in relation to complaints that cannot be managed under Part 9 of the Health Act 2004 and therefore cannot be investigated under the Your Service Your Say policy. The poster will provide guidance to staff by outlining the policy, procedure, guideline and / or legislation to be followed in order to redirect the complaint via the appropriate pathway while considering the 'No Wrong Door' approach in relation to complaints received.
- **Complaints Management Pathway**
  Designed to provide an overview of the four stages in the Your Service Your Say process and the key steps to take at each stage along with the timeframes applying.
- **Timeframes for the Complaints Management Process**
  Designed to provide a guide for each person involved in the Your Service Your Say process regarding the legislative and policy timeframes applying to the various stages of the complaints management process.

Posters are available on request from NCGLT or alternatively a PDF version can be downloaded by following this link: **https://www.hse.ie/eng/about/qavd/complaints/ysysguidance/appendices/**

2.3 HSE Website

The HSE website continues to be updated with new developments. Visit www.hse.ie/yoursay



2.4 Awareness

While events to promote awareness of Your Service Your Say were limited due to COVID and public health restrictions, NCGLT did exhibit at the National Office for Clinical Audit (NOCA) annual conference in February 2020.

2.4.1 National Office for Clinical Audit (NOCA)

The NOCA Annual Conference took place on Wednesday 12th February 2020, as part of RCSI's Charter Week programme.

The event saw over 500 healthcare professionals in attendance with national and international speakers and panelists.

This year's conference theme was 'Quality in Healthcare: Challenging perceptions'

NOCA's Clinical Director, Brian Creedon, opened the fourth Annual Conference welcoming attendees from all areas of the healthcare system in Ireland, with representatives from hospitals, hospital groups, HSE, Department of Health, healthcare professional bodies, patient advocacy groups and many more.

Attendees at the 2020 NOCA Conference

The event saw the launch of two national clinical audit reports - the Irish National ICU Audit Annual Report 2018 and Major Trauma Audit National Report 2018.

There were also three projects shortlisted to present for the NOCA Quality Improvement Champion Award 2020.

- 'CodeHip' presented by Ricardo Paco, Trauma Audit Coordinator, St James' Hospital.
- 'Seven-day Physiotherapy Stroke Assessment' presented by Helen Kavanagh, Clinical Specialist Physiotherapist, St James' Hospital.

And the winner of the QI Award Champion 2020 . . .

- 'Paediatrics ECG interpretation checklist' presented by Muhammad Moazzam Gulzar, Registrar Emergency Medicine, Children's Health Ireland at Crumlin.

NCGLT exhibited at the conference and engaged with healthcare professions on the importance of encouraging and listening to the patient voice in healthcare to drive improvement in service quality and safety.

Pictured *(left): members of the NCGLT Team at their exhibition stand, (right) Loretta Jenkins, General Manager, Quality, Risk and Safety; Chris Rudland, Assistant National Director, Quality Assurance and Verification; Anne Marie Oglesby, National Quality and Patient Safety Manager, National Ambulance Service; Cate Hartigan, Assistant National Director, Quality Assurance and Verification.*

2.5 Training

NCGLT develop and deliver both train the trainer and training programmes to support staff to respond to and deal with complaints from point of contact through to the internal review stage.

During 2020, COVID and public health restrictions affected not only the delivery of training but also the access to training by staff. NCGLT responded by designing and recording a series of webinars that are hosted on the Discovery Zone Hub of HSELanD.

HSELanD is an online learning forum developed and run by the Health Service Executive. Access to hseland.ie is available over the internet, on a secure site. It is available to all Healthcare Professionals in the Republic of Ireland, both within Health Service Executive (HSE), Voluntary Hospital Sector, and associated Non-Government-Organisations (NGO's).

By providing guidance through this online platform, NCGLT hoped to increase the access by staff to training as well as offer greater flexibility over that access.

The following webinars were developed during 2020 to support staff in managing complaints.

- Assessment of Need and Complaints Awareness Training
- Complaints Management System Training
- Learning from Complaints
- Telephone Etiquette and Tips for Managing Unreasonable Caller Behaviour
- Your Service Your Say Review Officer Training

2.5.1 Assessment of Need Complaints Awareness Training

This course was designed to outline best practice for Assessment Officers and Liaison Officers in relation to Assessment of Need applications, based on the requirements of the Disability Act, 2005, S.I. No. 263 of 2007 and iHIQA Standards for the Assessment of Need.

The course also covers the role of the Complaints Officer under the Disability Act 2005 and the responsibilities of staff with regard to engagement with the Assessment of Need Complaints process.

2.5.2 Complaints Management System Training

This course has been developed to support both existing and new CMS Users. It is made up of 14 sections and covers all aspects of use of the CMS from how to get a CMS account to creating/editing a complaints or review record, searching, and generating reports. The topics covered within this training include:

Section 1 Introduction to the CMS
Section 2 Accessing the CMS
Section 3 Creating an initial record of a complaint
Section 4 Creating a record of an issue within a complaint
Section 5 Search for a Record
Section 6 Edit a Record
Section 7 Record a Recommendation
Section 8 Attachments
Section 9 Close a Complaint
Section 10 Record a Review
Section 11 Reports
Section 12 Menus & Buttons
Section 13 Troubleshooting
Section 14 Useful Links and Contacts

2.5.3 *Learning from Complaints*

This course was designed to outline why learning from complaints is so important. It provides an overview of some of the initiatives that have been put in place across the HSE to facilitate the learning from complaints.

2.5.4 *Telephone Etiquette and Tips for Managing Unreasonable Caller Behaviour*

This course was designed to outline best practice techniques for communicating with service users over the phone. It outlines the recommended etiquette for answering calls, taking messages, placing a call on hold as well as the importance of actively listening and correctly closing a call.

This course also outlines best practice techniques for dealing with difficult or unreasonable clients over the phone and gives practical examples on how to respond to these types of callers. These type of callers include – the overly chatty caller, the angry caller, the confused caller, the persistent caller and dealing with abusive callers.

2.5.5 *Review Officer Training*

The National Complaints Governance and Learning Team provide complaint training courses for Review Officers. These courses help develop and enhance delegated Review Officers' knowledge of the key elements within the complaints legislation and policy for the management of complaints at internal review stage. Participants learn how to identify key considerations when reviewing a complaint from initial receipt through to the issuing of recommendations. The course focuses on the review process steps including guidance on how to conduct an investigation. Representatives from the Office of the Ombudsman also attend and present at each of these training days.

The National Complaints Governance and Learning Team provided training to 7 staff at the beginning of 2020 but the remaining training schedule had to be cancelled due to COVID and the public health restrictions in effect.

However, NCGLT in recognising that the traditional method of delivering Review Officer training was no longer appropriate immediately commenced redesigning the programme. NCGLT developed an online modular format comprising of 11 key sections. The programme supports Reviewers from the moment a review is sent to them, right through the investigative process, to formulating the report at the end of the process. The topics are set out in the table below.

Section 1 Your Service Your Say Policy Background
Section 2 Your Service Your Say Policy Guiding Principles
Section 3 An overview of the stages & background legislation
Section 4 Functions of the Review Officer
Section 5 The Review Process
tion 6 Commencing the review investigation
Section 7 Interview & Discussion skills
Section 8 Making Findings & Recommendations
Section 9 The Review Report
Section 10 The Apology
Section 11 The Complaints Management System

2.5.6 New HSELanD Module for Clinical Staff

NCGLT designed, developed and launched a new HSELanD elearning module in 2020 for clinical staff. The module gives practical application to the guidance document, *YSYS Guidance for Clinical Staff,* which was developed to provide support to the various clinical professionals who may, at some point, be asked to contribute their views as part of a complaints investigation or to write a specific clinical report as part of the complaints investigation.

The HSELanD module, entitled, ***Your Service Your Say: Complaints Handling Guidance for Clinical Staff*** will:

1. Provide clinical staff with a clear understanding of the YSYS complaints process and outline how individual clinical staff may become involved in the process.
2. Assist clinical staff in understanding what is required of them under the YSYS complaints management process.
3. Promote the benefits of attempting informal resolution of a complaint

The module takes approximately **1 hour to complete** and is broken down into 4 topics which have been specially selected to support clinical staff through their involvement in the Your Service Your Say process.

