Managing Feedback within the Health Services

Your Service Your Say 2021

Foreword

The HSE continued to navigate the challenges of providing services while responding to COVID-19 during 2021. However, the pandemic also presented opportunities to reimagine ways of working and to develop new models to deliver care in a COVID-19 environment.

The National Complaints Governance and Learning Team used technology solutions to support staff in responding to feedback. Training was delivered through elearning modules and webinars were developed and hosted on HSeLanD. The Complaints Managers Governance and Learning Forum moved to an online platform to preserve access to peer support, networking and learning opportunities.

During April to September NCGLT staff were redeployed to establish a new service, Vaccination Client Services (VCS), to support the national vaccination programme. This new service, under the remit of NCGLT, provides a dedicated portal for national offices to direct all vaccine related queries received by them for examination and response by the VCS team.

While some services provided by NCGLT were curtailed during this period of redeployment, resources for critical services were ring-fenced. The CMS helpline continued to support staff recording data on the Complaints Management System (CMS). The National Your Service Your Say Office and the Disability Complaints Service remained fully operational. Indeed, the National Your Service Your Say office experienced significant demand on its services with a growth of 84% in client interactions from 2020.

The majority of the NCGLT team returned from redeployment in September and resumed reporting, governance and learning functions. NCGLT produced an end of year Anonymised Feedback Learning Casebook for 2021 with a total of 28 cases presented. The self-assessment returns setting out compliance with the Ombudsman's recommendations within Learning to Get Better were collated and issued to the Office of the Ombudsman.

The HSE continued to respond to feedback received. It is acknowledged that delays were experienced. I wish to thank those Service Users engaged in the Your Service Your Say process during this time for their patience and understanding.

I am pleased to present the data on feedback received by the health services during 2021, 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.

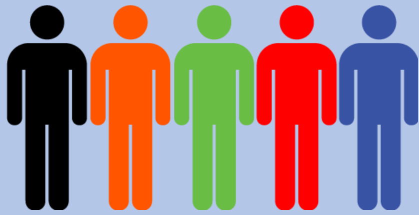
I acknowledge and appreciate the engagement and cooperation of the operational system to work with NCGLT to realise the potential that a positive feedback culture can deliver.

I hope that you are also encouraged and reassured that the HSE welcomes, values and wants to learn from your experience.

Mr Christopher Rudland
Assistant National Director
Patient and Service User Experience

2021. . . at a glance

The health services received

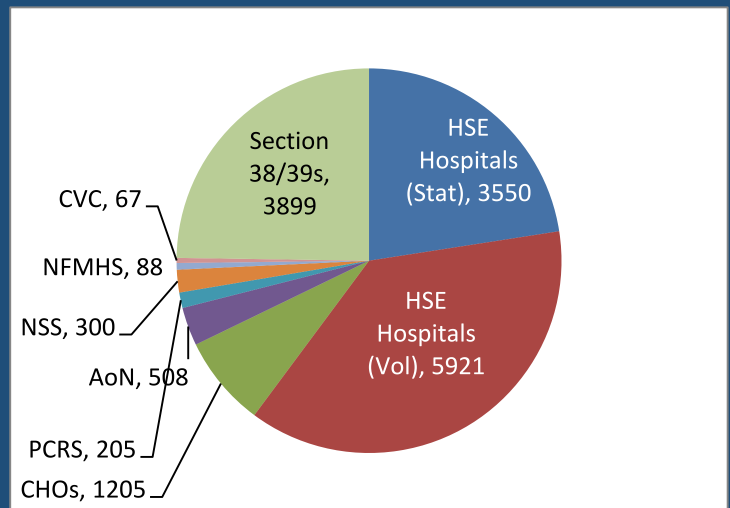


15,743 new complaints

- 15,743 Stage 2 complaints recorded and examined by Complaints Officers in both the HSE and Voluntary Health Services.
- 5% increase in complaints compared with 2020.
- Overall the health services responded to 73% of complaints within 30 working days (KPI of 75%).

- **5,923 complaints to statutory services.**
  - 540 complaints excluded under Your Service Your Say or withdrawn.

- **9,820 complaints to Voluntary Hospitals and Agencies.**
  - 537 were either excluded under complaints procedure or withdrawn.



Causes for Complaints

- **Safe and Effective Care**
- **Access**
- **Communication & Information**
- **Dignity and Respect**
- **Accountability**

508 Assessment of Need (AoN) Complaints relating to Disability Services were received.

- **5899** applications for Assessment of Need in 2021, an increase of 26% from 2020.
- **55%** decrease in complaints received compared to 2020.
- **33%** were dealt with by a complaints officer within 30 days.
- Days taken by a Complaint Officer to close out a complaint decreased from 89 days in 2020 to **47 days** in 2021.

HSE Staff completing YSYS online training:

- **10,070 completed Effective Complaints Handling.**
- **2,163 completed Effective Complaints Investigation.**
- **2,542 completed YSYS Guidance for Clinical Staff.**

COMPLAINTS MANAGEMENT SYSTEM (CMS)

- **85% of all complaints recorded on CMS.**
- **101 new inputters trained.**

The National Your Service Your Say Team had

32,467

client interactions

- **84%** Increase in activity since 2020.
- **Email** is preferred method of contact accounting for 43% of all office activity.
- **Key issues**: Access (33%), Communication and Information (24%) and Safe & Effective Care (22%).

Vaccination Client Services (VCS) Responded to 5,502 email queries

- **Key issue categories were *Access* (63%) and *Communication and Information* (34%).**

Table of Contents

Foreword 1
2021. . . at a glance 2
Background 5
Part One: Data on Complaints recorded in the Health Services 2021 (Community Services, Statutory Hospitals, Voluntary Hospitals and Voluntary Agencies) 6
1.0 Introduction 6
1.1 Key Findings 7
1.2 Overall Findings 7
1.3 Variance from 2020 8
1.4 Breakdown of Recorded 2021 9
1.5 Complaints resolved by COs ≤30 working days 10
1.6 Hospital Groups (Statutory and Voluntary) 10
1.7 Community Healthcare Organisations 19
1.8 Category of Complaint 20
Part Two: Self-Assessment of Compliance with the Ombudsman's Learning to Get Better Recommendations 32
2.0 Introduction 32
2.1 Self-Assessment of Compliance 32
2.2 Hospital Group: Compliance Position 2021 33
2.3 Community Healthcare Organisation: Compliance Position 2021 36
2.4 NCGLT Audit of Compliance 38
Part Three: The National Complaints Governance and Learning Team 39
3.0 Introduction 39
3.1 Complaints Governance 40
3.2 Your Service Your Say Materials 49
3.3 HSE Website 50
3.4 Training 50
3.5 Audit 53
3.6 Complaints Management System (CMS) 54
3.7 Healthcare Complaints Audit Tool (*HCAT)* 56
3.8 Learning from Individual Complaints: HSE Anonymised Feedback Learning Casebook 58
Part Four: The National Complaints Governance and Learning Team: Operational Services 60
4.0 Introduction 60
4.1 The National Your Service Your Say Office 60
4.2 COVID-19 Vaccination Client Services 67
4.3 National Disability Complaints – Assessment of Need (AoN) 68
Appendices 74
Appendix 1: Data Tables 74
Appendix 2: Complaint Categories 88
Appendix 3: Learning to Get Better: Recommendations 94

Background

Feedback, both positive and negative, can provide unique insights into the standards of care those who use our services receive. Capturing and analysing this feedback should be central to how we learn and improve the quality of our services.

The National Complaints Governance and Learning Team is the national office 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 national unit was established in response to the Ombudsman's, *Learning to Get Better, an investigation into how public hospitals handle complaints* report which set out 36 recommendations to ensure an accessible, comprehensive and compassionate response to feedback and to commit to using that feedback to inform and drive quality and patient safety.

Following the corporate reorganisation undertaken by the HSE during 2021, the National Complaints Governance and Learning Team (NCGLT) moved from Quality Assurance and Verification to the newly established Patient and Service User Experience function under Integrated Operations. This change came into effect in July 2021.

Part One: Data on Complaints recorded in the Health Services 2021 (Community Services, Statutory Hospitals, Voluntary Hospitals and Voluntary Agencies)

1.0 Introduction

Learning from feedback is fundamental in providing high quality services. Listening to and acting on the views, concerns and experiences of patients, service users and their families enable us to provide the best possible care. The recording, analysing and reporting of such data across our health services will ensure feedback is integral to business improvement.

A Complaints Management System (CMS) was developed in partnership with the State Claims Agency and is the mandatory national standardised database for complaint recording and reporting.

In 2021, there were 15,743 complaints received by the health services. Of these, 5,923 were recorded as received and examined by Complaint Officers in the Health Service Executive with 9,820 recorded and examined by Complaints Officers in Voluntary Hospitals and Agencies.

Under legislation and policy, Complaints Officers should attempt to complete formal investigations within 30 working days. For 2021, 73% of complaints were dealt with within 30 days or less. The HSE key performance indicator (KPI) target is 75%.

The main issues within complaints for 2021, as with past years, relate to *Safe and Effective Care*, *Access*, and *Communication and Information*.

Compared with 2020, there was an overall rise of 5% in complaints to health services in 2021. Complaints to HSE statutory hospitals rose by 18% and voluntary hospitals by 11% with HSE Community Healthcare Organisations experiencing the greatest increase of 31%.

Complaints relating to Assessment of Need experienced a significant decrease of 55% compared with 2020 complaints data due primarily to the impact of the Preliminary Team Assessment (PTA) approach, which led to a decrease in time taken to complete assessments, and consequently a decrease in related complaints.

1.1 Key Findings

The data presented in this report is collected from Complaints Officers who make regular returns to the National Complaints Governance and Learning Team. Data relating to Statutory HSE services is taken primarily from the Complaints Management System (CMS)[1]. 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 National Complaints Governance and Learning Team.

In 2021, there were 15,743 complaints received by the health services.

Of these, 5,923 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, 540 were excluded from investigation under the Your Service Your Say complaints process, or withdrawn. Of the remaining 4,875 complaints, 2,989 or 61% were dealt with ≤30 working days (Part 9: Health Act, 2004, and Part 3: Disabilities Act, 2005). There were 508 complaints relating to Assessment of Need of which 33% were dealt with by a Complaints Officer within 30 working days.

There were 9,820 complaints recorded and examined by Complaints Officers in Voluntary Hospitals and Agencies. Of the total number of complaints received, 9,283 were investigated. The other 537 were either excluded or withdrawn. Of those investigated 7,614 or 82% were addressed by a complaints officer either informally or through formal investigation within 30 working days.

1.2 Overall Findings

- There were **15,743** 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] The Complaints Management System (CMS) is a standardised national database management system developed in partnership with the State Claims Agency. This web-based solution captures valuable real-time data from feedback; enables learning from complaints throughout the organisation and is a critical part of the quality assurance process in both complaints management and in compliance with National Standards for Safer Better Healthcare. The Complaints Management System will provide HSE sites with end-to-end complaint reporting and support the tracking of investigations, outcomes and recommendations resulting in better complaints management standards in those sites and nationally throughout the HSE. This also enables all participating sites to report on, interrogate and interpret their data and enables them to take appropriate decisions in the light of accurate and up-to-date information

1.3 Variance from 2020

Summary Table of Variance

Summary Table of Variance	2021	2020	%Change
HSE Statutory Hospitals	3550	3013	18%
Voluntary Hospitals within Hospital Groups	5921	5317	11%
HSE Community Healthcare Organisations	1205	917	31%
HSE Assessment of Need (AoN)	508	1135	-55%
HSE National Ambulance Service	-	138	-
Primary Care Reimbursement Service (PCRS)	205	193	6%
National Screening Service (NSS)	300	-	
National Forensic Mental Health Service (NFMHS)	88	-	
COVID Vaccine Clinic - Cork & Kildare Locations (CVC)	67	-	
Other Voluntary Hospitals and Agencies	3899	4316	-10%
Total	15743	15029	5%

