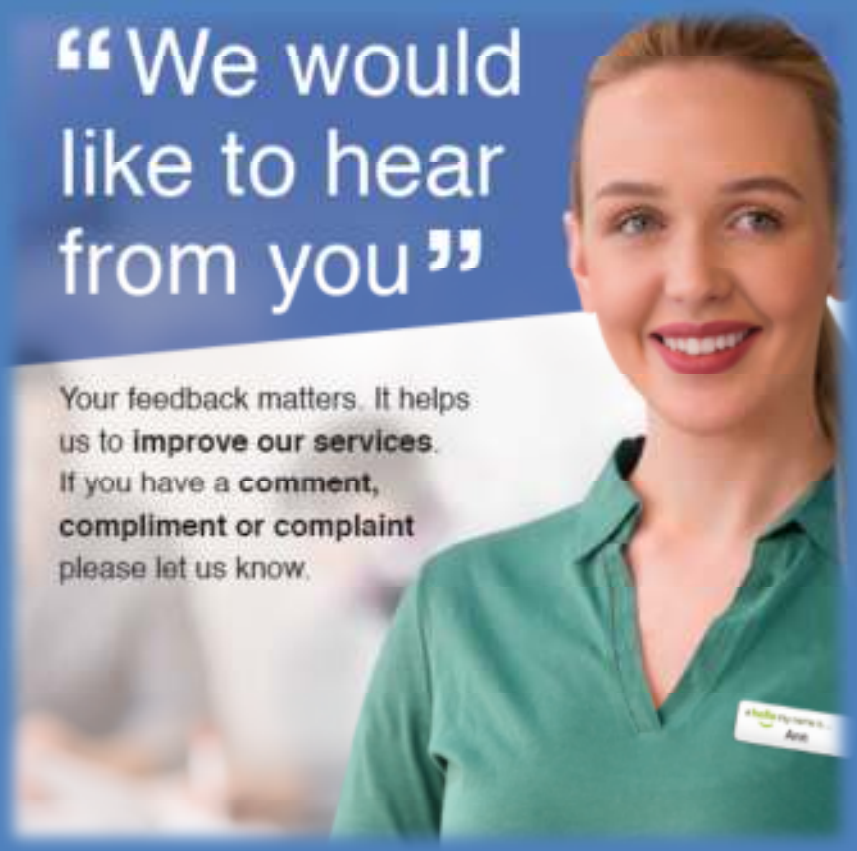
Your Service
Your Say



Quality Assurance and Verification Division

National Complaints Governance and Learning Team

Annual Report 2017

Foreword

A critical component in our efforts to ensure responsive services that reflect our values of care, compassion, trust and learning is that of the patient voice. Without the benefit of the experience of our service users we cannot make any meaningful progress on improving quality and safety.

The HSE has become more proactive in encouraging and facilitating service users to partner with us in the continued development of our health services. 2017 saw the introduction of the first *National Patient Experience* and *Your Voice Matters* Surveys, with patients and service users willing to share their experiences with us. Such initiatives will help us to set our priorities, plan and deliver more responsive services that result in better outcomes for people.

The importance of the patient voice is championed in the Ombudsman's *Learning to Get Better* report. In this, the Ombudsman highlighted 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.

Pictured (L to R)Mr Christopher Rudland, Assistant National Director, National Complaints Governance and Mr Patrick Lynch, National Director, National Quality Assurance and Verification Division

Since the launch of that report the National Complaints Governance and Learning Team within the QAV Division was tasked with the reform of the *Your Service Your Say* process to ensure that the fundamental right for people to voice opinions, provide comments and to complain would be to the fore, with a focus on creating a positive environment and culture to encourage and learn from feedback, especially complaints.

A number of key actions were mandated to ensure strong leadership in the area of feedback and complaints, including benchmarking the HSE against the thirty six recommendations outlined in the Learning to Get Better Report. In addition, the appointment of named managers with responsibility for leading the complaints management process within Community Healthcare Organisations, Hospital Groups and National Divisions was a significant step towards greater governance across the HSE.