There are segments within the module that outline what happens when only part of a complaint is resolved. It shows how issues within a complaint are categorised as either clinical or non-clinical. Users of the module are shown the importance of engaging with their local complaints officer to effectively try to resolve complaints. As complaints officers act as the co-ordinator of the complaint, it is important to engage with them early on in the process.

The four topics covered by this module are:

1. Setting the Scene (an overview of the YSYS Complaints process).
2. Understanding informal resolution
3. Completing a Clinical Judgment Report
4. Extend my Learning (extra support information).

The clinical staff member must undertake a separate assessment at the end of the module. On successful completion of the module the clinical staff member will be able to print of a certificate of completion. Your Service Your Say: Complaints Handling Guidance for Clinical Staff has been added to the *Personal Effectiveness Skills* and *HR Skills* catalogues on HSELanD.

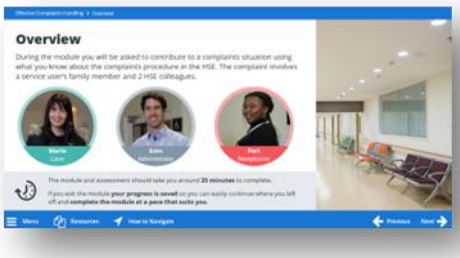
This module offers **1 Continuing Education Unit** (CEU) from the Nursing and Midwifery Board of Ireland (NMBI) once completed. A total of **786 staff** completed this module in 2020.

2.5.7 *Other HSELanD Complaint Modules*

Staff can also access other complaint modules on HSELanD.

- Module 1: Effective Complaints Handling
- Module 2: Effective Complaints Investigation

Both modules have been reviewed and assessed by the Nursing and Midwifery Board of Ireland (NMBI) and each has been awarded one continuing education unit (1 CEU)



Module 1, Effective Complaints Handling is for all staff to use and encompasses a number of interactive complaint handling scenarios that encourages engagement of the staff member through the exploration of different e-learning paths. This is very effective for empowering staff with the confidence to response to point of contact complaints.

A total of **9,632** staff completed this module in 2020.

Module 2, Effective Complaints Investigation is an interactive learning tool for Complaints Officers. It takes the user through the entire process of handling a written complaint from when it initially received on the Complaints Officer's desk, right through to guiding the user on who to create a final report.

A total of **1,875** staff have completed this module in 2020.

2.5.8 *Effective Telephone Techniques Workshop*

Office of the HSE Chief Executive Officer

In January 2020, NCGLT designed and delivered a workshop on Effective Telephone Techniques for the office of the HSE Chief Executive Officer. The workshop covered telephone etiquette, techniques for dealing with difficult calls and responding to unreasonable callers. The session also explored the type of behaviours that callers can engage in, and how to respond to and manage these effectively. HSELive also presented at the session providing advice and guidance on managing the various interactions encountered to ensure a positive and productive engagement.

Procurement

A further workshop on Effective Telephone Techniques for National Procurement was held online in April 2020 with 10 participants. This training was made available on You Tube, via a private link, for those who could not attend the live online training.

2.6 Audit

2.6.1 Mental Health Review

In 2019, NCGLT commenced work on a review of the Mental Health Services in relation to compliance with the *Your Service Your Say, the Management of Service User Feedback for Comments, Compliments and Complaints 2017 Policy.*

The purpose of the Mental Health review is to establish the extent to which Mental Health Services comply with the requirements set out in Part 9 of the Health Act 2004 and the HSE's policy.

The review will include an assessment into the overall quality of responses provided to complainants and evidence of any learning identified by the service itself.

The Review would comprise of two parts, an online survey and onsite audit.

Part one, conducted in June 2019, consisted of two surveys using Survey Monkey; one for service users to feed back on how they found their experience of making a complaint, and one for Complaints Officers within Mental Health services to provide details on complaints they have responded to within a particular time period and how they found this process.

The survey results together with selected onsite audits would inform the review report.

Part two of the Review, onsite audits, were due to be conducted in 2020. Due to COVID and public health restrictions, the onsite visits could not be carried out. Part two of the Mental Health Review will be deferred until access to sites can be facilitated.

2.6.2 General Audit

A general audit of services in relation to compliance with the *Your Service Your Say, the Management of Service User Feedback for Comments, Compliments and Complaints 2017 Policy* which was scheduled for 2020 has been deferred as a result of COVID and public health restrictions. Audit will be deferred until access to both relevant staff and sites can be facilitated.

2.6.3 Learning to Get Better – Self-Assessment Returns

In 2015 the Ombudsman conducted an investigation into how Irish public hospitals handle complaints. He published his findings in *Learning to Get Better, An investigation by the Ombudsman into how public hospital handle complaints'* and set out 36 recommendations in total applying to the HSE, both at operational and strategic level as well as to the Department of Health. (*See Appendix 3 for the full recommendation listing)*.

The HSE welcomed the report and committed to delivering on the recommendations contained within. Although the recommendations only referred to acute services, the HSE gave an undertaking to extend these to community settings.

Self-Assessment of Compliance

The Ombudsman developed a self-assessment template to be completed by Hospital Groups to track their progress with implementing the 29 recommendations applying to the delivery system. The same template was also to be used by Community Healthcare Organisations.

In November 2018, the Ombudsman published his progress report on Learning to Get Better. At the launch of that report, the Ombudsman welcomed the strides made by the HSE in addressing the recommendations but pointed out the remaining work needed to achieve full compliance. The HSE renewed their commitment to ensure full implementation of all recommendations.

In 2019 the self-assessment templates were amended. A new template for Community Healthcare Organisations was developed with the wording of recommendations updated to reflect community settings. The revised template also saw the removal of recommendation #6 relating to volunteer advocacy as this pertained mainly to acute settings. In addition, both templates now provided greater guidance regarding the specific criteria to be assessed and assist in the standardisation of determination of compliance with a recommendation across the system.

2020 Self-Assessment Returns

The self-assessment returns for the year 2020 were due for return to NCGLT in February 2021. However, because of the pressures being experienced by the operational system in providing an emergency response to COVID, an extension to April 2021 was agreed between the HSE and the Office of the Ombudsman.

In April 2021, NCGLT was redeployed into a new service, Vaccination Client Services, to support the work of the HSE vaccination programme, which is a national priority. The redeployment is due to last for six months. This redeployment has impacted on the return of the self-assessment templates and the Ombudsman has acknowledged and accommodate this. Returns will be issued and reported on as soon as NCGLT complete their redeployment.

Self-Assessment Audit

To provide assurance to the system that the compliance rating specified by Community Healthcare Organisations and Hospital Groups is accurate and reflects practice, NCGLT was to partner with Healthcare Audit to conduct an audit of the returns to validate the rating of compliance stated.

Due to the redeployment of Healthcare Audit to the HSE Testing and Tracing arm of the COVID response, these audits have been deferred.

2.7 Complaints Management System (CMS)

In addition to the learning forms, which identify learning from individual complaints, it was necessary to develop a system to capture and aggregate complaint data from Community healthcare Organisations, Hospital Groups and National Service. This would enable meaningful analysis and reporting of issues and trends at various levels throughout the HSE, to assist in decision making and the targeting of resources to deliver quality improvements and better health outcomes and experiences for those who use our services.

As a result, an online database, the Complaints Management System, was developed in conjunction with the State Claims Agency and facilitates the capture of comprehensive complaints data to enable analysis and comparison. This supports learning from complaints and ensures evidence based best practice can be shared across services.

Leads for the Complaints Management System have been identified in each CHO and HG and are the link between the services and our Division to ensure that the reporting from the system is providing the information needed to guide decision making and resource allocation.