Table 1: Summary of % Variance Complaints recorded 2020 to 2021

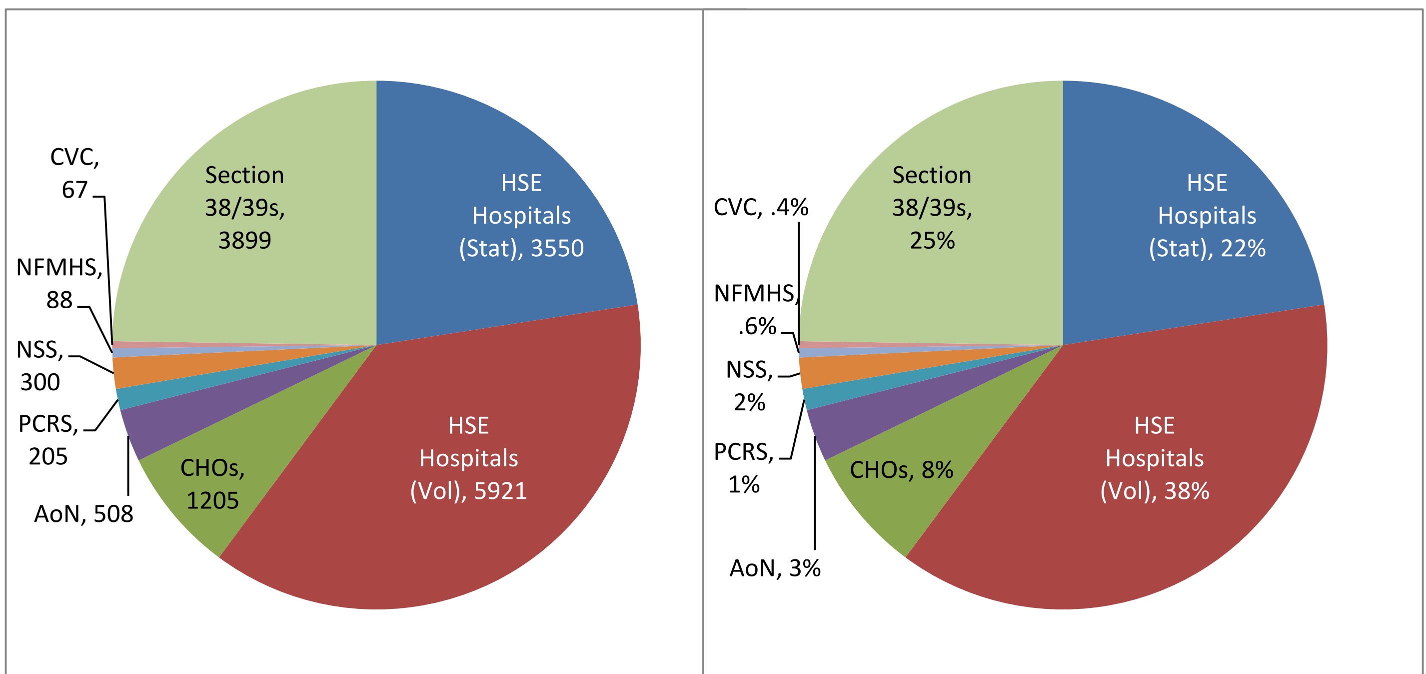


Figure 1: Breakdown of health service complaints recorded 2021

Figure 2: Percentage breakdown of health service complaints recorded 2021

1.4 Breakdown of Recorded 2021

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	1205
HSE: Statutory Hospitals	3550
HSE: National Ambulance Service	-
HSE: Primary Care Reimbursement Fund	205
Complaints under Part 2 of the Disabilities Act 2005 (Assessment of Need)	508
National Screening Service	300
National Forensic Mental Health Service	88
COVID Vaccine Clinic (Cork & Kildare Locations)	67
Total	**5923**

Table 2: Complaints (Excluding Voluntary Hospitals and Agencies and Complaints under Part 3 of the Disabilities Act 2005)

Complaints received to Voluntary Services

Complaints received to Voluntary Services	Total
HSE Voluntary Hospitals	5921
Other Voluntary Hospitals and Agencies	3899
Total Complaints received to Voluntary Services	9820

Table 3: Complaints received to Voluntary Services

Total Complaints Received

Total Complaints received 2021	Total
Total Complaints received to the HSE	5923
Total Complaints received to Voluntary Services	9820
Total Complaints received 2021	**15743**

Table 4: Total Complaints received 2021

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 2021, 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)

1.6.1 University Limerick Hospitals Group

University Limerick Hospitals Group Statutory Hospitals

Hospital	Complaints received 2021	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	14	0	14	2	**14%**	5
Ennis Hospital	26	1	25	3	**12%**	5
Nenagh Hospital	29	0	29	0	**0%**	1
University Hospital Limerick	567	12	555	184	**33%**	127
University Maternity Hospital Limerick	133	1	132	27	**20%**	20

Table 5: ULHG Reported Complaints 2021 (Statutory)

University Limerick Hospitals Group Voluntary Hospitals

Hospital	Complaints received 2021	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	13	0	13	11	**85%**	2

University Limerick Hospitals Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
ULH Statutory Hospitals	769	0	7	7	26	190	158	29%
ULH Voluntary Hospitals	13	0	0	0	3	8	2	85%

Table 6: ULHG Reported Complaints 2021

1.6.2 *South/South West Hospital Group*

South/South West Hospital Group Statutory Hospitals

Hospital	Complaints received 2021	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	1	**100%**	0
Cork University Hospital	263	5	258	165	**64%**	74
Cork University Maternity Hospital	180	1	179	82	**46%**	16
Mallow General Hospital	1	0	1	1	**100%**	0
South Tipperary General Hospital	91	13	78	65	**83%**	12
University Hospital Waterford & Kilcreene	115	1	114	19	**17%**	67
University Hospital Kerry	100	16	84	11	**13%**	53

Table 7: SSWHG Reported Complaints 2021 (Statutory)

South/South West Hospital Group Voluntary Hospitals

Hospital	Complaints received 2021	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	69	5	64	25	**39%**	29
South Infirmary Victoria University Hospital	80	3	77	58	**75%**	18

Table 8: SSWHG Reported Complaints 2021 (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	751	15	21	0	99	245	222	48%
SSWHG Voluntary Hospitals	149	6	2	0	5	78	47	59%

Table 95: SSWHG Reported Complaints 2021

1.6.3 Saolta University Health Care Group (Statutory)

Saolta University Health Care Group

Hospital	Complaints received 2021	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	371	25	346	275	79%	67
Merlin Park University Hospital	44	4	40	31	78%	9
Sligo Regional Hospital	78	0	78	42	54%	36
Letterkenny General Hospital	147	1	146	41	28%	105
Mayo General Hospital	-	-	-	-	-	-
Portiuncula Hospital	-	-	-	-	-	-
Roscommon County Hospital	-	-	-	-	-	-

Table 106: Saolta Reported Complaints 2021

Saolta Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
Saolta Statutory Hospitals	640	6	24	0	73	316	217	64%

Table 11: Saolta Reported Complaints 2021

1.6.4 RCSI Hospital Group

RCSI Hospital Group Statutory Hospitals

Hospital	Complaints received 2021	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	94	49	45	33	73%	12
Connolly Hospital	159	33	126	95	75%	26
Our Lady of Lourdes Hospital, Drogheda & Louth	248	46	202	162	80%	34

Table 12: RCSI Reported Complaints 2021 (Statutory)

RCSI Hospital Group Voluntary Hospitals

Hospital	Complaints received 2021	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	449	188	261	207	79%	54
Rotunda	166	0	166	163	98%	3

Table 13: RCSI Reported Complaints 2021 (Voluntary)

RCSI Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
RCSI Statutory Hospitals	501	77	51	0	82	208	72	78%
RCSI Voluntary Hospitals	615	180	8	0	17	353	57	87%

Table 14: RCSI Reported Complaints 2021

1.6.4 Ireland East Hospital Group

Ireland East Hospital Group Statutory Hospitals

Hospital	Complaints received 2021	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	164	4	160	95	**59%**	47
Our Lady's Hospital, Navan	44	1	43	13	**30%**	23
St. Columcille's Hospital	43	0	43	29	**67%**	14
St Luke's General Hospital, Kilkenny	117	43	74	47	**64%**	25
Wexford General Hospital	118	0	118	111	**94%**	6

Table 15: IEHG Reported Complaints 2021 (Statutory)

Ireland East Hospital Group Voluntary Hospitals

Hospital	Complaints received 2021	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	39	21	18	10	**56%**	8
Mater Misericordiae University Hospital	1637	9	1628	1390	**85%**	238
National Maternity Hospital (Vol)	142	15	127	119	**94%**	8
St Michael's Hospital, Dun Laoghaire	44	2	42	35	**83%**	5
St Vincent's University Hospital	145	0	145	126	**87%**	17
Royal Victoria Eye and Ear Hospital	48	1	47	12	**26%**	19

Table 167: IEHG Reported Complaints 2021 (Voluntary)

Ireland East Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
IEHG Statutory Hospitals	486	43	1	4	81	214	115	67%
IEHG Voluntary Hospitals	2055	31	15	2	1126	566	295	84%

Table 17: IEHG Reported Complaints 2021

1.6.6 Dublin Midlands Hospital Group

Dublin Midlands Hospital Group Statutory Hospitals

Hospital	Complaints received 2021	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	75	0	75	37	49%	34
Midlands Regional Hospital, Tullamore	222	59	163	97	60%	42
Naas General Hospital	106	0	106	91	86%	15

Table 18: DMHG Reported Complaints 2021 (Statutory)

Dublin Midlands Hospital Group Voluntary Hospitals

Hospital	Complaints received 2021	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)	1705	4	1701	1607	94%	94
The Coombe	163	0	163	148	91%	12
St. Luke's Radiation Oncology Network	-	-	-	-	-	-
St. James's Hospital	527	0	527	258	49%	96

Table 19: DMHG Reported Complaints 2021 (Voluntary)

Dublin Midlands Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
DMHG Statutory Hospitals	403	59	0	0	1	224	91	65%
DMHG Voluntary Hospitals	2395	0	4	0	1001	1012	202	84%

Table 20: DMHG Reported Complaints 2021

1.6.7 Children's Health Ireland Group (Voluntary)

Children's Health Ireland Group (Voluntary)

Hospital	Complaints received 2021	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	326	0	326	222	68%	104
Children's University Hospital Temple Street	87	1	86	83	97%	3
Tallaght University Hospital	281	4	277	190	69%	87

Table 218: CHI Reported Complaints 2021

Children's Health Ireland Hospital Group

Service	Complaints	Excluded	Withdrawn	Anonymous	Resolved informally	Formal ≤30 wds	Formal >30 wds	% Resolved ≤30 wds
CHG Voluntary Hospitals	694	0	5	0	113	382	194	72%

Table 22: CHI Reported Complaints 2021

HSE

Your Service Your Say

1.6.8 All HSE Statutory and Voluntary Hospitals

All HSE Statutory and Voluntary Hospitals

All Statutory and Voluntary Hospitals	Complaints received 2021	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved ≤30 working days by CO formally & informally	% resolved ≤30 working days by CO
Total	9471	568	8903	6423	72%

Table 23: All HSE Statutory and Voluntary Hospitals Reported Complaints 2021

1.6.9 Other HSE Statutory and Voluntary Hospitals

Other Voluntary Hospitals and Agencies

Hospital	Complaints received 2021	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	3899	284	3615	2946	81%

Table 24: Other Voluntary Hospitals Reported Complaints 2021

1.7 Community Healthcare Organisations

1.7.1 Complaints Reported by each CHO

Complaints Received/Resolved under the Health Act: CHOs

Community Healthcare Organisation (CHO)	Complaints received 2021	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	206	54	0	8	46	44	54	63%
CHO 2	117	29	1	0	5	46	26	59%
CHO 3	72	0	3	0	3	46	20	71%
CHO 4	73	20	1	0	4	29	13	63%
CHO 5	2	0	0	0	1	1	0	100%
CHO 6	83	0	0	0	1	57	5	70%
CHO 7	237	6	2	0	54	112	51	72%
CHO 8	340	33	30	8	36	119	72	58%
CHO 9	75	2	0	0	2	49	12	70%

Table 25: CHOs Complaints resolved 2021

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 2021	Complaints excluded under Part 2 of the Disability Act 2005	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	508	23	18	0	0	154	292	33%

Table 26: AoN Complaints resolved 2021

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 2021
Access	1475	2377	3852
Dignity and respect	640	1333	1973
Safe and effective care	1900	3638	5538
Communication and information	1268	3755	5023
Participation	32	178	210
Privacy	66	161	227
Improving health	38	161	199
Accountability	182	433	615
Clinical judgement	230	171	401
Vexatious complaints	2	61	63
Nursing homes / residential care for older people (65 and over)	3	29	32
Nursing homes / residential care (aged 64 and under)	0	6	6
Pre-school inspection services	0	0	0
Trust in care	13	42	55
Children first	2	49	51
Safeguarding vulnerable persons (new 2016)	5	230	235
Total Issues	**5856**	**12624**	**18480**

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	7	0	6	1	0	0	0	1
Ennis Hospital	8	4	12	7	0	0	0	1
Nenagh Hospital	1	0	5	0	0	0	0	0
University Hospital Limerick	162	99	363	174	4	7	14	38
University Maternity Hospital Limerick	55	28	52	47	2	4	0	1
Total Issues	**233**	**131**	**438**	**229**	**6**	**11**	**14**	**41**