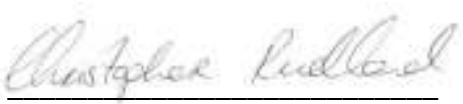
The revised National *Your Service Your Say* policy was launched in November 2017. It will ensure that hearing from, dealing sensitively with and learning from the experiences of those who use our services is a priority. We have invested in our staff to empower them to handle complaints by rolling out training as well as developing two new e-learning modules for self-directed learning. We have committed significant efforts to learning from feedback and from complaints in particular, with the development of an online Complaints Management System to record, analyse and report on complaints data. This data will go a long way to informing decisions, targeting resources and highlighting areas for further improvement.

The above efforts represent a renewed and genuine commitment by the HSE to encourage feedback, engage with those who use our services and use their experience to improve our care and treatment so we can deliver better outcomes.

While systems and procedures are critical to ensuring robust responses to feedback, the heart of any feedback process is the people who enable it, receive it and manage it. I would like to thank all those who work in the HSE for their effort, dedication and willingness to improve the quality of the healthcare services they provide.

Our work is by no means complete and we will continue to develop our feedback mechanisms and build on our capacity to capture and analyse feedback data to support learning and quality improvements. I hope the efforts outlined in this report reaffirm the commitment of the HSE to encourage and support those who use our services to share their experiences with us, to value this and demonstrate our intention to respond appropriately and to learn.

Mr Patrick Lynch
National Director
Quality Assurance and Verification



Mr Christopher Rudland
Assistant National Director
Quality Assurance and Verification

Your Service Your Say

2017. . .at a glance

The health services received **20,381** new complaints

WE TRAINED **290** USERS ON OUR NEW COMPLAINTS MANAGEMENT SYSTEM

A total of **104** staff attended Complaint Review Officer training

We received **101** requests for Internal Reviews

WE EXCEEDED OUR KPI AND HANDLED OVER **80%** OF COMPLAINTS WITHIN 30 WORKING DAYS OR LESS

The Your Service Your Say Team had **10,179** client interactions

744 Disability Complaints relating to Assessment of Need were received

Causes for complaints relate to:

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

Foreword

Table of Contents

Background

Your Service Your Say was introduced into the health services in January 2007 as a means to encourage people to have their say about their experience of the health services, and how these were delivered. It was part of an overall effort to engage with those who use our services not only to give them a voice but also to ensure that they would be listened to.

Feedback on our services, especially when these are articulated in the form of complaints, offer us valuable insight into how we are delivering health services, if these are person-centred and appropriate or where improvements are needed. When a system fails to respond to this feedback it cannot hope to identify where it is failing in meeting the care needs of those who use its services or identify repeated failures in service delivery that can, if left unchecked, escalate with potentially harmful consequences.

Reports, in recent times from the UK, such as the Mid Staffordshire NHS Foundation Trust Public Inquiry, have highlighted the importance of encouraging and reviewing feedback and learning from this to improve and develop services.

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

"A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service."

Sir Robert Francis QC
Mid Staffordshire NHS Foundation Trust Public Enquiry Report - final report 2013

The publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry Report prompted the Office of the Ombudsman in Ireland to undertake a review of how public hospitals within Ireland handle complaints. The report, *Learning to Get Better, an investigation by the Ombudsman into how public hospitals handle complaints, 2015,* made a number of key findings and as a result set out thirty six recommendations to address these.

The report was welcomed by the HSE who acknowledged that it provided a very valuable platform for improving the HSE's complaints management system and set out, through its recommendations, a means to improve the quality and safety of health services in a way that would deliver, over time, measurable benefits for patients and service users. The report highlighted the absolute importance of the patient voice, and a culture that values person centeredness, patient safety, quality and learning.

At the launch of the Ombudsman's report in May 2015, Mr Tony O'Brien, Director General of the HSE gave a public commitment that the HSE would review and improve its feedback processes and that it would strive to develop a culture that embraces feedback and use it as a quality indicator and driver.

A number of actions resulted to reflect best practice highlighted in the Ombudsman's report and strengthen the capacity of the HSE to engage in healthy and honest dialogue with patients and service users with a clear commitment to learn from this.