Complaints Officers and Support Staff trained in the Complaints Management System	2020 General User Training	2020 Report Training
Hospital Group		
CHG	0	0
ULH	0	0
Saolta	3	0
SSWHG	4	0
DMHG	1	0
RCSI	3	0
IEHG	2	0
Community Health Organisations		
CHO 1	4	0
CHO 2	16	0
CHO 3	0	0
CHO 4	6	0
CHO 5	2	0
CHO 6	3	0
CHO 7	13	0
CHO 8	5	0
CHO 9	5	0
Corporate		
PCRS	0	0
NAS	2	0
Total 2020	**69**	**0**
Total Trained to date	**894**	**73**

Table 42: Complaints Officers and Support Staff who received CMS training 2020

2.7.1 Complaints Management System (CMS) Steering Group

The CMS Steering Group is a formal sub group of the NIMS Steering Group. The Steering Group was established to provide governance and direction for the implementation and further development of agreed modules of the Complaints Management System. The group also functions as an approval committee and clearing house for change requests from users of the CMS before changes are forwarded to the NIMS Steering Group.

CMS leads within each Community Healthcare Organisation and Hospital Group meet as a group to further progress the development of the CMS existing module for Stage 2 complaints and the development of new modules on capturing Stage 1 or point of contact complaints and modules for comments and compliments.

Each member of the CMS Steering Group is a nominated lead and represents their own Community Healthcare Organisation and Hospital Groups current and future requirements with regard to complaints management and reporting on the CMS.

Attendees

Due to the COVID-19 pandemic during 2020, no face to face meetings of the steering group were held. Some of the CMS leads were also re-deployed during this period of time. Conference calls were held in January and March.

2.8 Healthcare Complaints Audit Tool (*HCAT)*

The Healthcare Complaints Audit Tool (HCAT) is an innovative method of classifying complaints developed by the London School of Economics (LSE) after a rigorous analysis of 80,000 NHS complaints. The HCAT tool is a reliable method of coding and systemising healthcare complaints that also supports international comparability of data.

The Healthcare Complaints Analysis Tool (HCAT) treats each complaint as an 'incident', and asks the following:

1. *What is the problem being reported?*
2. *How severe was it?*
3. *Where, in the system, did it happen?*
4. *Who did it involve?*
5. *Was there a consequence?*

The NCGLT in partnership with NUIG analysed a large sample of complaints from across the HSE's services. The purpose of this analysis is to improve the classification system used by the HSE and hence our understanding of the nature and severity of complaints, leading to improvements in healthcare delivery and ensuring high standards of quality and safety.

Classification is an essential part of the processing of each complaint that is received by the Health Services and is a requirement of the HSE's compliance with the Health Act 2004 Section 55.—(2) (b). Under the Act, it is essential the HSE analyse complaints to establish and classify the nature of each complaint received.

This project has been running from 2018 and is due to finish in February 2022 and is divided into 2 sections which run concurrently. The first focused on Acute Services related complaints and the second on Community Services related complaints.

Improved classification systems support the identification of systemic issues and trends within systems and services leading to improvements in healthcare delivery and ensuring high standards of quality and safety.

The first progress reports for both projects were developed in late 2019 and while it wasn't possible to draw definitive conclusions or make recommendations nationally based on the area specific data analysed so far it was still a very positive indicator of the future analysis when larger samples of complaints were analysed during 2020.

The broad trends from complaints received by Acute Services in the initial sample point to issues with institutional processes, particularly delays in accessing care, and to poor relationships between staff and patients. While no harm is reported in a large number of complaints, complainants nonetheless sought answers to their questions and expressed the desire that other patients have a better experience. Complaints analysed also gave further insight into clinical, management and relationship issues, severity of events or actions, levels of harm, stage of care where the event or action occurred, service users' motivations for complaints and complainant profiles.

The initial analysis of complaints regarding Community Services was directed towards informing the adaptation of the HCAT into an appropriate model for community care settings. The broad trends from complaints in this initial sample point to issues at the "Accessing care" stage, the next most frequent stage of care resulting in a complaint was "During the appointment". Analysis to date has given insight into domains and categories of complainant profiles, motivations for complaints, severity of events, levels of harm, stage of care where the event occurred and has clearly identified the next steps of the research.

Further data requirements were identified for the next stage of the project.
This initial analysis has made it clear that there is extensive learning to be derived from using HCAT for analysis of complaints.

Due to the covid pandemic, analysis of further complaints had to be paused. However, during this time, a webinar training module and guide were developed by NCGLT in relation to determining harm and severity levels.

2.9 Learning from Individual Complaints: HSE Anonymised Feedback Learning Casebook

The HSE has, in recent years, become more proactive in encouraging and facilitating service users to partner with us in the continued development of our health services. Initiatives such as the *National Patient Experience* and *Your Voice Matters* Surveys, including Your Service Your Say, encourages and enables service users to share their experiences with us which in turn assist us to set our priorities and plan and deliver more responsive services that result in better outcomes for people.

Feedback, be it a comment, compliment or complaint, when categorised and analysed, offers valuable data about our services and helps us to identify issues and target remedies. However, much is to be learned from the narrative of individual complaints and hearing and understanding the real impact that a poor or good service experience can have.

One way to capture and share the narrative from complaints is through casebooks.

The publication of national quarterly casebooks commenced in 2019. Casebooks form part of the HSE's commitment to use complaints as a tool for learning and to share that learning. The development and publication of casebooks was also a recommendation by the Ombudsman in his report, *Learning to Get Better* and further progresses the HSE's promise to implement all recommendations from the Ombudsman's report pertaining to the HSE.

The National Casebooks are published on the HSE website. Casebooks are also widely circulated throughout the HSE enabling various service areas across the system to learn from experiences elsewhere in the organisation and use these to further develop the quality and safety of their own services and remedy or prevent the occurrence of similar issues in their area.

By publishing the casebooks online, the HSE can also demonstrate to services users that sharing their experience has made a difference and has led to change.

The HSE Anonymised Feedback Learning Casebooks are available to view on www.hse.ie/yoursay

2.9.1 Casebook Development

National casebooks are generated from the learning notification forms that are completed by Complaints Officers, following a complaint investigation, and Review Officers, following a complaint review and forwarded to Complaints Managers. Complaints Managers review these forms and submit those cases with organisational learning to NCGLT for the inclusion in the national casebook.

2.9.2 2020 Quarterly Anonymised Feedback Learning Casebook

The publication of quarterly casebooks in 2020 was not possible due to the impact on resources as a result of the emergency response to COVID. However, in wanting to assure service users that feedback was processed during 2020 and that learning was captured and shared, a full year casebook was compiled instead and presented just some of the feedback received and dealt with during the past year.

The cases included in the 2020 edition, although each unique, present themes and issues that need to be examined in the context of quality and service improvement.

The casebook presented a total of 27 cases covering both complaints and compliments received by Hospitals, Community Healthcare Organisations and the National Screening Services.

The casebook contains six complaints from Hospital Groups, nine from Community Healthcare Organisations and one from National Screening Services, which were investigated and/or reviewed, along with their outcomes. In addition, the casebook features five compliments from Hospital Groups and six from Community Healthcare Organisations and demonstrates the learning to be gained from positive feedback.

The following services contributed to the 2020 Casebook:

Community Healthcare Organisations	Hospital Groups	National Services
CHO 1	Children's Health Ireland	National Screening Services
Community Healthcare West	Dublin Midlands Hospital Group	
Cork Kerry Community Healthcare	University of Limerick Hospital Group	
South East Community Healthcare		

The main themes for the 2020 casebook related to *safe and effective care*, *communication and information* and *access*, with these categories featuring in 25 cases (10 compliments and 15 complaints).

The key categories of *safe and effective care* and *communication and information* feature in the majority of the compliments presented. Some compliments relate to *dignity and respect* and *improving health*.

These same categories, *safe and effective care* and *communication and information*, also feature in the majority of the complaints received. The category of *safe and effective care* encompasses many issues that are presented in the cases such as patient property, healthcare records, processes, diagnoses, tests, infection control, etc. while communication skills was the single dominant issue recorded under *communication and information*.

The category of *access* also features in the complaint cases presented and relates primarily to the issue of having appropriate hospital facilities or resources available to meet the particular needs of Service Users as well as the issue of appointment delays.