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	6	2	3	3	0	2	0	0
Total Issues	**6**	**2**	**3**	**3**	**0**	**2**	**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	1	0	0	0	0	0	0
Total Issues	**0**	**1**	**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	1	2	0	1	0	0	0	0
Cork University Hospital	50	30	116	61	0	1	1	6
Cork University Maternity Hospital	81	5	70	31	5	2	0	1
Mallow General Hospital	0	0	0	1	0	0	0	0
South Tipperary General Hospital	17	17	21	37	0	1	0	0
University Hospital Waterford & Kilcreene	7	3	64	52	0	0	0	6
University Hospital Kerry	5	29	27	35	0	2	0	2
Total Issues	**161**	**86**	**298**	**218**	**5**	**6**	**1**	**15**

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	1	1	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	**2**	**1**	**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	9	7	34	16	0	1	1	1
South Infirmary Victoria University Hospital	18	1	27	26	0	2	0	5
Total Issues	**27**	**8**	**61**	**42**	**0**	**3**	**1**	**6**

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	1	1	0	0	0	0	0	0
Total Issues	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**

Table 31: 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	110	34	113	101	2	3	1	11
Merlin Park University Hospital	27	2	1	14	0	0	0	2
Sligo Regional Hospital	15	25	14	33	0	2	0	4
Letterkenny General Hospital	42	3	74	21	0	6	1	0
Mayo General Hospital	-	-	-	-	-	-	-	-
Portiuncula Hospital	-	-	-	-	-	-	-	-
Roscommon County Hospital	-	-	-	-	-	-	-	-
Total Issues	**194**	**64**	**202**	**169**	**2**	**11**	**2**	**17**

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	13	0	0	0	0	10	0	0
Letterkenny General Hospital	0	0	0	0	0	0	0	0
Mayo General Hospital	-	-	-	-	-	-	-	-
Portiuncula Hospital	-	-	-	-	-	-	-	-
Roscommon County Hospital	-	-	-	-	-	-	-	-
Total Issues	**13**	**0**	**0**	**0**	**0**	**10**	**0**	**0**

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	24	25	59	29	0	1	0	2
Connolly Hospital Blanchardstown	43	18	123	77	3	3	4	17
Our Lady of Lourdes Hospital, Drogheda & Louth	61	51	93	39	0	2	2	11
Total Issues	**128**	**94**	**275**	**145**	**3**	**6**	**6**	**30**

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	46	0	0	0	0	0	0	0
Connolly Hospital Blanchardstown	52	0	0	0	0	0	0	0
Our Lady of Lourdes Hospital, Drogheda & Louth	4	0	0	0	0	0	0	0
Total Issues	**102**	**0**	**0**	**0**	**0**	**0**	**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	67	32	316	32	2	1	1	28
Rotunda	122	32	217	343	6	7	7	5
RCSI Voluntary Hospitals Total Issues	**189**	**64**	**533**	**375**	**8**	**8**	**8**	**33**

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	3	0	0	0	0	0	0	0
Rotunda	78	0	0	0	0	0	0	0
Total Issues	**81**	**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	24	13	79	35	0	6	7	9
St Luke's General Hospital, Kilkenny	25	6	64	22	7	3	1	8
St. Columcille's Hospital	7	4	26	6	0	0	0	1
Our Lady's Hospital, Navan	6	9	25	4	0	0	0	0
Wexford General Hospital	34	25	37	47	2	2	0	2
Total Issues	**96**	**57**	**231**	**114**	**9**	**11**	**8**	**20**

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	43	0	0	0	0	0	0	1
St. Columcille's Hospital	0	0	0	0	0	0	0	0
Our Lady's Hospital, Navan	0	0	0	0	0	0	0	0
Wexford General Hospital	12	0	0	0	0	0	0	0
Total Issues	**55**	**0**	**0**	**0**	**0**	**0**	**0**	**1**

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	11	29	34	1	1	0	3
Mater Misericordiae University Hospital	281	33	485	1206	8	12	14	90
National Maternity Hospital	23	11	66	101	6	1	2	1
St Michael's Hospital, Dun Laoghaire (V)	9	11	7	10	0	0	0	4
St Vincent's University Hospital	3	9	120	48	0	1	1	1
Royal Victoria Eye and Hospital	12	21	5	8	0	0	0	1
Total Issues	**344**	**96**	**712**	**1407**	**15**	**15**	**17**	**100**

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	12	0	0	0	0	0	0	0
Mater Misericordiae University Hospital	19	0	0	0	0	4	0	0
National Maternity Hospital	1	0	0	0	0	0	0	0
St Michael's Hospital, Dun Laoghaire (V)	6	1	0	0	0	0	0	0
St Vincent's University Hospital	0	0	0	0	0	0	0	0
Royal Victoria Eye and Hospital	0	1	0	0	0	0	0	0
Total Issues	**38**	**2**	**0**	**0**	**0**	**4**	**0**	**0**

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	15	20	32	15	1	1	0	2
Midlands Regional Hospital, Tullamore	62	7	76	54	0	2	1	30
Naas General Hospital	9	0	36	60	0	1	0	1
Total Issues	**86**	**27**	**144**	**129**	**1**	**4**	**1**	**33**

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	3	0	0	0	0	0	0	0
Naas General Hospital	0	0	0	0	0	0	0	0
Total Issues	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Table 37: 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	372	193	570	651	7	15	17	69
The Coombe Women & Infant University Hospital	41	4	35	78	0	2	2	1
St. Luke's Radiation Oncology Network	-	-	-	-	-	-	-	-
St. James's Hospital	175	82	282	218	9	11	16	28
Total Issues	**588**	**279**	**887**	**947**	**16**	**28**	**35**	**98**

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	-	-	-	-	-	-	-	-
St. James's Hospital	15	4	0	0	0	3	1	2
Total Issues	**15**	**4**	**0**	**0**	**0**	**3**	**1**	**2**

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	137	21	156	179	10	3	12	44
Children's University Hospital Temple Street	125	15	100	51	3	8	5	15
Tallaght University Hospital	19	15	37	29	0	1	1	7
Total Issues	**281**	**51**	**293**	**259**	**13**	**12**	**18**	**66**

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	0	0	0	0	0	0	0	0
Tallaght University Hospital	0	0	0	0	0	0	0	0
Total Issues	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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

Your Service Your Say

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	89	31	51	62	5	9	2	6
CHO 2	47	19	24	25	0	2	0	2
CHO 3	39	23	6	3	0	0	0	1
CHO 4	22	10	19	28	0	5	2	0
CHO 5	0	1	1	0	0	0	0	0
CHO 6	49	3	16	8	0	0	0	1
CHO 7	134	30	102	40	0	0	0	6
CHO 8	172	48	66	81	1	1	0	10
CHO 9	25	16	27	17	0	0	2	0
Total	**577**	**181**	**312**	**264**	**6**	**17**	**6**	**26**

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	0	0	0	0	0	0	0	0
CHO 2	2	1	2	0	0	3	0	0
CHO 3	0	0	0	0	0	0	0	0
CHO 4	0	0	1	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	4	0	0	0	0	0	0	0
CHO 8	49	0	0	0	0	0	0	4
CHO 9	0	0	0	0	0	0	2	0
Total	**55**	**1**	**3**	**0**	**0**	**3**	**2**	**4**

Table 40: Complaints broken down by category for Community Healthcare Organisations 2021

Part Two: Self-Assessment of Compliance with the Ombudsman's Learning to Get Better Recommendations

2.0 Introduction

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 hospitals handle complaints' (LTGB) 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.

The HSE conducts an annual self-assessment on its compliance with the LTGB recommendations applying to the operational system.

For 2021, Hospital Groups returned a 74% self-assessed compliance rating with recommendations. This was an 8% improvement compared with 2020. Recommendations relating to volunteer advocacy and casebooks were the most common recommendations assessed as non-compliant. Recommendations under Access, Process and Learning need to be prioritised.

For 2021, Community Healthcare Organisations (CHOs) returned an 82% self-assessed compliance rating. This was the same as the self-assessed position for 2020. Three recommendations were assessed as being fully compliant across all CHOs; dealing with anonymous complaints, independent investigation and the fostering of positive attitudes. A much improved compliance with recommendations under Learning was reflected in the returns, although further work is needed under both Learning and Leadership.

2.1 Self-Assessment of Compliance

Learning to Get Better[2] set out 36 recommendations covering the HSE and the Department of Health with 29 applying to the HSE operational system. (*See Appendix 1 for the full recommendation listing)*.
To track the progress with implementing the recommendations at operational level, the Ombudsman developed a self-assessment template for Hospital Groups to complete. The same template was also to be used by Community Healthcare Organisations.

Following requests for standardised assessment criteria for recommendations, CHO specific wording for recommendations and individual Hospital site templates, the master templates was amended and now three templates are in operation.

[2] *Learning to Get Better, An investigation by the Ombudsman into how public hospitals handle complaints'*. The Ombudsman 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. To address this, the Ombudsman set out 36 recommendations in total applying to the HSE, both at operational and strategic level as well as to the Department of Health.
The HSE publicly welcomed the report and committed to delivering on the recommendations across acute and community to ensure that our feedback system would be open and responsive.

1. Master Hospital Group Learning to Get Better Template
2. Master Hospital site Learning to Get Better Template
3. Master Community Healthcare Organisation Learning to Get Better Template

All revised templates were approved by the Ombudsman. The templates will be kept under review to improve ease and accuracy of reporting on self-assessed compliance.

2.2 Hospital Group: Compliance Position 2021

Overview

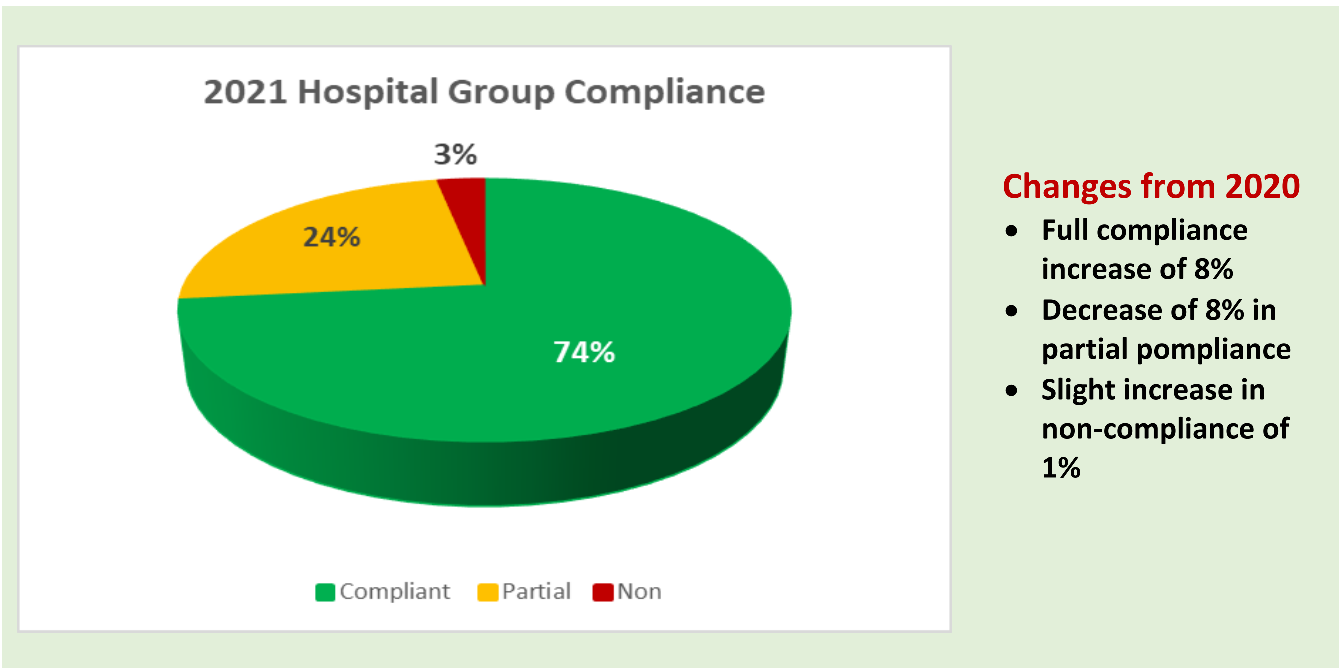


Figure 3: Chart showing (averaged) compliance level assessed by Hospital Groups for 2020