Other categories featured are *privacy, dignity and respect* and *accountability.*

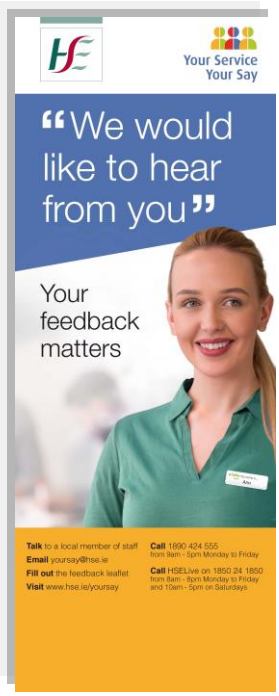
The cases presented both complaints and compliments offering services an opportunity to reflect on service delivery, to understand the issues experienced by Service Users, to examine the measures and initiatives used to address these and how such methods can be utilised in their area to address or prevent similar issues.

2.10 The National Your Service Your Say Office

The Ombudsman's Learning to Get Better Report sets out a number of recommendations for best practice in complaints handling. The recommendations under the heading of *Access* are aimed at promoting and encouraging feedback from service users.

The HSE, in accepting these recommendations have been investing in efforts to widen the options for service users to engage with the HSE and relate their experience.

The revised policy, *Your Service You Say, the Management of Service User Feedback for Comments, Compliments and Complaints* (November 2017), placed greater emphases on encouraging and enabling our service users to give feedback and for staff and managers to learn and improve services as a result.



Service Users have many ways to share their experiences, from telling a staff member or their health care professional, to completing a feedback form or filling out the online form on the HSE website.

In addition, the HSE offers, through the National Your Service Your Say office, a dedicated national contact point for service users to find out more about giving feedback, the Your Service Your Say policy or to directly relate their experience.

The National Your Service Your Say office comes under the remit of the National Complaints Governance & Learning Team (NCGLT).

The National Your Service Your Say office can be contacted via telephone, **9am to 5pm, Monday to Friday on 1890 424 555 or on 045 880 429 (if calling from a mobile) or via email at yoursay@hse.ie**

The service is supplemented by HSELive who can offer assistance to callers outside of these hours from Monday to Friday, 8am to 8pm as well as on a Saturday from 10am to 5pm. HSELive can be contacted on 1800 700 700 or on 01 240 8787.

The Your Service Your Say Team will answer your queries, provide advice and information if needed and will ensure that any feedback given is directed to the appropriate local service for their examination and direct response to the person raising the concern. The office does not examine concerns directly as under policy they must route the issue to the local service.

The Team also supports the office of the HSE Chief Executive Officer and the Department of Health. The Team ensure that Service Users who have been in contact with these offices have their issues routed to the appropriate service for examination and response within the Your Service Your Say process so as to provide them access to review mechanisms both internally and externally, if required.

This central HSE access point provides a valuable 'no wrong door' service, facilitating and supporting Service Users and other agencies and ensuring that their comments, compliments and complaints are directed to the appropriate service for them to respond to and learn from.

In line with the new General Data Protection Regulations, where complaints submitted to the HSE's National Your Service Your Say office relate to a HSE funded agency, the team will:

(a) request your permission to forward on your complaint to that funded agency for investigation under their own complaints policy and direct response to you, or
(b) advise you that you can submit your complaint directly to that facility/agency.

Where you submit a complaint that relates to a private facility or service, you will be advised to send your complaint directly to the service in question.

2.10.1 The National Your Service Your Say Office Activity

Activity for the National Your Service Your Say office is based on the interactions generated by calls, emails, online forms and post received into the National Your Service Your Say office either directly from Service Users or through the Office of the Chief Executive Officer or the Department of Health.

Activity has increased year on year from 9,907 interactions in 2016 to 17,603 interactions in 2020. From 2016 to 2018 interactions increased by 11%. The following year, 2019, saw a further jump in activity to 13,101 interactions, almost 19% ahead of 2018 figures. An increase has again been experienced in 2020, with activity 34% ahead of the 2019 figure. Some of this increase in activity can be explained as a result of COVID where members of the public sought information and guidance on COVID related issues from many HSE avenues. For the National Your Service Your Say office, COVID related interactions accounted for 16% or 2,782 interactions of the total 2020 figure.

Email is the preferred method of contact with the National Your Service Your Say office accounting for 59% of office activity. Online forms account for 15% and phone calls account for 13% of office activity.

Breakdown of monthly activity and contact method

2020	YSYS emails	YSYS Online Form	Feedback via CEO	Feedback via DoH	Letters	Reviews	Office calls received	Office missed calls	Total interactions
January	620	236	5	120	9	0	234	21	1224
February	616	261	3	65	21	0	213	14	1179
March	877	296	6	180	4	0	195	6	1558
April	836	164	1	72	1	0	243	0	1317
May	746	121	0	177	0	0	242	0	1286
June	639	149	0	160	14	0	171	8	1133
July	1228	271	6	153	12	0	62	16	1732
August	996	179	1	133	1	1	228	0	1539
September	978	313	5	229	1	0	248	11	1774
October	1343	268	9	207	6	0	196	17	2029
November	843	245	8	204	5	0	156	24	1461
December	727	211	7	143	2	0	145	18	1235
Total	10449	2714	52	1843	76	1	2333	135	**17603**

Table 43: Breakdown of YSYS monthly activity and contact method for 2020

2.11.2 Analysis of 2020 Activity

Community Healthcare Organisations accounted for 31% of all activity while Acute Hospitals accounted for 28%.

A full breakdown of activity per service is presented below:

CHO	Acute	National Service	Nursing Home	Voluntary Agency	Voluntary Hospital	Non HSE
31%	28%	29%	0.2%	0.8%	7%	4%

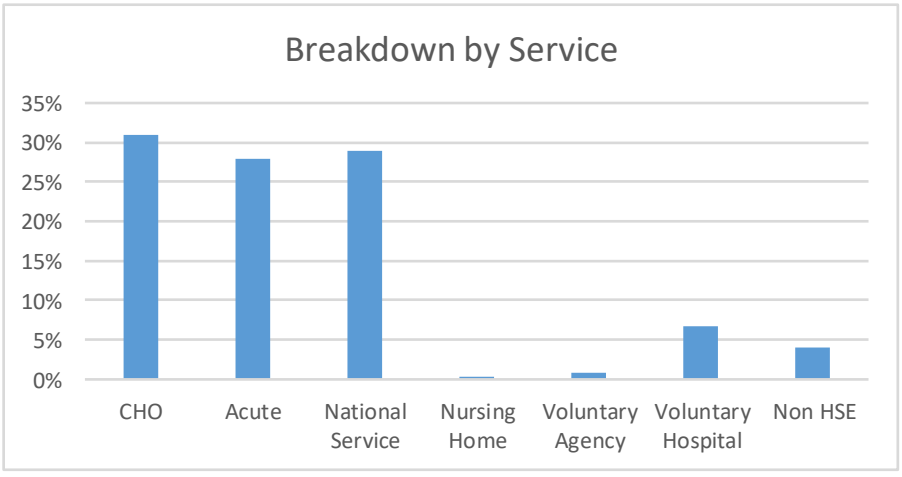


Figure 2: YSYS National Office activity breakdown per service area

Activity, generated directly through Your Service Your Say, and received from the Office of the HSE Chief Executive Officer and the Department of Health, is detailed below.

Your Service Your Say

Of all feedback received through Your Service Your Say, 30% related to Acute Hospitals and 29% to Community Healthcare Organisations. This was a decrease on 2019 figures with feedback for Acutes falling by 11% and 8% for Community Healthcare Organisations. The biggest increase was feedback to National Services, which saw this rise from 8% in 2019 to 28% in 2020, a substantial increase of 20%.

Some of this increase can be attributable to COVID as some National Services became more public facing, such as public health, testing and contact tracing, etc. and therefore, would have attracted greater contact from the public.