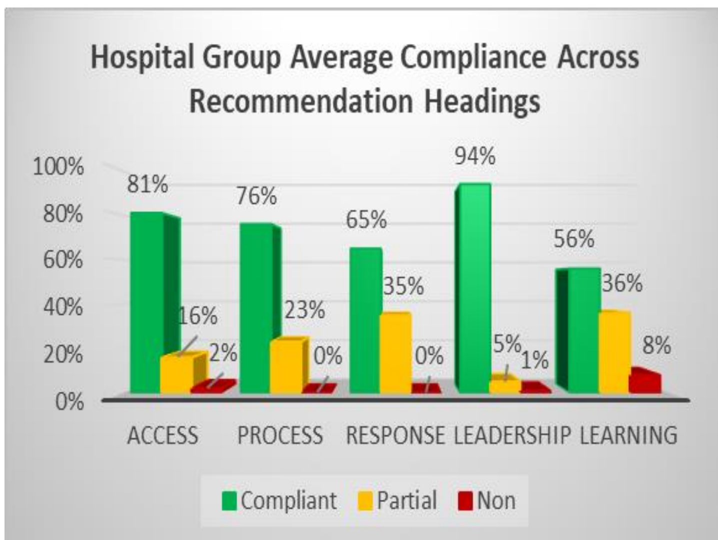


Figure 4: Chart showing averaged compliance levels assessed by Hospital Groups for 2021 for each recommendation category

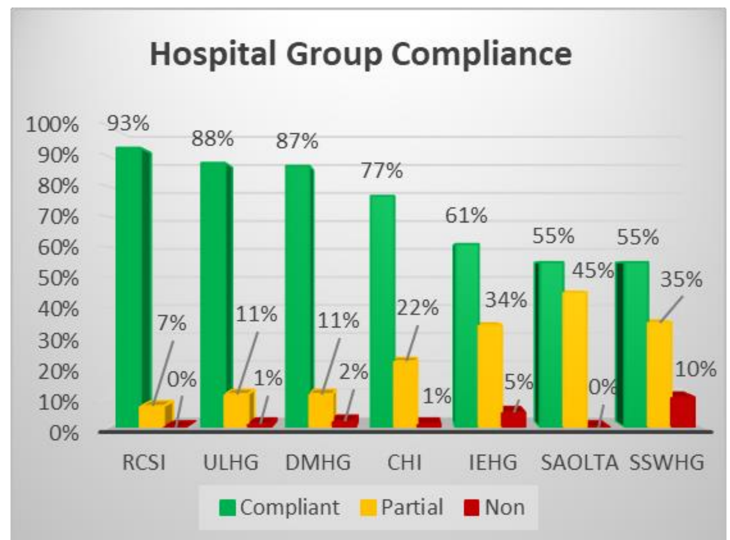


Figure 5: Chart showing individual Hospital Group compliance rating returned for 2021.

HG
No Full Compliance

HG
High Compliance
RCSI - 27
DMHG - 25
CHI - 22

HG
Non Compliance
SSWHG – 3
IEHG -2

Common Non Compliances: #6 and #36

Your Service Your Say

2.2.1 Hospital Group Compliance Position for 2021

For 2021, Hospital Groups have presented an overall compliance rate of 74% with the Ombudsman's recommendations, an increase of 8% from 2020. This was also reflected in the recommendations assessed as partially compliant, falling from 32% in 2020 to 24% for 2021. However, there was a slight rise in recommendations assessed as non-compliant, from 2% in 2020 to 3% for 2021.

Progress towards full compliance for all recommendations under each of the headings of Access, Process, Response, Leadership and Learning was reflected in the 2021 self-assessment returns. However, full compliance with recommendations under Learning still remains low. This area needs priority attention as the benefits for service delivery from examining service user experience is not being fully realised. Learning from feedback is a key area for Your Service Your Say and the HSE.

The emergency response to COVID and the resulting redeployment or loss of staff has severely impacted on the progress towards achieving full compliance with the recommendations under Learning to Get Better. However, the overall compliance position is on a steady upward trajectory and the commitment to achieve full compliance is evident.

Further work is needed, particularly under Learning as this is critical to ensuring that HSE can provide patients and service users with a robust response to complaints and use these to drive improvement.

2.3 Community Healthcare Organisation: Compliance Position 2021

Overview

CHOs recorded
82% full compliance,
18% partial compliance
0% non-compliance
(averaged) across 28
recommendations.

3 recommendations are assessed as fully compliant across all CHOs. (Recommendations **9, 23, and 33**).

Compliance with recommendations under **Learning** have experienced the greatest improvement.

1 recommendation received an assessment of non-compliant by 1 CHO. (Recommendation **22**)

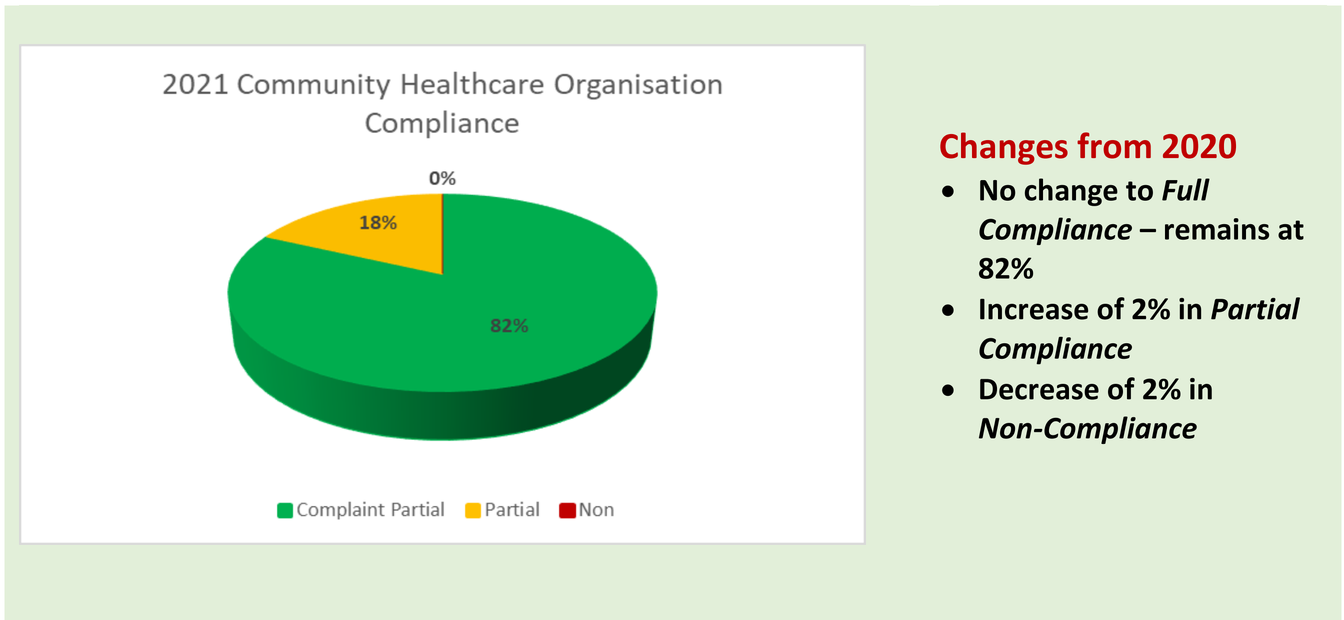


Figure 6: Chart showing compliance level assessed by Community Healthcare Organisations for 2021

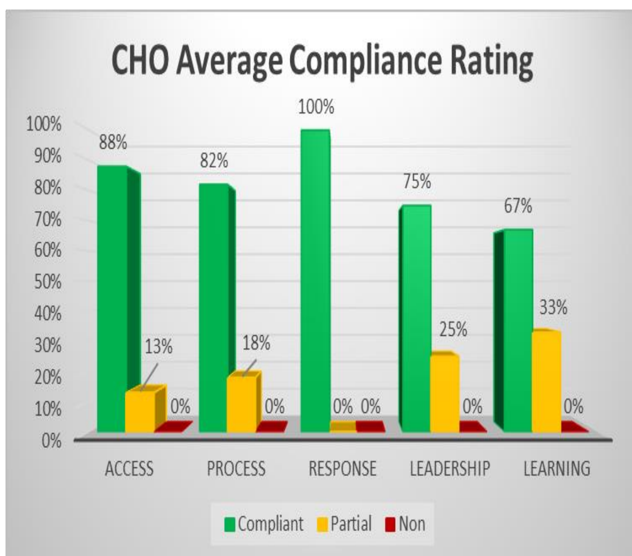


Figure 7: Chart showing averaged compliance levels assessed by Community Healthcare Organisations for 2021 for each recommendation heading category

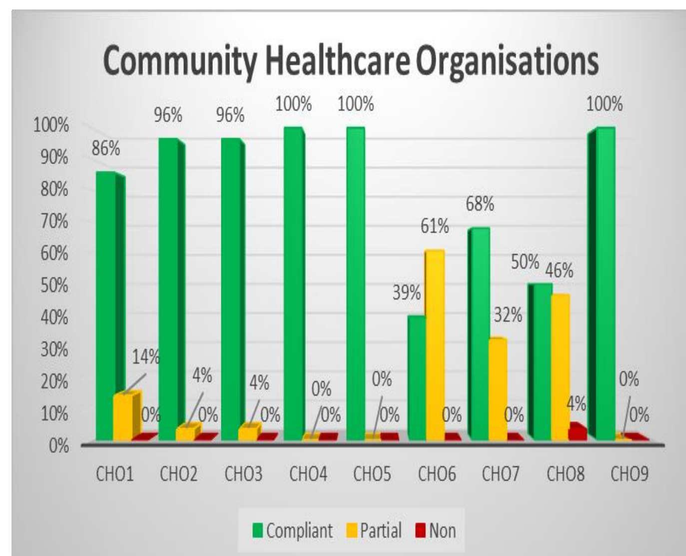


Figure 8: Chart showing individual CHO compliance rating returned for 2021.

CHO Full Compliance	**CHO High Compliance**	**CHO Non Compliance**
CHO 4 - **28**	CHO 2 - **27**	CHO 8 - **1**
CHO 5 - **28**	CHO 3 - **27**	
CHO 9 - **28**		

Non Compliances: # 22 – bi-monthly audit

2.3.2 Community healthcare Compliance Position for 2021

For 2021, Community Healthcare Organisations returned an overall compliance rate of 82% with the Ombudsman's recommendations, no change from 2020. There was an increase in recommendations assessed as partially compliant, rising from 16% in 2020 to 18% for 2021. When averaged across all CHOs, 0% non-compliance was assessed for 2021, a fall of 2% from the 2020 position. Although one CHO, Midlands Louth Meath Community Healthcare, recorded non-compliance for one recommendation under *Process*, #22 (bi-monthly audit).

Further work is needed to progress CHOs to full compliance with all recommendations, particularly with those under *Leadership* and *Learning* followed closed by *Process* and *Access*, as these are critical to ensuring that HSE can provide patients and service users with a robust response to complaints and drive improvement through learning.

2.4 NCGLT Audit of Compliance

The Ombudsman's templates are based on a Hospital Group's or Community Healthcare Organisation's self-assessment of their own compliance rating with a recommendation using the criteria for assessment set out in the template for guidance.

To provide assurance to the system that the compliance rating specified is accurate and reflects practice, NCGLT will conduct an audit of the returns to validate the rating of compliance stated. A sample of Community Healthcare Organisation and Hospital Group returns will be selected and the evidence used to determine the compliance rating will be examined. An audit report will be issued to the areas selected and to the national system.

While this audit was initially scheduled for 2021, due to redeployments as a result of COVID, the audit will now commence in 2022.

HSE

Your Service Your Say

Part Three: The National Complaints Governance and Learning Team

3.0 Introduction

The National Complaints Governance and Learning Team (NCGLT) is a national unit 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.

NCGLT provides a range of services broadly covering policy development, assurance & governance, training and development and data analytics.

NCGLT also facilitates the quarterly National Complaints Managers Governance and Learning Forum providing a platform for shared learning, peer support and networking for Complaints Managers across Hospital Groups, CHOs and national services. The Forums were hosted through the CISCO Webex Meetings platform for 2021. However, only three of the four scheduled meetings were held as NCGLT were redeployed during May to the national vaccination programme.

NCGLT continued to utilise technology solutions to deliver training for Review Officers under Stage Three of the Your Service Your Say Policy and support staff to respond to feedback by developing and hosting online elearning modules and webinars on HSeLanD. During 2021 a total of 14,775 HSE staff completed the online YSYS training modules.

Audits were again deferred for 2021 and will resume once face to face and onsite visits can be facilitated.

NCGLT published an annual edition of the National Anonymised Feedback Learning Casebook for 2021. The casebook featured a total of 28 cases, both complaints and compliments, received and responded to by Community Healthcare Organisations, Hospital Groups and National Services.

NCGLT operates two national frontline complaints services that are co-located between Naas and Limerick as well as a national query portal for the COVID-19 vaccination programme. Please see part four for further details.