Areas that received feedback through Your Service Your Say are set out in the table below:

CHO	Acute	National Service	Nursing Home	Voluntary Agency	Voluntary Hospital	Non HSE
29%	30%	28%	1%	1%	6%	5%

Table 44: Breakdown of YSYS feedback by service for 2020

Feedback received through Your Service Your Say fell under the categories of Access, Accountability, Communication and Information, Dignity and Respect, Safe and Effective Care, Improving Health, Participation and Privacy. The two main feedback categories were Safe and Effective Care at 45% and Access at 28%. Feedback relating to Communication and Dignity and Respect saw the biggest increase of 5.5% and 2.5% respectively.

Access	Accountability	Communication and Information	Dignity and Respect	Safe and Effective Care	Improving Health	Participation	Privacy
28%	2.5%	12.5	10.5%	45%	.5%	.5%	.5%

Table 45: Breakdown of YSYS feedback by category for 2020

The Office of the HSE Chief Executive Officer

Of all feedback received through the HSE Chief Executive Officer's office, 40% (down 15% from 2019) related to Community Healthcare Organisations and 29% (up 17% from 2019) to Acute Hospitals. All areas that received feedback through the Office of the HSE's Chief Executive Officer are presented in the table below.

CHO	Acute	National Service	Non HSE	Voluntary Hospital
40%	29%	21%	4%	6%

Table 46: Breakdown of YSYS feedback received through the office of the CEO for HSE services for 2020

Feedback for National Services increased by 6% from 2019 again reflecting their greater public presence.

The feedback received through the HSE Chief Executive Officer's office was categorised under Access, Accountability, Communication and Information, Dignity and Respect and Safe and Effective Care. The top two categories were Safe & Effective Care at 39% and Dignity & Respect at 29%.

The category with the largest increase was Dignity and Respect with feedback for this category jumping from 5% in 2019 to 29% for 2020, an increase of 24%

Access	Privacy	Communication & Information	Dignity & Respect	Safe & Effective Care
17%	2%	13%	29%	39%

Table 47: Breakdown of YSYS feedback received through the office of the CEO by category for 2020

Department of Health

Of all feedback received through the Department of Health, 39% related to Community Healthcare Organisations and 15% to Acute Hospitals. All areas that received feedback through the Department of Health are presented in the table below.

CHO	Acute	National Service	Nursing Home	Non HSE	Voluntary Agency	Voluntary Hospital
39%	15%	35%	.05%	1%	0.5%	9%

Table 48: Breakdown of YSYS feedback received through the Department of Health for HSE services for 2020

Again National Services experienced the greatest increase from 14% in 2019 to 35% for 2020, an increase of 21%.

The feedback received through the Department of Health was categorised under Access, Accountability, Communication and Information, Safe and Effective Care and Improving Health. The main feedback category was Access, accounting for 70% of feedback received.

Access	Accountability	Communication and Information	Dignity & Respect	Safe and Effective Care	Improving Health
70%	6%	5%	1%	17%	1%

Table 49: Breakdown of YSYS feedback received through the Department of Health by category for 2020

Feedback received from the National Your Service Your Say Office, the HSE Chief Executive Officer's Office and the Department of Health fell within eight main complaint categories with **Access (at 34%)** and **Safe and Effective Care (at 41%)** the top two categories recorded.

Access	Accountability	Communication and Information	Dignity and Respect	Safe and Effective Care	Improving Health	Participation	Privacy
34%	3%	11%	10%	41%	.49%	0.02%	.49%

Table 49: Breakdown of category of YSYS feedback received through the office of the CEO, the Department of Health and YSYS combined for 2020

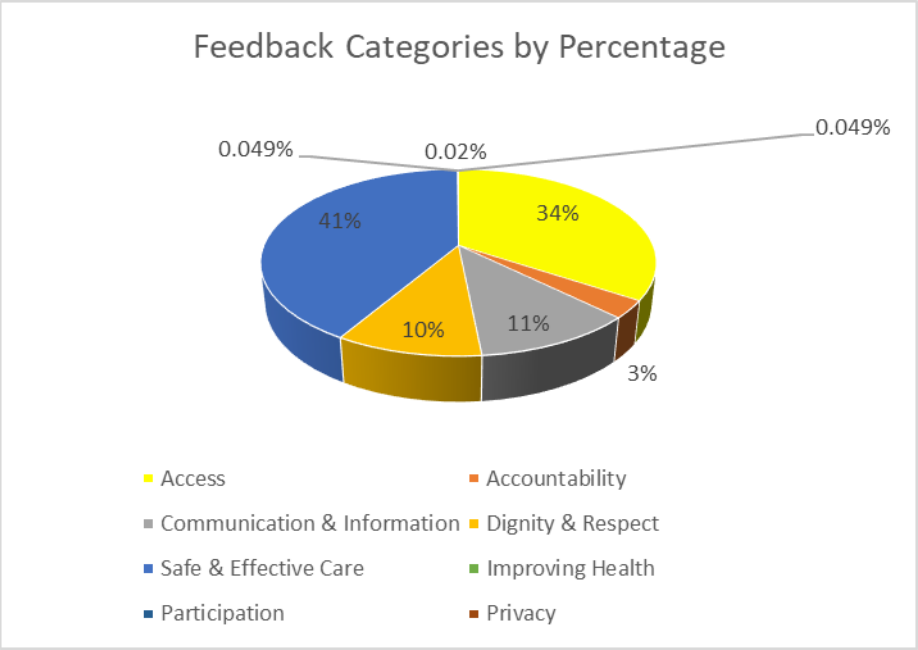


Figure 3: YSYS National Office feedback categories by percentage

Treatment and Care emerged as the key sub category within **Safe & Effective Care** and ***Accessibility and Resources*** emerged as the key sub category within the ***Access*** category for 2020.

2.11 National Disability Complaints – Assessment of Need (AoN)

The Disability Act 2005 provides for a special complaints and appeals procedure for service users if they are unhappy with their child's assessment of need or Service Statement.

Under the Disability Act 2005 a parent/guardian can make a complaint regarding Assessment of Need if:

1. The child is found not to have a disability and the Parent/Guardian does not agree
2. The assessment is not done in line with the standards set by the Health Information and Quality Authority
3. An assessment is not started and completed within the agreed timeframes
4. Parent/Guardian believes that the content of the child's Service Statement is inaccurate or incorrect
5. Services in the child's Service Statement are not being delivered.

- In 2020, 1135 disability complaints relating to Assessment of Need (AoN) were received.
- 28% were dealt with by a complaints officer within 30 days.
- Variance from 2019

Variance	2020	2019	% change
HSE Assessment of Need	1135	1244	-9%

Table 50: Assessment of Need complaints – variance 2019 and 2020

- Breakdown of Complaints Recorded 2020

Complaints (Excluding Voluntary Hospitals and Agencies)

HSE: Excluding Voluntary Hospitals and Agencies	Total
Complaints under Part 2 of the Disabilities Act 2005 (Assessment of Need)	1135

Table 51: Total complaints for Assessment of Need received by HSE, excluding voluntary hospital and agencies for 2020

- Complaints received/resolved relating to AoN (Disabilities) (across all CHOs) under the Disability Act.

AoN Nationally (across all CHOs)	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	1135	46	31	0	0	300	784	28%

Table 52: Complaints received / resolved for Assessment of Need across all CHOs for 2020

The number of applications for Assessment of Need in 2020 was 4674, a 29% decrease on the previous year.

There is a significant variance between the decrease in AoN applications of 29% and the decrease in complaints of 9%, which in effect means there was a rise in complaints per application.

The number of days taken by a Complaint Officers to close out a complaint increased from 23 days to 89 days; back to 2018 figures.

The number of complaints received in the first two months of 2020 was up 272% on the previous year. From March 2020 through to April 2020 there was a steady and significant decline in the number of complaints, with the lowest number of complaints for the year seen in April 2020, with 35 complaints, 53% lower than the previous year.

From April to July 2020 the numbers of complaints rose steadily to a similar number of complaints in July 2019. From this point onwards the number of complaints forms a similar trajectory with the previous year, albeit down on the previous year, with a significant spike in September, the start of the school year.

The primary ground for complaint was again Ground B, accounting for 87% of all grounds for complaint, a decrease of 3% on the previous year.

Single issue complaints continue to make up the vast majority of complaints however the further rise in multi-issue complaints is also worth noting, indicating cross-sectoral issues for AoN assessment and service provision.

Area	Applications for AoN	Complaints relating to AoN	Complaints relating to AoN per 100 applications
CHO 1	265	14	5
CHO 2	97	7	7
CHO 3	413	36	9
CHO 4	1097	275	25
CHO 5	256	167	65
CHO 6	245	80	33
CHO 7	752	237	32
CHO 8	579	156	27
CHO 9	970	163	17

Table 53: Applications versus complaints relating to Assessment of Need 2020

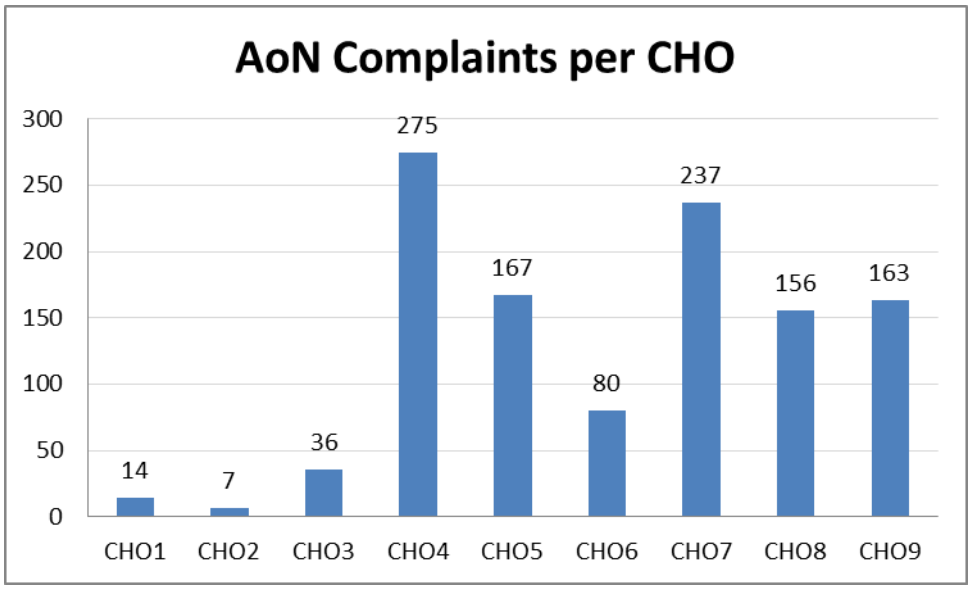


Figure 32: Assessment of Need related complaints per CHO

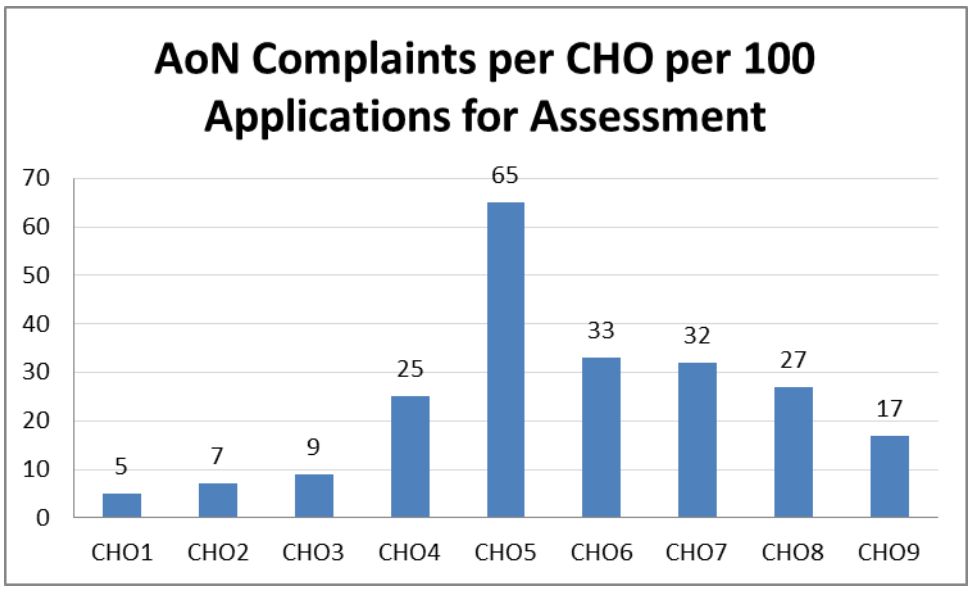


Figure 4: Assessment of Need related complaints per CHO per 100 Applicants for AoN

Assessment of Need Nationally (across all CHOs)

Assessment of Need Nationally (across all CHOs)	Access	Dignity and Respect	Safe and Effective Care	Communication and information	Participation	Privacy	Improving Health	Accountability
AoN	1089	0	40	0	0	0	0	0

Assessment of Need Nationally (across all CHOs)	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
AoN	8	0	0	0	0	0	0	0

Table 54: Complaint categories for Assessment of Need 2020

Complaints Reported by Service

Assessment of Need Nationally (across all CHOs) 2020

Assessment of Need Nationally (across all CHOs)	Social Care	Primary Care	Mental Health	Health and Wellbeing
AoN	1135	0	0	0

Table 55: Assessment of Need complaints 2020 by division

Appendices

Appendix 1: Data Tables

Hospitals: Statutory

Hospitals in Ireland are organised into seven Hospital Groups. The services delivered include inpatient scheduled care, unscheduled/emergency care, maternity services, outpatient and diagnostic services.

HSE Statutory Complaints data was extracted through statistical reports created from complaints recorded on the Complaints Management System and data sheets.

University Limerick Hospitals Group (ULH) Statutory Hospitals	University Hospital Limerick, University Maternity Hospital, Croom Hospital, Nenagh Hospital, Ennis Hospital	**RCSI Statutory Hospitals**	Connolly Hospital, Our Lady of Lourdes Hospital, Drogheda and Louth County Hospital, Cavan General Hospital and Monaghan Hospital
Dublin Midlands Hospital Group (DMHG) Statutory Hospitals	Midlands Regional Hospital, Tullamore, Naas General Hospital, Midlands Regional Hospital Portlaoise	**South/South West Hospital Group (SSWHG) Statutory Hospitals**	Cork University Hospital/CUMH, University Hospital Waterford, Kerry General Hospital, South Tipperary General Hospital, Bantry General Hospital, Mallow General Hospital, Lourdes Orthopaedic Hospital, Kilcreene, Hospital, Kilcreene
Ireland East Hospital Group (IEHG) Statutory Hospitals	Midland Regional Hospital Mullingar, St Luke's General Hospital, Kilkenny, Wexford General Hospital, Our Lady's Hospital, Navan, St Columcille's Hospital	**Saolta Statutory Hospitals**	University Hospital Galway, Merlin Park University Hospital, Sligo Regional Hospital, Letterkenny General Hospital, Mayo General Hospital, Portiuncula Hospital, Roscommon County Hospital

Complaints Received/Resolved: Statutory Hospitals

Hospital Groups

Hospital Groups (Statutory)	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
DMHG Statutory Hospitals	338	0	2	0	158	104	74	78%
IEHG Statutory Hospitals	521	0	3	14	46	241	217	37%
RCSI Statutory Hospitals	385	17	35	0	37	259	37	89%
Saolta Statutory Hospitals	841	1	5	0	198	347	290	65%
SSWHG Statutory Hospitals	313	3	14	0	39	74	183	38%
ULH Statutory Hospitals	615	1	9	8	270	93	234	61%

Table 56: Complaints reported: Statutory Hospitals within Hospital Groups 2020

Complaints Received/Resolved: National Ambulance Service

National Ambulance Service

National Ambulance Service	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	138	0	6	0	2	5	125	46%

Table 57: Reported complaints National Ambulance Service

Complaint Categories: Statutory Hospitals

Hospital Groups (Statutory Hospitals)