3.1 Complaints Governance

3.1.1 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.

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

Complaints Managers are involved in education, training and reporting arrangements around Your Service Your Say. They ensure implementation of HSE's feedback policy 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 also responsible for assigning Review Officers to complaints following request for a review.

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.

3.1.2 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.

The Forum convened virtually in March, June and December during 2021. The May 2021 Forum was cancelled due to the redeployment of NCGLT to the national vaccination programme.

Key messages and learning 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.

March 2021 Forum

For the first Forum of 2021, the Ombudsman addressed the Forum members to acknowledge the incredible pressure that Health Service employees were under during the COVID-19 pandemic and to thank staff for delivering a remarkable service in difficult times.

The Ombudsman highlighted his report, *Learning to Get Better (LTGB)*, for the benefit of the new forum members. He acknowledged the emotional engagement that complainants have in terms of the subject matter in healthcare complaints. He also stressed that the reason for LTGB was the strong belief that the health service needs decent feedback loops. If mistakes are caught early services can be improved which makes for a safer and better healthcare service. He acknowledged the services' willingness to learn from complaints.

The Ombudsman welcomed improvements in relation to key issues such as access to mechanisms for providing feedback and continuing with commitments in encouraging complaints and making it easier for complainants to share experiences.

The Ombudsman acknowledged the strides made in standardisation, such as forms and IT systems for recording data, which allows for a much better chance in identifying patterns. He highlighted that he was very pleased with initiatives that have been taken in relation to training and online training and is keen to promote this with other sectors.

The Ombudsman acknowledged the importance of having access to Forums, such as this, which adds to a healthy cross-agency working relationship which he hopes to see continue.

The National Director for Quality Assurance and Verification also acknowledged the exceptionally challenging period that the Health Service was navigating and the impact the response to COVID was having. However, he reiterated that priorities remained the same in relation to training and the use of CMS to achieve valuable data. He advised that the Safety & Quality Committee of the HSE Board had taken a particular interest in this and their main agenda was around learning, not just from complaints but also from incidents and a range of other initiatives.

The National Director highlighted that when someone takes the time to put a complaint down on paper, not only are they giving their time, they are also pouring out an experience that the HSE needs to hear and to respond in a way that reflects our values of care, compassion, trust and learning. He recognised the progress made in implementing the Learning to Get Better recommendations but reaffirmed the commitment to achieving full compliance.

Case Study Presentation

Case studies are an integral part of the learning agenda that is fostered and facilitated at the Forum. NCGLT would like to thank Saolta University Healthcare Group and Children's Health Ireland for presenting cases to the Group.

- **Saolta University Health Care Group** presented a complex case that highlighted how advocacy can be highly effective at providing critical support for complainants.

- **Children's Health Ireland (CHI)** presented a positive feedback case from CHI at Crumlin which resulted in a new process for clinic procedures and the development of a child friendly information leaflet that was co-designed by the young person who provided the feedback and CHI staff. CHI highlighted the importance of sharing positive learning across sites to allow other areas to learn from the approach and ultimately better the patient experience.

Specialist Topic

Forums also feature presentations on specialist topics as requested by members. In March, NCGLT were delighted to welcome the national Patient Advocacy Service (PAS).

PAS outlined the background to the establishment of the service, the services provided as well as the key trends identified to date. They highlighted the Memorandum of Understanding between PAS and the HSE that formalised how both services would cooperate and work together for the benefit of service users.

NCGLT updated members on the ongoing work around the CMS and training.

May 2021 Forum – Cancelled due to the redeployment of NCGLT to the national vaccination programme.

September 2021 Forum

The AND, Patient & Service User Experience, acknowledged that NCGLT staff were affected by the cyber-attack in May and further impacted by a short-term redeployment to develop and run the new Vaccination Client Services (VCS) which was set up to handle complaints/queries on various aspects of the Covid19 vaccination programme.

The AND also confirmed that following the HSE corporate reorganisation, NCGLT has moved from Quality Assurance and Verification into the new Patient & Service User Experience function within Integrated Operations.

The disruption to the National Mental Health Review was highlighted. While Phase 1 is complete, Phase 2 will be delayed until 2022.

Office of the Ombudsman

The representative from the Office of the Ombudsman, who attends the quarterly Complaint Managers Governance and Learning Forums, addressed Forum members. She expressed appreciation for the work by healthcare staff throughout the past 18 months on behalf of the Ombudsman. She also paid tribute to those who lost their lives or lost relatives due to the COVID-19 pandemic.

The representative outlined how the Office of the Ombudsman handled 630 complaints related to Health and Social Care in 2020, which was a large proportion of the overall number of complaints.

The representative welcomed the HSE's annual self-assessment of compliance with the Learning to Get Better recommendations as these returns serve as a useful audit tool for the Ombudsman to check progress with implementation.

The representative advised that while the Ombudsman's own health casebook was delayed due to the impact of COVID, the Office is committed to improving the level of feedback provided to the health service and highlighting the importance of learning from this.

Following the Ombudsman's recent review of HSE websites, the representative expressed how pleased they were to see the prominence and ease of access to information regards providing feedback which is very positive for service users. Special mention was given to the Wexford General Hospital website.

The representative also welcomed the publication of the HSE National Anonymised Feedback Learning Casebook for 2020 that demonstrated very clearly that learning is a priority for the HSE.

Complaints Management System (CMS)
NCGLT provided an update on the Complaints Management System (CMS) and outlined how the cyber-attack had impacted on CMS usage resulting in reduced numbers of complaints logged to date in 2021.

The London School of Economics Healthcare Complaints Analysis Tool (HCAT) was implemented on the CMS for complaints received in 2021. HCAT *Severity* and *Harm* ratings are now to be assessed as part of the desktop review of a complaint by a Complaints Officer and these ratings are to be entered onto the CMS.

NCGLT provided a further update on the acute and community HCAT projects and advised that the December Forum would be dedicated to HCAT.

Case Study Presentation
Case studies were again presented at this Forum as these are an integral part of the learning focus that is fostered and facilitated at the Forum. NCGLT would like to thank Children's Health Ireland who again presented another interesting case.

- **Children's Health Ireland** outlined how feedback was received from a young person's family following a procedure at an outpatient clinic. The family highlighted how the patient felt alone as staff changed in the clinical lab environment, and felt very uncomfortable emotionally and physically throughout. The patient was reluctant to attend the next scheduled procedure. CHI outlined how they responded to this feedback and how this resulted in a number of recommendations including staff training, the introduction of a dedicated staff member in advance who is available throughout the patient journey as a support person and meeting with clinical staff in advance of procedures. As a result of these changes, the patient and their family reported a much better experience at the follow up procedure. The implementation of recommendations following this complaint examination is anticipated to improve future patient experience for similar procedures.

Specialist Topic
In September, NCGLT were delighted to welcome Sage Advocacy, an independent national organization providing information, support and advocacy services to vulnerable adults, older people and healthcare patients.

Sage outlined the pathway for referrals for advocacy and how such referrals are responded to. Sage advised that referrals for information/support calls and Rapid Response helpline calls totaled 1,670. The Nursing Home Residents Family Forum, which was a 2020 initiative, reported in excess of 20,000 engagements with families.

Sage also outlined the key findings from their 2020 annual report. These included issues such as moving residence, financial queries particularly concerning the Nursing Home Support Scheme, access to community services as well as restrictions on visiting times due to COVID.

Sage also outlined that some of their casework frequently relates to support in applying for and accessing home care packages and supporting individuals moving from council housing.

NCGLT closed the Forum by providing a general update on the work of the office.

December 2021 Forum
The final Forum for 2021 was held in December and this was dedicated to the Healthcare Complaints Analysis Tool (HCAT) developed by the London School of Economics.

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.

Dr Aelx Gillespie, London School of Economics and co-developer of HCAT addressed members of the Forum and outlined in detail the research background and developments in HCAT. Dr Gillespie provided an overview of the various HCAT development pieces around the world, buy in to the classification system and usage of it.

The NCGLT in partnership with National University of Ireland, Galway are currently undertaking a body of work involving the analysis of approximately 2,400 complaints from across the HSE’s services. The purpose of this analysis is to improve the classification system used by the HSE to support the identification of systemic issues and trends within systems and services leading to improvements in healthcare delivery. HCAT will also offer a greater understanding of the nature and severity of complaints that will feed into higher standards of quality and safety.

This project will run from 2018 to 2022 and is divided into two sections that will run concurrently. The first focusing on acute services related complaints and the second on community services related complaints.

Dr Emily O’ Dowd, NUIG, provided an update on the HCAT project.

Dr O'Dowd explained that using HCAT enhances the classification of complaints by examining the problems or issues within a complaint and determining the severity and the level of harm caused as identified by the patient/service user. HCAT also identifies the specific stage of care that resulted in harm, as well as 'Hot Spots' (i.e. an area in care where harm occurs frequently) and Blind spots (i.e. areas in care where harm can occur that are not easily observed). The use of HCAT will lead to a more developed understanding of the impact of complaints and assist management to prioritise service improvements to address those issues with high *Severity* and *Harm* ratings.

For acute services, the broad trends from complaints received point to issues with institutional processes, particularly delays in accessing care, and to poor relationships between staff and patients. While no harm was 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.

For community services, the broad trends from complaints received 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 provided insight into complaint profiles, motivations for complaints, severity of events, levels of harm, stage of care where the event occurred and has clearly identified the next steps for areas to translate this information into improvements.

NCGLT has now commenced efforts to link what has been learned from HCAT to other data sources, such as incidents, patient experience survey, etc. in order to develop improvement initiatives.

Presentation from St James on the use of HCAT
St James' outlined their experience of using HCAT within the Hospital and the value of HCAT analysis. They identified that the benefit of HCAT analysis for them was the richer understanding of complaints data that they gained. Their next step is to link this analysis with other quality, patient safety and risk data to co-design improvements with local management.

Application of HCAT data for generating improvements in care is expected to take time, for example over a 12-24 month's timeframe. Improvement in patient experience and care was highlighted as the overall aim.

The Forum closed with an update on NCGLT service developments.

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

Forum Attendees

While the National Complaints Managers Governance and Learning Forum is attended by Complaints Managers nominated at CHO, Hospital Group and National Service level, the Forum also has representatives from Consumer Affairs, the Office of the 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. Please see summary table of attendance for 2021. Please note that the Forum scheduled for May was cancelled due to redeployment of the NCGLT Team to the National Vaccination Programme.

2021 Complaints Managers Governance and Learning Forum Attendance

KEY: Attended (green) | No Show (red) | Issued Apologies (blue) | **AM** Affiliate Member – will attend if requested

Area	2021 Forum Dates				Summary Attendance	
	08/03/2021	31/05/2021 Cancelled	20/09/2021	06/12/2021	Total Attended	% Attended
Hospital Groups						
Ireland East Hospital Group	Yes		Yes	Yes	3	100%
South / South West Hospital Group	Yes		Yes	Yes	3	100%
Dublin Midlands Hospital Group	Yes		Yes	Yes	3	100%
Children's Health Ireland	Yes		Yes	Yes	3	100%
Saolta University Healthcare Group	Yes		Apologies	Yes	2	66%
RCSI Hospital Group	Yes		Apologies	Yes	2	66%
UL Hospitals Group	Yes		Yes	Yes	3	100%
Community Healthcare Organisations						
CHO Area 1	Yes		Yes	Yes	3	100%
Community Healthcare West	Yes		Yes	Yes	3	100%
Mid West Community Healthcare	Apologies		Apologies	Yes	1	33%
Cork Kerry Community Healthcare	Yes		Apologies	Yes	2	66%
South East Community Healthcare	Yes		Apologies	Yes	2	66%
Community Healthcare East	Yes		Apologies	Yes	2	66%
Dublin South Kildare & West Wicklow Community Healthcare	No		Yes	Yes	2	66%
Midlands Louth Meath Community Healthcare	Yes		Yes	Yes	3	100%
Dublin North City and County Community Healthcare	Apologies		Apologies	Yes	1	33%
National Services						
Internal Audit	AM		AM	AM		
Communications	No		No	No	0	0%
Mental Health	No		Yes	Apologies	1	33%
National Ambulance Service	Apologies		Yes	Yes	2	66%
Acute Hospitals	No		Yes	Yes	2	66%
Primary Care	Apologies		No	Yes	1	33%
Older Persons	N/A		Yes	Yes	2	66%
Public Health	N/A		Yes	Yes	2	66%
PCRS	Yes		Yes	Yes	3	100%
Other Attendees						
Office of the Ombudsman	Yes		Yes	Apologies	2	66%
Ombudsman for Children's Office	AM			AM		
Consumer Affairs	Yes		Yes	Yes	3	100%

Table 41: Attendance at the Complaints Managers Governance and Learning Forum 2021

3.1.2 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 **827 delegated Complaints** officers and **291 delegated Review officers**.