Hospital Groups (Statutory)	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
DMHG Statutory Hospitals	66	19	166	145	5	7	2	48
IEHG Statutory Hospitals	151	64	208	150	10	14	11	43
RCSI Statutory Hospitals	66	118	196	83	0	6	0	16
Saolta Statutory Hospitals	223	102	279	172	4	8	5	40
SSWHG Statutory Hospitals	116	67	235	144	2	7	5	34
ULH Statutory Hospitals	201	70	340	123	3	8	20	42
Total	**823**	**440**	**1424**	**817**	**24**	**50**	**43**	**223**

Table 58: Complaints Categories Statutory Hospitals

Hospital Groups (Statutory) Contd.	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
DMHG Statutory Hospitals	2	0	1	0	0	0	0	0
IEHG Statutory Hospitals	89	4	0	0	0	1	2	0
RCSI Statutory Hospitals	81	0	0	0	0	3	0	0
Saolta Statutory Hospitals	3	0	2	0	0	1	0	1
SSWHG Statutory Hospitals	1	0	0	0	0	0	0	0
ULH Statutory Hospitals	0	0	0	0	0	0	0	0
Total	**176**	**4**	**3**	**0**	**0**	**5**	**2**	**1**

Table 59: Categories of Complaints reported: Hospital Group Contd.

Complaint Categories: National Ambulance Service

National Ambulance Service

National Ambulance Service	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Total	7	61	98	22	0	1	0	0

Table 60: Complaints Categories NAS

National Ambulance Service Contd.	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
Total	0	0	0	0	0	0	0	0

Table 61: Categories of Complaints reported: NAS.

Community Health Organisations (CHOs)

CHO 1	Donegal, Sligo, Leitrim, Cavan, Monaghan	**CHO 6**	Wicklow, Dun Laoghaire, Dublin South East
CHO 2	Galway, Mayo, Roscommon	**CHO 7**	Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West
CHO 3	Clare, Limerick, North Tipperary	**CHO 8**	Louth, Longford, Laois, Offaly, Meath, Westmeath
CHO 4	Kerry, Cork	**CHO 9**	Dublin North, Dublin North Central, Dublin North West
CHO 5	South Tipperary, Carlow, Kilkenny, Waterford, Wexford		

Complaints Received / Resolved: CHOs

Community Healthcare Organisations

Community Health Organisation (CHO)	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
CHO 1	122	0	0	0	12	15	95	22%
CHO 2	141	23	9	3	28	47	31	71%
CHO 3	66	0	3	0	21	22	20	68%
CHO 4	78	0	6	0	14	28	30	58%
CHO 5	31	0	0	0	23	3	5	84%
CHO 6	29	0	0	0	1	7	21	10%
CHO 7	222	1	9	0	84	101	27	87%
CHO 8	116	3	2	0	23	40	48	57%
CHO 9	101	1	2	0	40	29	29	70%

Table 62: CHOs Complaints resolved 2020

Assessment of Need Nationally (Disabilities) (across all CHOs)

Assessment of Need Nationally (across all CHOs)	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	1135	46	31	0	0	300	784	28%

Table 63: AoN Complaints resolved 2020

Complaints Received / Resolved: Primary Care Reimbursement Service (PCRS)

Primary Care Reimbursement Service (PCRS)

PCRS	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	193	0	30	0	41	122	0	100%

Table 64: PCRS Complaints resolved 2020

Complaints Data: Voluntary Hospitals and Agencies

Voluntary Hospitals within Hospital Groups

Hospitals in Ireland are organised into **seven Hospital Groups.** The services delivered include inpatient scheduled care, unscheduled/emergency care, maternity services, outpatient and diagnostic services.

University Limerick Hospitals Group (ULH) Statutory Hospitals	St. John's Hospital	**RCSI Statutory Hospitals**	Beaumont Hospital, Rotunda Hospital
Dublin Midlands Hospital Group (DMHG) Statutory Hospitals	St James's Hospital, St. Luke's Radiation Oncology Network, The Adelaide & Meath Hospital, Dublin, The Coombe Women & Infant University Hospital	**South/South West Hospital Group (SSWHG) Statutory Hospitals**	Mercy University Hospital, South Infirmary Victoria University Hospital
Ireland East Hospital Group (IEHG) Statutory Hospitals	Mater Misericordiae University Hospital, Cappagh National Orthopaedic Hospital, St Vincent's University Hospital, National Maternity Hospital, St Michael's Hospital, Dun Laoghaire, Royal Victoria Eye and Ear Hospital	**The Children's Hospital Group (CHG) Voluntary Hospitals**	Children's University Hospital Temple Street, The National Children's Hospital, Tallagh, Our Lady's Children's Hospital, Crumlin ***Note:*** *The three Dublin paediatric hospitals formerly in the Children's Hospital Group transferred into a single public body on 1st January 2019 named Children's Health Ireland.*

Complaints Received/Resolved: Voluntary Hospitals

Voluntary Hospitals within Hospital Groups	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
CHG Voluntary Hospitals	704	0	1	0	103	419	182	74%
DMHG Voluntary Hospitals	1710	0	0	0	592	669	449	74%
IEHG Voluntary Hospitals	2156	15	27	0	1572	348	194	91%
RCSI Voluntary Hospitals	553	7	34	0	8	484	20	96%
SSWHG Voluntary Hospitals	184	5	9	1	70	63	36	79%
ULH Voluntary Hospitals	10	0	0	0	8	2	0	100%

Table 65: Complaints reported: Voluntary Hospitals within Hospital Groups 2020

Complaint Categories: Voluntary Hospitals within Hospital Groups

Voluntary Hospitals within Hospital Groups	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
CHG Voluntary Hospitals	308	48	358	312	15	13	24	63
DMHG Voluntary Hospitals	495	185	675	592	29	20	19	87
IEHG Voluntary Hospitals	236	142	498	439	18	11	13	69
RCSI Voluntary Hospitals	179	64	401	264	7	9	7	56
SSWHG Voluntary Hospitals	34	17	52	61	0	0	0	5
ULH Voluntary Hospitals	0	0	0	2	0	0	0	0
Total	**1252**	**486**	**1984**	**1670**	**69**	**53**	**63**	**281**

Table 66: Complaint Categories: Voluntary Hospitals within Hospital Groups

HSE Voluntary Hospitals contd.	Clinical Judgement	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons
CHG Voluntary Hospitals	1	0	0	0	0	0	0	0
DMHG Voluntary Hospitals	12	2	0	1	0	2	0	1
IEHG Voluntary Hospitals	96	40	0	1	0	2	0	1
RCSI Voluntary Hospitals	59	0	0	0	0	0	0	0
SSWHG Voluntary Hospitals	3	0	0	0	0	0	0	0
ULH Voluntary Hospitals	0	0	0	0	0	0	0	0
Total	**170**	**42**	**0**	**2**	**0**	**4**	**0**	**2**

Table 67: Complaints Categories reported: Voluntary Hospitals within Hospital Groups 2020

Other Voluntary Hospitals & Agencies

In 2020 Complaints Data relating to Voluntary Hospitals & Agencies was returned by hospitals and agencies directly to the National Complaints Governance and Learning Team.