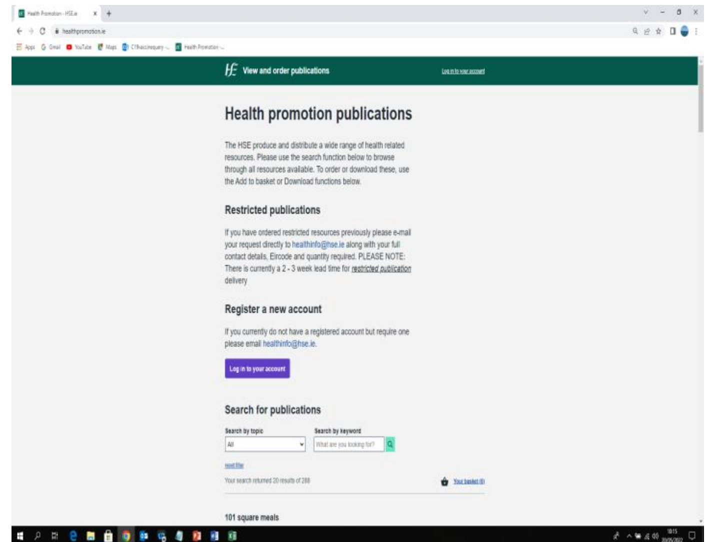
The revised Delegation Forms and Guidance are available on www.hse.ie/yoursay

3.2 Your Service Your Say Materials

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

The Health Promotion website was impacted as a result of the cyber attack. Work is ongoing to restore this site to full functionality.

To order materials, log into www.healthpromotion.ie and follow the instructions on screen.



Your Service Your Say publications are only available to order by healthcare staff. You will need to register for an account to access these.

If you have previously registered for an account, enter in your login details and enter *Your Service Your Say* in the search box. All publications available to order will be returned.

If you do not currently have a registered account and require one, please email healthinfo@hse.ie

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.

- **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.

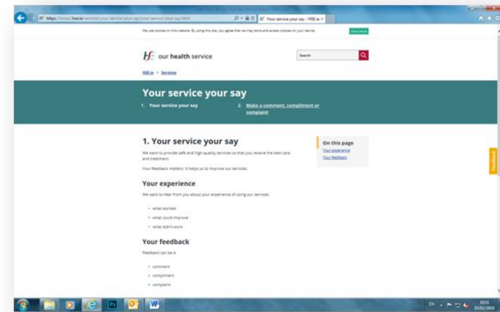
- **Complaints Management Pathway**
  Designed to provide an overview of the four stages in the Your Service Your Say process and the key steps to take at each stage along with the timeframes applying.

- **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/**

3.3 HSE Website

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



3.4 Training

NCGLT develop and deliver training programmes in order to support staff in their efforts to respond to and deal with complaints from point of contact through to the internal review stage as well as delivering train the trainer workshops.

COVID 19 and public health restrictions continued to affect delivery of face to face training throughout 2021. NCGLT continued to support and signpost staff to access online training modules and webinars on the HSeLanD platform developed by NCGLT in response to the absence of in person training.

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 remain available to staff to support them in managing complaints as well as guiding them through the complaints process.

- 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

3.4.1 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.

3.4.2 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

3.4.3 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.

3.4.4 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.

3.4.5 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.

Public health restrictions remained in place throughout 2021 due to COVID 19 meaning that the National Complaints Governance and Learning Teams training schedule for Review Officers remained suspended for the duration of 2021.

However, NCGLT continued to signpost Review Officers to an online modular format of NCGLT Review Officer Training 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 7** Interview & Discussion skills
Section 2 Your Service Your Say Policy Guiding Principles	**Section 8** Making Findings & Recommendations
Section 3 An overview of the stages & background legislation	**Section 9** The Review Report
Section 4 Functions of the Review Officer	**Section 10** The Apology
Section 5 The Review Process	**Section 11** The Complaints Management System
Section 6 Commencing the review investigation	

3.4.6 HSELanD Complaint Modules

Staff can access NCGLT complaint modules on HSELanD.

- Module 1: Effective Complaints Handling
- Module 2: Effective Complaints Investigation
- Your Service Your Say: Complaints Handling Guidance for Clinical Staff

All three 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 **10,070** staff completed this module to date up to December 2021.

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 **2,163** staff have completed this module ito date up to December 2021.

Module 3: Your Service Your Say: Complaints Handling Guidance for Clinical Staff gives practical application to the guidance document *YSYS Guidance for Clinical Staff.* Both the guide and the module were 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 provides clinical staff with a clear understanding of the YSYS complaints process and outlines how individual clinical staff may become involved in the process as well as assisting clinical staff in understanding what is required of them under the YSYS complaints management process.

A total of 2,542 staff completed this module to date up to December 2021.

3.5 Audit

3.5.1 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 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 2022 when access to sites can be facilitated.

3.5.2 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 also been deferred as a result of COVID and public health restrictions. Audit will be deferred until 2022 when access to both relevant staff and sites can be facilitated.

3.5.3 *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 reports annually on its self-assessed compliance status with the recommendations. (please see Part two for the current compliance position).

To provide assurance to the system that the compliance rating specified is accurate and reflects practice, NCGLT will conduct an audit of the returns to validate the rating of compliance stated. A sample of Community Healthcare Organisation and Hospital Group returns will be selected and the evidence used to determine the compliance rating will be examined. An audit report will be issued to the areas selected and to the national system.

While this audit was initially scheduled for 2021, due to redeployments as a result of COVID, the audit will now commence in 2022.

3.6 Complaints Management System (CMS)

NCGLT in conjunction with the State Claims Agency developed a system to capture and aggregate complaints data from Community Healthcare Organisations, Hospital Groups and National Service.

The Complaints Management System (CMS) facilitates the capture of comprehensive complaints data to enable analysis and comparison. This supports learning from complaints by enabling the reporting of issues and trends at various levels throughout the HSE and ensuring that evidence based best practice can be shared across services 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

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	2021 General User Training	2021 Report Training
Hospital Group		
CHG	0	0
ULH	2	0
Saolta	1	0
SSWHG	5	15
DMHG	2	0
RCSI	4	0
IEHG	1	0
Community Health Organisations		
CHO 1	2	0
CHO 2	19	0
CHO 3	0	0
CHO 4	6	0
CHO 5	4	0
CHO 6	5	0
CHO 7	22	0
CHO 8	5	0
CHO 9	18	0
Corporate		
PCRS	0	0
NAS	1	0
NSS	2	0
NFMHS	1	0
NHWD (National Health & Wellbeing Division)	1	0
Total 2021	**101**	**15**
Total Trained to date	**974**	**88**

Table 42: Complaints Officers and Support Staff who received CMS training 2021

3.6.1 Complaints Management System (CMS) Steering Group

The CMS Steering Group is a formal sub group of the NIMS Steering Group. The Steering Group provides 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.

3.7 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 broad trends from complaints received by Acute Services 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 received by Community Services point to issues at the "Accessing care" stage, the next most frequent stage of care resulting in a complaint was "During the appointment". Analysis has given insight into domains and categories of complainant profiles, motivations for complaints, severity of events, levels of harm and the stage of care where the event occurred.

Once the complaints categorisation was completed, those complaints identified as frequent and high severity in Acute Services were brought to two focus groups in November 2021. These were carried out with stakeholders (researchers, healthcare workers, HSE managers, patients) in order to identify solutions to address and prevent the issues identified in these complaints reoccurring. After each of the workshops, the participants were then asked to rate each potential solution using the APEASE criteria. That is, the Affordability, Practicability, Effectiveness, Acceptability, Side effects (i.e. potential for the intervention to have negative unexpected consequences), and Equity (i.e. could be carried out in any hospital in the Republic of Ireland) of the intervention.

Recommendations

1. Institutional processes issues were the most prevalent in the complaints, and the system/ hospitals should focus on improving the issues raised in these complaints.
2. High-harm and high-severity complaints need to be examined in order to improve patient safety.
3. Hot spots and blind spots that emerge from complaints analysis can help researchers and the health service to prioritise what issues to address.
4. Stakeholder workshops and groups should be used to identify useful, and feasible, solutions to improve safety and quality from issues identified in patient complaints.

3.8 Learning from Individual Complaints: HSE Anonymised Feedback Learning Casebook

The HSE continues to develop a cohesive framework for patient engagement including initiatives to encourage and enable service users to share their experiences with us that, in turn, assist us to set our priorities when planning services to deliver 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 also 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 casebooks commenced in 2019. While the aim is to publish these on a quarterly basis, the emergency response to COVID only allowed an annual casebook to be published for both 2020 and 2021.

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 to demonstrate to services users that sharing their experience has made a difference and has led to change.

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.

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

3.8.1 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.

3.8.2 2021 Anonymised Feedback Learning Casebook

The publication of quarterly casebooks in 2021 was again not possible due to the impact on resources as a result of the emergency response to COVID. However, a full year casebook was compiled and presents just some of the feedback received and dealt with during the past year.

While individual cases are included in the 2021 edition, themes and common issues can be identified that need to be examined in the context of quality and service improvement.

The 2021 casebook presents a total of 28 cases covering both complaints and compliments received by Hospitals and Community Healthcare Organisations.

The casebook contains eight complaints from Hospital Groups and nine from Community Healthcare Organisations that were investigated and/or reviewed along with their outcomes. The casebook also features seven compliments from Hospital Groups and four from Community Healthcare Organisations that highlight the learning to be gained from positive feedback.

The following services contributed to the 2020 Casebook:

Community Healthcare Organisations	**Hospital Groups**
CHO 1	Children's Health Ireland
Community Healthcare West	Ireland East Hospital Group
Community Healthcare Mid West	South South West Hospital Group
Cork Kerry Community Healthcare	University of Limerick Hospital Group
HSE Community Healthcare East	
Dublin South, Kildare and West Wicklow Community Healthcare	

The main themes for the 2021 casebook relate to *communication and information, safe and effective care* and *access*, with these categories featuring in 26 cases (11 compliments and 15 complaints). These were also the main categories for the 2020 casebook.

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

The categories of *communication and information, access* and *safe and effective care* feature in the majority of the complaints received. Other categories such as *dignity and respect, and accountability* also feature.

The dominant category for complaints relates to *communication and information* and concern issues such as the provision of information, delay and failure to communicate, general communication skills and meeting diverse information needs. S*afe and effective care* covers issues relating to treatment and care, tests, continuity of care and discharge. *Access* also features as a key category and issues relate to appointment delays, accessibility and resources as well as visiting times.

For dignity and respect, issues around delivery of care and end of life care were raised while accountability concerned issues around overcharging and use of resources.

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.

Current and past casebooks can be accessed at https://www.hse.ie/eng/about/who/complaints/hse-complaints-casebook/

Part Four: The National Complaints Governance and Learning Team: Operational Services

4.0 Introduction

The National Complaints Governance and Learning Team (NCGLT) operates two national frontline complaints services that are co-located between Naas and Limerick as well as a national query portal for the COVID-19 vaccination programme.

The **National Your Service Your Say office** provides a dedicated national contact point for Service Users and their families to seek assistance with or to provide feedback (comments, compliments and complaints) on their experience with our health services. In 2021 the office engaged in 32,467 client interactions.

The **COVID-19 Vaccination Client Services (VCS)** team was established in April 2021 under the National Your Service Your Say Office, to support the national HSE vaccination programme and provide a dedicated portal for the National Offices to direct all vaccine related queries received by them. From April 2021 to December 2021 there was a total of 5,502 email queries. Of these, 1428 were complaints, 3905 were queries, 116 comments and 53 were compliments.

NCGLT also offers a specialised service for those wishing to make a complaint under the Disability Act 2005 where they are unhappy with their child's assessment of need or Service Statement. In 2021, the **Assessment of Need Disability Complaints service** received 508 disability complaints relating to Assessment of Need (AoN). This was down 55% from 2020 figures.

4.1 The National Your Service Your Say Office

The HSE is committed to encouraging and enabling those who use our services to share their experience with us so that we learn from this and improve the safety and quality of those services as a result.

This commitment is reflected in our *Your Service You Say, the Management of Service User Feedback for Comments, Compliments and Complaints* (November 2017), which sets out many avenues for relating experiences and supports the HSE's *No Wrong Door*[3] approach.

[3] No Wrong Door means that a service user can provide feedback (comments, compliments or complaints) to any member of staff and it will be the responsibility of that staff member to either respond to it or ensure that the feedback is routed to the correct service for examination and response to the person providing the feedback.

Service Users have many ways to share their experiences, from telling a staff member or their health care professional, to sending in a letter or 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 supports the 'no wrong door' approach, facilitating and supporting Service Users and other agencies and ensuring that their feedback comments, compliments and complaints are directed to the appropriate service for response and learning.

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.

4.1.1 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.

For 2021, the National Your Service Your Say Office recorded **32,467** interactions. This was an 84% increase on 2020. Part of this increase can be attributed to COVID-19 related activity which accounted for 16,447 interactions or 51% of the office activity.

Activity has increased year on year from 9,907 interactions in 2016 to 32,467 interactions for 2021. 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. A significant increase was experienced in 2020, with activity 34% ahead of the 2019 figure at 17,603 interactions. The demand on the service continued to increase throughout 2021 resulting in an 84% jump in activity.

The table below outlines total interactions for each year. Interactions have grown from 2016 by 22,560, an increase of 327% in 5 years.

Year	Total Interactions
2021	32,467
2020	17,603
2019	13,101
2018	11,023
2017	10,179
2016	9,907

Table 43: Breakdown of YSYS yearly activity 2016-2021

Email continued to be the preferred method of contact with the National Your Service Your Say office accounting for 43% of office activity. Online forms were the next preferred method of contact accounting for 14%.

4.1.1 Activity Breakdown

Below is a breakdown of 2021 (*COVID figures are included in monthly figures):*

2021	Email activity	Phone activity	Online Form activity	Letter activity	CEO activity	DOH activity	Board activity	Review Requests	Calls received	Calls made	Missed calls	Total interactions
Jan	541	38	346	10	33	309	0		237	23	35	1572
Jan COVID	*232*	*19*	*132*	*0*	*2*	*25*	*0*		*89*	*9*	*11*	*519*
Feb	**590**	**51**	**242**	**13**	60	301	0		287	44	52	1640
Feb COVID	*250*	*26*	*73*	*0*	*15*	*21*	*0*		*66*	*7*	*5*	*463*
March	804	65	412	12	44	339	0	1	505	82	90	2354
March COVID	*408*	*51*	*100*	*2*	*5*	*44*	*0*		*168*	*26*	*25*	*829*
April	643	94	307	16	37	249	0		605	236	260	2447
April COVID	*454*	*20*	*70*	*0*	*6*	*26*	*0*		*338*	*114*	*123*	*1151*
May	35	46	26	18	9	124	0		783	361	406	1808
May COVID	*206*	*46*	*26*	*0*	*5*	*8*	*0*		*472*	*207*	*205*	*1175*
June	1601	20	184	19	20	77	2		562	105	133	2723
June COVID	*1352*	*14*	*80*	*0*	*5*	*1*	*0*		*275*	*54*	*53*	*1834*
July	2501	99	445	12	35	174	0		671	180	188	4305
July COVID	*1995*	*48*	*206*	*2*	*19*	*7*	*0*		*479*	*83*	*77*	*2916*
Aug	1868	95	359	36	38	227	0		512	71	68	3274
Aug COVID	*1211*	*14*	*106*	*6*	*17*	*10*	*0*		*459*	*31*	*27*	*1881*
Sept	1145	77	439	16	34	259	0		468	107	125	2670
Sept COVID	*542*	*18*	*133*	*0*	*6*	*2*	*0*		*358*	*69*	*85*	*1213*
Oct	945	75	511	11	30	179	2		449	108	127	2437
Oct COVID	*313*	*24*	*146*	*0*	*4*	*6*	*0*		*376*	*81*	*105*	*1055*
Nov	1717	129	627	14	37	248	0		624	186	203	3785
Nov COVID	*685*	*57*	*332*	*0*	*12*	*13*	*0*		*216*	*51*	*64*	*1430*
Dec	1587	156	728	11	25	149	0		498	149	149	3452
Dec COVID	*1113*	*144*	*488*	*0*	*7*	*22*	*0*		*150*	*30*	*27*	*1981*
To date 2021	13977	945	4626	188	402	2635	4	1	6201	1652	1836	**32467**

Table 44: Breakdown of YSYS monthly activity and contact method for 2020

Peak activity was experienced for the months of June, July and August and again in November and December.

4.1.2 Activity Overview

Your Service Your Say Office
In 2021 there were 18,362 comments, compliments, complaints and queries logged under Your Service Your Say, compared to 7022 in 2020. Of this, 15013 were complaints, 1521 were compliments, 527 related to comments while 1300 queries were received. Just one review request was received into the office.

The feedback can be broken down between services as follows:

CHO	Acute	National Service	Nursing Home	Voluntary Agency	Voluntary Hospital	Non HSE	VCS	FOI
3299	2740	3981	6	23	487	2644	5181	1

Table 45: Breakdown of YSYS feedback by service for 2021

The top two issues under Your Service Your Say 2021 were under the classification categories of *Safe & Effective Care,* accounting for 15% and *Access*, accounting for 20%. As with 2021, *Treatment & Care* emerged as the key sub category within *Safe and Effective Care* and *Accessibility & Resources* emerged as the key sub category within the category of *Access* for 2021.

Full breakdown of the issue categories logged is below:

Access	Accountability	Improving Health	Communication & Information	Dignity & Respect	Safe & Effective Care	Participation
29	19	5	78	75	25	2
12%	**8%**	**2%**	**33%**	**32%**	**11%**	**0.86%**

Table 46: Breakdown of issue categories for YSYS feedback for 2021

Office of the HSE Chief Executive Officer

In 2021 there were 233 pieces of feedback received from the CEO's office; a significant increase when compared with only 52 items received in 2020.

The feedback can be broken down between services as follows:

CHO	Acute	National Service	Non HSE	Voluntary Hospital
52	54	85	22	20

Table 47: Breakdown of YSYS feedback by service received via CEO's office for 2021

Communication & Information along with *Dignity & Respect* were the key issue categories at 33% and 32% respectively of all feedback sent from the CEO's office. This was a jump for Communication & Information; which only featured in 13% of complaints forwarded in 2020. *Safe and Effective Care* featured in 38% of all feedback forwarded in 2020 but only was an issue in 11% of all feedback forwarded in 2021.

Full breakdown of the issue categories logged is below:

Access	Accountability	Improving Health	Communication & Information	Dignity & Respect	Safe & Effective Care	Participation
29	19	5	78	75	25	2
12%	8%	2%	33%	32%	11%	0.86%

Table 48: Breakdown of issue categories for YSYS feedback received via CEO's office for 2021

Department of Heath

In 2021 there was a total of 1096 pieces of feedback received from the Department via email.

The feedback can be broken down between services as follows:

CHO	Acute	National Service	Non HSE	Voluntary Hospital
456	143	338	34	125

Table 49: Breakdown of YSYS feedback by service received via DoH for 2021

Access was the main area of concern raised through the Department of Health accounting for 63% of feedback, similar to 2020 (69%). This was followed by *Safe and Effective Care* at 19%, also similar to 2020 (17%).

Full breakdown of the issue categories logged from the Department of Health is below:

Access	Accountability	Communication & Information	Dignity & Respect	Safe & Effective Care	Improving Health	Privacy	Participation
666	43	130	7	201	11	1	3
63%	4%	12%	0.66%	19%	1%	0.09%	0.28%

Table 50: Breakdown of issue categories for YSYS feedback received via DoH for 2021

Summary

Issues relating to *Access* along with *Communication and Information* and *Safe & Effective Care* were the three main categories of feedback received from Service Users into the National Your Service Your Say Office either directly or through the CEO's office or the Department of Health.

Overall, *Access* accounted for 4443 (33.34%) categories recorded, *Communication and Information* accounted for 3219 (24.15%) and *Safe & Effective Care* accounted for 2954 (22.17%) of the categories recorded.

Access	Accountability	Communication & Information	Dignity & Respect	Safe & Effective Care	Improving Health	Participation	Privacy
4443	484	3219	2072	2954	57	35	63
33.34%	3.63%	24.15%	15.55%	22.17%	0.43%	0.26%	0.47%

Table 51: Breakdown of issue categories for YSYS feedback received by the National YSYS Office from all sources for 2021

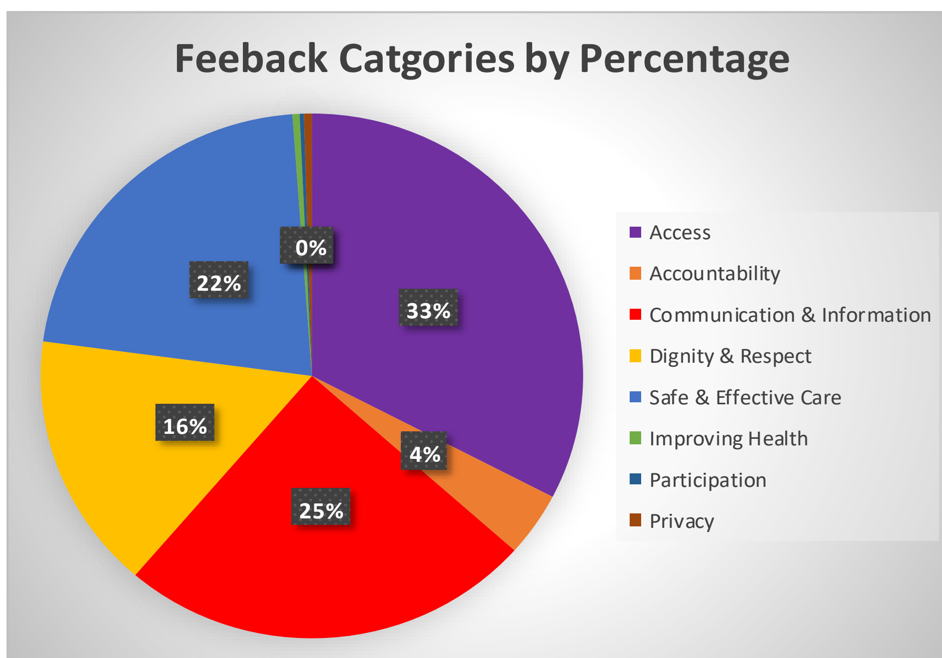


Figure 9: Feedback categories by percentage

4.2 COVID-19 Vaccination Client Services

The COVID-19 Vaccination Client Services (VCS) Team was established in April 2021 under the National Complaints Governance and Learning Team to support the national HSE vaccination programme and provide a dedicated portal for National Offices to direct all vaccine related queries received by them.

The responsibility of the VCS team is to examine all correspondence received, triage all urgent queries, identify the issues and link with the relevant services as needed with direct response to the member of the public

From April 2021 to December 2021 there was a total of 5,502 email queries logged and responded to. Of these, 1428 were complaints, 3905 were queries, 116 comments and 53 were compliments.

The main issue categories were *Access* (63%) and *Communication and Information* (34%).

Full breakdown of the issue categories logged through VCS is below.

Access	Accountability	Communication & Information	Dignity & Respect	Safe & Effective Care	Improving Health	Privacy
3444	32	1873	21	112	19	1

Table 52: Breakdown of issue categories for feedback received into VCS for 2021

The VCS team was also responsible for processing all Subject Access Requests and Parliamentary enquiries that were vaccine related.

The VCS team has been an essential component of the overall HSE vaccination programme in terms of its role in directly responding to the public's queries and concerns. The VCS team has been hugely beneficial to the National Offices, especially the CEO and CCO offices, in its role as a dedicated customer service portal to route queries. Management of the VCS team has involved liaising with other services in the HSE to highlight trends and raise any concerns from the public in relation to their interaction with the service. This, in turn, enabled services to amend delivery to better improve the Service User experience and promote trust and confidence in the programme.

The VCS team will continue to operate in its current capacity to meet demand in line with the overall COVID-19 vaccination roll-out programme.

4.3 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.

The specific grounds for complaint set out in the Act are as follows:

(A) a determination by the assessment officer concerned that he or she does not have a disability;
(B) the fact, if it be the case, that the assessment under section 9 was not commenced within the time specified in section 9(5) or was not completed without undue delay;
(C) the fact, if it be the case, that the assessment under section 9 was not conducted in a manner that conforms to the standards determined by a body referred to in section 10;
(D) the contents of the service statement provided to the applicant;
(E) the fact, if it be the case, that the Executive or the education service provider, as the case may be, failed to provide or to fully provide a service specified in the service statement.

In 2021, 508 disability complaints relating to Assessment of Need (AoN) were received. 33% were dealt with by a complaints officer within 30 days.