Others	Complaints received 2020	Complaints excluded under Part 9 of the Health Act 2004	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Other Voluntary Hospitals & Agencies	4316	145	73	31	2805	973	289	93%

Table 68: Complaints reported: Other Voluntary Hospitals and Agencies 2020

Complaints Categories: Other Voluntary Hospitals & Agencies

Other Voluntary Hospitals & Agencies	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
	1269	1021	1290	726	184	160	121	210
Other Voluntary Hospitals & Agencies	**Clinical Judgement**	**Vexatious Complaints**	**Nursing Homes/residential care age >65**	**Nursing homes and residential care age ≤64**	**Pre-school inspection services**	**Trust in Care**	**Children First**	**Safeguarding**
	40	40	27	21	7	887	35	0

Table 69: Complaints Categories reported: Other Voluntary Hospitals and Agencies 2020

Appendix 2: Complaint Categories

Incident /Category	Sub Category Type	Sub Category Please Specify
Access	Accessibility / resources	Equipment
		Medication
		Personnel
		Services
		Treatment
	Appointment - delays	Appointment - cancelled and not rearranged
		Appointment - delay in issuing appointment
		Appointment - postponed
		Surgery / therapies / diagnostics - delayed or postponed
		Operation and opening times of clinics
	Appointment - other	No / lost referral letter
		Appointment - request for earlier appointment
		Unavailability of service
	Admission - delays	Delayed - elective bed
		Delayed - emergency bed
		Admission - delay in admission process
		Admission - postponed
	Admission - other	Admission - refused admission by hospital
	Hospital facilities	Crèche
		Lack of adequate seating
		Lack of baby changing facilities
		Lack of / minimal breastfeeding facilities
		Lack of toilet and washroom facilities (general)
		Lack of toilet and washroom facilities (special needs)
		Lack of wheelchair access
		No treatment area / space for consultation / trolley facilities
		Shop
		Signage (internal and external)
	Hospital room facilities (access to)	Bed location
		Disability facilities
		Isolation / single room facilities
		Overcrowding
		Public
		Semi-private / private
	Parking	Access to disabled spaces
		Access to spaces
		Car parking charges
		Clamping / Declamping of car
		Condition or maintenance of car parks
		Damaged cars
		Location of pay machine

Access contd.	Transfer issues	External transfer
		Internal transfer
	Transport	External transportation
		Internal transportation
	Visiting times	Lack of visiting policy enforcement
		Special visiting times not accommodated
Dignity and Respect	Alleged inappropriate behaviour	Patient
		Staff
		Visitor
	Delivery of care	Lack of respect shown to patient during examination / consultation
		No concern for patient as a person
		Patient's dignity not respected
	Discrimination	Age
		Civil status
		Disability
		Family status
		Gender
		Membership of traveller community
		Race
		Religion
		Sexual orientation
		Socio-economic
	End-of-Life Care	Breaking bad news
		Breaking bad news - private area unavailable
		Death cert - delay in issuing death cert
		Death cert - incorrect / returned death cert
		Delay in release and condition of body
		Inattention to patient discomfort
		Mortuary facilities
		Organ retention
		Palliative care
		Poor communication
	End-of-Life Care (contd.)	Single room for patient unavailable
		Treatment of deceased not respected
	Ethnicity	Insensitivity to cultural beliefs and values
		Requests not respected
		Special food requests unavailable
Safe & Effective Care	Human Resources	Competency
		Complement
		Skill mix
	Diagnosis	Diagnosis - misdiagnosis
		Diagnosis - delayed diagnosis
		Diagnosis - contradictory diagnosis

Safe & Effective Care contd.	Test	Delay / failure to report test results
		Incorrect tests ordered
		No tests ordered
		Mislabelled test result/sample
		Mislaid sample
		Performed on wrong patient
		Repeat test required
		Result not available
		Delay in transport/collection of sample
	Continuity of care (internal)	Poor clinical handover
		Lack of approved home care packages
		Lack of community supports
		Lack of medical devices / faulty equipment
		Lack of support services post discharge
		Unsuitable home environment
	Discharge	Adherence to discharge policy
		Delayed discharge
		Discharge against medical advice
		No discharge letter
		Patient / family refuse discharge
		Premature discharge
	Health and Safety issues	Building not secure
		Central heating
		Equipment (lack of / failure of / wrong equipment used)
		Failure to provide a safe environment
		Fixtures and fittings
		Furnishing
		Lights
		Manual handling
		Noise levels
		Overcrowding
		Pest control
		Slips / trips and falls
		Temperature regulation
		Waste Management
	Health Care Records	Admission / registration process error
		Inaccurate information on healthcare record / hospital systems
		Missing chart
		Missing films/scans
		Patient impersonation (identify theft)
		Poor quality control of chart
		Poor recording of information
		Wrong records applied to patient

Safe & Effective Care contd.	Hygiene	Cleanliness of area
		Hand Hygiene / Gel Dispensers
		Linen (beds and Curtains)
		Spills on floors
		Waste management
	Infection prevention and control	Communication deficit - infection status
		Health Care Associated Infection
		Non-compliance with Infection and Control policies and protocols
		Personal hygiene of staff
	Patient property	Clothes
		Dentures
		Glasses
		Hearing Aid
		Jewellery
		Lack of secure space
		Money
		Personal equipment
		Toys
	Medication	Administering error
		Dispensing
		Prescribing
	Tissue Bank	Bone marrow
		Cord blood
		Cornea implant
		Cryogenics
		Fertility issues
		Heart valves
		Samples/test results
		Skin
		Stem cell
	Treatment and Care	Failure / delay in treatment / delivery of care
		Failure / delay to diagnose
		Failure to act on abnormal diagnostic results
		Inconsistent delivery of care
		Insufficient time for delivery of care
		Lack of follow-up care
		Lack of knowledge in staff
		Lack of monitoring of pain control
		Lack of patient supervision
		Practitioners not working together / cooperating
		Prolonged fasting
		Unsatisfactory treatment or care
		Unsuccessful treatment or care

Communication & Information	Communication skills	Patient felt their opinion was dismissed / discounted
		Disagreement about expectations
		Inadequate listening and response
		Inappropriate comments from staff member
		Lack of support
		Language barrier between patients/relatives and staff
		No opportunity to ask questions
		Non-verbal tone / body language
		Open disclosure (lack of)
		Patient dissatisfied with questions
		Patient felt rushed
		Staff not introducing themselves and letting patients know their role
		Staff unsympathetic
		Tone of voice
		Untimely delivery of information
	Delay and failure to communicate	Breakdown in communication between staff or areas
		Failure / delay to communicate with outside agency/organisation
		Failure / delay in communicating with patient
		Advising patient of treating consultant
		Failure / delay in communicating with relatives
		Failure / delay in notifying consultant (external)
		Failure / delay to communicate with GP / referral source
		Lack of information provided about medication side effects (KPI)
	Diverse Needs	Interpretation service (e.g. Braille services)
		Special needs
		Translation service
	Information	Conflicting information
		Confusing information
		Insufficient and inadequate information
		Misinformation
	Telephone calls	Telephone call not returned
		Telephone call unanswered
Participation	Consent	Consent not obtained
		Lack of informed consent
		Patient felt coerced
	Parental Access and Consent	Consent, guardianship and information issues related to lesbian, gay parental relationships
		Correct procedure not consented for
		Guardianship consent not explained
		Mother or father unable to access information
		Mother/Father/Guardian not informed

Participation contd.	Patients/ Family/ Relatives	Excluded from decision making process - family / relatives / advocate / next of kin
		Excluded from decision making process - patient
		Opinion discounted - family / relatives / advocate / next of kin
		Opinion discounted - patient
		Parent not allowed accompany child in recovery room
		Parent not allowed accompany child to theatre
		Second opinion
Privacy	Confidentiality	Breach of another patient's confidentiality
		Breach of patient confidentiality
		Security of files and records
	Hospital Facilities (Privacy)	Lack of privacy during consultation/discussing condition
		Lack of privacy during examination/ treatment
		Privacy - No single room
		Privacy - Overcrowding
Improving Health	Empowerment	Independence and self care not supported
		Lack / provision of patient / carer education
		Patient / family preference discounted / disrespected
	Holistic Care	Lack of information / support on how to prevent further illness / disease
		Lack of understanding as to what is important to the patient
	Catering	Dietary requirements not met
		Food quality
	Smoking Policy	Non-compliance (visitor, patient, staff smoking)
Accountability	Patient feedback	Feedback not provided to patients on improvements made as result of their feedback
		Information about the complaints / patient feedback process not available
		Patient concerns not dealt with promptly
		Quality of response to the complaint made
		Where to go to ask questions in relation to services and giving feedback (visibility of customer services)
	Finance	Bill dispute
		Bill sent to deceased patient
		Cost of products
		Insurance cover
		Invoice error
		Unhappy with income collection process

Table 70: Complaints Classification

Appendix 3: Learning to Get Better: 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.