4.3.1 Variance from 2020

Variance	2021	2020	% change
HSE Assessment of Need	508	1135	-55%

Table 53: Assessment of Need complaints – variance 2020 and 2021

4.3.2 Breakdown of Complaints Recorded 2021

HSE Complaints: Excluding Voluntary Hospitals and Agencies	Total
Complaints under Part 2 of the Disabilities Act 2005 (Assessment of Need)	508

Table 54: Total complaints for Assessment of Need received by HSE, excluding voluntary hospital and agencies for 2021

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

AoN Nationally (across all CHOs)	Complaints received 2021	Complaints that do not fall under Part 2 of the Disability Act 2005	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	508	23	18	0	0	154	292	33%

Table 55: Complaints received / resolved for Assessment of Need across all CHOs for 2021

The number of applications for Assessment of Need in 2021 was 5899, a 26% increase on the previous year.

The number of complaints received by the AON Complaints Office was 508; a 55% decrease in complaints received in 2020.

This decrease may reflect the impact of the Preliminary Team Assessment (PTA) approach under the Standard Operating Procedure (SOP) for Assessment of Need (AON) which came into effect in January 2020. While this SOP commenced its rollout in January 2020, the impact of this change on complaints data was seen for the first time in 2021 due to the time taken for the rollout out of the SOP across the country and consequently the time taken for this new procedure to result in complaints. The implementation of the PTA format for assessment led to an overall decrease in time taken to complete assessments and consequently a decrease in related complaints.

Also, when we analysed the complaints that were received in 2021 it was apparent that there was a significant shift in complaint types received in 2021 which we attribute to the PTA. The most notable indicators for this were;

- The proportion of complaints in relation to timeframes for assessment was down from 87% in 2020 to 65% in 2021, which was particularly remarkable because assessment timeframes have historically made up the vast majority of complaints.
- Service Statement related complaints were up 100% in 2021 from the previous year; and average wait times for services to commence (in the complaints we investigated) was 21 months, indicating that there was growing pressure on service delivery due to assessments being completed in a more timely manner.
- The PTA format for assessment was also a subject of complaint from service users, via complaints in relation to determinations of no disability (ground A) and complaints in relation to the iHIQA standards for assessment (ground C); most often because the applicant was of the view that the assessment was not comprehensive enough to identify all of the health needs of their child; or due to the absence of a diagnosis. Complaints made under these grounds were up 200% on the previous year.

There is a significant variance between an increase in AON applications (26%) and the decrease in complaints received (55%).

There is also a notable decrease in the average number of complaints received per 100 AON applications, down from 24 in 2020 to 8 in 2021.

The number of days taken by a Complaint Officer to close out a complaint decreased from 89 days in 2020 to 47 days in 2021.

The primary ground for complaint was again Ground B (*assessment not started and completed within the agreed timeframes*), accounting for 65% of complaints received, which is down from 87% of complaints received in 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. There was a 120% increase in multiple issue. Complaints received in 2021; in a context where complaints have decreased significantly from the year prior. Of these multiple issue complaints received, 80% relate to the Service Statement indicating that issues in relation to service provision are increasingly becoming an issue.

Area	Applications for AoN	Complaints relating to AoN	Complaints relating to AoN per 100 applications
CHO 1	440	5	1
CHO 2	167	2	1
CHO 3	478	5	1
CHO 4	734	100	14
CHO 5	271	53	20
CHO 6	323	28	9
CHO 7	1224	162	13
CHO 8	875	31	4
CHO 9	1387	81	6

Table 56: Applications versus complaints relating to Assessment of Need 2021

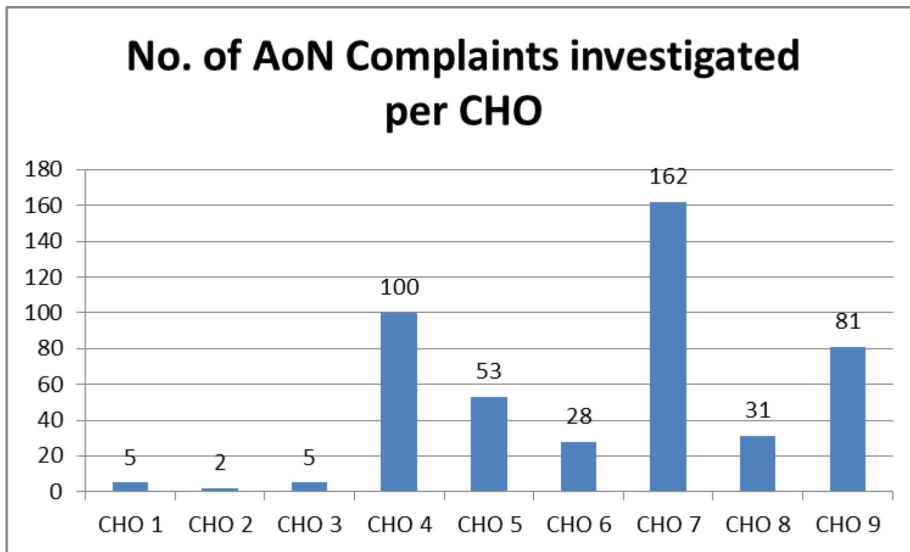


Figure 10: Assessment of Need related complaints per CHO

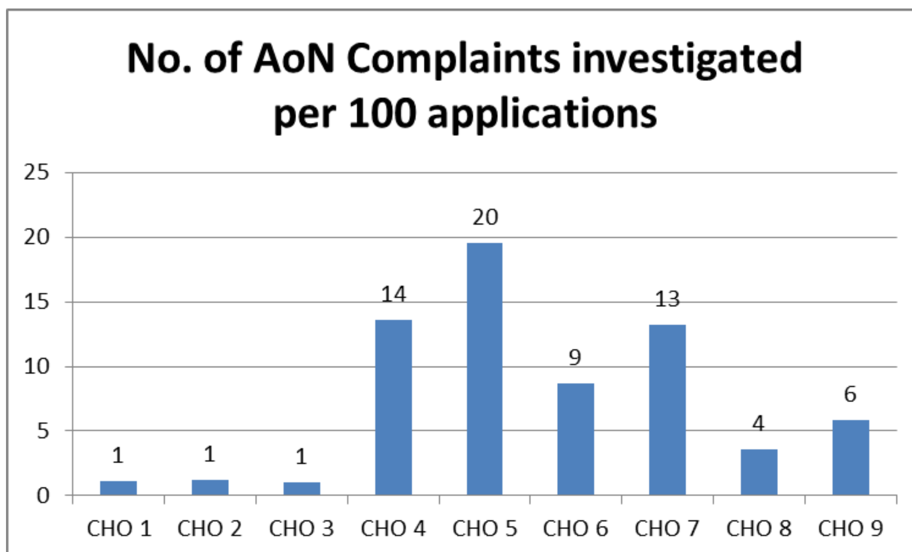


Figure 11: Assessment of Need related complaints per CHO per 100 Applicants for AoN

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	447	0	24	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	24	0	0	0	0	0	0	0

Table 57: Complaint categories for Assessment of Need 2021

Complaints Reported by Service

Assessment of Need Nationally (across all CHOs) 2021

Assessment of Need Nationally (across all CHOs)	Social Care	Primary Care	Mental Health	Health and Wellbeing
AoN	508	0	0	0

Table 58: Assessment of Need complaints 2021by 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

Your Service Your Say

Complaints Received/Resolved: Statutory Hospitals

Hospital Groups

Hospital Groups (Statutory)	Complaints received 2021	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	403	59	0	0	1	224	91	65%
IEHG Statutory Hospitals	486	43	1	4	81	214	115	67%
RCSI Statutory Hospitals	501	77	51	0	82	208	72	78%
Saolta Statutory Hospitals	640	6	24	0	73	316	217	64%
SSWHG Statutory Hospitals	751	15	21	0	99	245	222	48%
ULH Statutory Hospitals	769	0	7	7	26	190	158	29%

Table 59: Complaints reported: Statutory Hospitals within Hospital Groups 2021

Complaints Received/Resolved: National Ambulance Service

National Ambulance Service

National Ambulance Service	Complaints received 2021	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	-	-	-	-	-	-	-	-

Table 60: Reported complaints National Ambulance Service

Your Service Your Say

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	86	27	144	129	1	4	1	33
IEHG Statutory Hospitals	96	57	231	114	9	11	8	20
RCSI Statutory Hospitals	128	94	275	145	3	6	6	30
Saolta Statutory Hospitals	194	64	202	169	2	11	2	17
SSWHG Statutory Hospitals	161	86	298	218	5	6	1	15
ULH Statutory Hospitals	233	131	438	229	6	11	14	41
Total	**898**	**459**	**1588**	**1004**	**26**	**49**	**32**	**156**

Table 61: 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	3	0	0	0	0	0	0	0
IEHG Statutory Hospitals	55	0	0	0	0	0	0	1
RCSI Statutory Hospitals	102	0	0	0	0	0	0	0
Saolta Statutory Hospitals	13	0	0	0	0	10	0	0
SSWHG Statutory Hospitals	2	1	0	0	0	0	0	0
ULH Statutory Hospitals	0	0	0	0	0	0	0	0
Total	**175**	**1**	**0**	**0**	**0**	**10**	**0**	**1**

Table 62: Categories of Complaints reported: Hospital Group Contd.

Your Service
Your Say

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	-	-	-	-	-	-	-	-

Table 63: 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	-	-	-	-	-	-	-	-

Table 64: Categories of Complaints reported: NAS.

Your Service Your Say

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		

Your Service Your Say

Complaints Received / Resolved: CHOs

Community Healthcare Organisations

Community Health Organisation (CHO)	Complaints received 2021	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	206	54	0	8	46	44	54	63%
CHO 2	117	29	1	0	5	46	26	59%
CHO 3	72	0	3	0	3	46	20	71%
CHO 4	73	20	1	0	4	29	13	63%
CHO 5	2	0	0	0	1	1	0	100%
CHO 6	83	0	0	0	1	57	5	70%
CHO 7	237	6	2	0	54	112	51	72%
CHO 8	340	33	30	8	36	119	72	58%
CHO 9	75	2	0	0	2	49	12	70%

Table 65: CHOs Complaints resolved 2021

Your Service Your Say

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

Assessment of Need Nationally (across all CHOs)	Complaints received 2021	Complaints excluded under Part 2 of the Disability Act 2005	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	508	23	18	0	0	154	292	33%

Table 66: AoN Complaints resolved 2021

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

Primary Care Reimbursement Service (PCRS)

PCRS	Complaints received 2021	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	205	0	22	0	27	156	0	100%

Table 67: PCRS Complaints resolved 2021

Your Service Your Say

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.

Hospital Group	Hospitals	Hospital Group	Hospitals
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.*

Your Service Your Say

Complaints Received/Resolved: Voluntary Hospitals

Voluntary Hospitals within Hospital Groups	Complaints received 2021	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	694	0	5	0	113	382	194	72%
DMHG Voluntary Hospitals	2395	0	4	0	1001	1012	202	84%
IEHG Voluntary Hospitals	2055	31	15	2	1126	566	295	84%
RCSI Voluntary Hospitals	615	180	8	0	17	353	57	87%
SSWHG Voluntary Hospitals	149	6	2	0	5	78	47	59%
ULH Voluntary Hospitals	13	0	0	0	3	8	2	85%

Table 68: Complaints reported: Voluntary Hospitals within Hospital Groups 2021

Your Service Your Say

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	281	51	293	259	13	12	18	66
DMHG Voluntary Hospitals	588	279	887	947	16	28	35	98
IEHG Voluntary Hospitals	344	96	712	1407	15	15	17	100
RCSI Voluntary Hospitals	189	64	533	375	8	8	8	33
SSWHG Voluntary Hospitals	27	8	61	42	0	3	1	6
ULH Voluntary Hospitals	6	2	3	3	0	2	0	0
Total	**1435**	**500**	**2489**	**3033**	**52**	**68**	**79**	**303**

Table 69: 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	0	0	0	0	0	0	0	0
DMHG Voluntary Hospitals	15	4	0	0	0	3	1	2
IEHG Voluntary Hospitals	38	2	0	0	0	4	0	0
RCSI Voluntary Hospitals	81	0	0	0	0	0	0	0
SSWHG Voluntary Hospitals	1	1	0	0	0	0	0	0
ULH Voluntary Hospitals	0	1	0	0	0	0	0	0
Total	**135**	**8**	**0**	**0**	**0**	**7**	**1**	**2**

Table 70: Complaints Categories reported: Voluntary Hospitals within Hospital Groups 2021

Your Service Your Say

Other Voluntary Hospitals & Agencies

In 2021 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 2021	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	3899	152	67	65	2201	745	200	81%

Table 71: Complaints reported: Other Voluntary Hospitals and Agencies 2021

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**
	942	833	1149	722	126	93	82	130
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**
	36	53	29	6	0	35	48	228

Table 72: Complaints Categories reported: Other Voluntary Hospitals and Agencies 2021

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

Your Service Your Say

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 73: 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.

Your Service Your Say

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.