These included:

- Benchmarking the HSE against the recommendations outlined in the Ombudsman's report, Learning to Get Better.
- The appointment of named managers within Community Healthcare Organisations, Hospital Groups and National Divisions to champion and take on a leadership role in the complaints management process
- The revision and updating of the Your Service Your Say policy and guidance
- Enhanced supports for staff in responding to complaints
- The development of an online database to facilitate the capture and analysis of comprehensive complaints data

Developing a person centred, learning health service requires the voice of the patient to be heard and acted upon. Systems and supports need to be cultivated to foster and deliver on this as well as being evaluated as to their effectiveness from both a health service and patient/service user perspective.

Part One

Data on Complaints recorded in the Health Services 2017 (Community Services, Statutory Hospitals, Voluntary Hospitals and Voluntary Agencies)

Introduction

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

This report is based on data collected through Complaints Officers who made regular returns to either regional Consumer Affairs offices or to the National Complaints Governance and Learning Team. Where available, data was taken from the new Complaints Management System.

This annual collection of 2017 is a count of Stage 2 complaints recorded and examined by Complaints Officers in both the HSE and Voluntary Health Services which receive funding from the HSE in the Republic of Ireland.

Key Findings

In 2017, there were **20381** complaints received (refer Table 5). Of these **8,281** complaints were recorded and examined by complaints officers in the Health Service Executive (Excluding Voluntary Hospitals and Agencies). Of the total number of complaints received, **6,298** or 76% were dealt with ≤30 working days (Part 9: Health Act, 2004, and Part 3: Disabilities Act, 2005).

There were **11356** complaints recorded and examined by complaints officers in Voluntary Hospitals and Agencies. Of the total number of complaints received, 10,040 or 88% were dealt with ≤30 working days (Part 9: Health Act, 2004, Part 3: Disabilities Act, 2005).

In addition, there were **744** complaints relating to Assessment of Need.

Of Reviews Data returned; **101** reviews were reported as requested arising out of service user dissatisfaction regarding an initial complaints investigation. 48 recommendations were made and 30 implemented or in progress of implementation based on these Reviews. This figure is based on 10 respondents; a further 6 did not return data.

Overall Findings

- There were 20381 new complaints recorded.
- Overall, the KPI of addressing complaints within 30 working days or less was met: 80% (which exceeds the 75% standard set).
- Of complaints resolved, 81% were addressed by Complaints Officers in 30 working days or less either informally, or through formal investigation.
- The top 5 causes of complaints, accounting for 92% of all issues recorded contained an issue relating to the following classification:
    - 31% related to **Access** (7410)
    - 26% related to **Safe and Effective Care** (6263)
    - 20% related to **Communication and Information** (4810)
    - 11% related to **Dignity and Respect** (2699)
    - 4% related to **Accountability** (908)
- 1% of complaints received by Complaints Officers was wholly excluded under part 9 of the Health Act and was referred to another investigative process.
- 96% of reported HSE Internal Review Requests were accepted by the HSE. Of these requests, 96% (93) were conducted. The remaining HSE Internal Reviews are outstanding. 30 recommendations arising from a HSE Internal Reviews were implemented/in progress of implementation.

Anomalies

Currently complaints data is collated according to where the original complaint was recorded. This results in an anomaly best displayed in CHO 8 for the second year.

For example, complaints are received in Regional Orthodontic Service Meath (now part of CHO 8) relating to the former DNE area (Cavan Monaghan Meath and Louth, Dublin North, North City and Dublin West) Orthodontic services which cover CHO 8, CHO 1 and CHO 9. This means that none of the returns for complaints for CHO 1, CHO 8 or CH0 9 is accurate.

Summary Table of Variance

Summary Table of Variance	2017	2016	%Change
HSE Statutory Hospitals	4848	5019	-3%
Voluntary Hospitals within Hospital Groups	7225	7104	2%
HSE Community Health Organisations	3236	3984	-19%
HSE Assessment of Need	744	1119	-34%
HSE National Ambulance Service	58	92	-37%
HSE Primary Care Reimbursement Service	139	63	121%
Other Voluntary Hospitals and Agencies	4131	5705	-28%
Total	**20381**	**23086**	**-12%**

Table 1: Summary of % Variance Complaints recorded 2016 to 2017

For full breakdown, see Table 49: Summary Table of Variance 2017 to 2016 in Appendix 2.

Breakdown of Complaints Received

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

HSE: Excluding Voluntary Hospitals and Agencies - Complaints under Part 3 of the Disabilities Act 2005	Total
HSE: Community Health Organisations	3236
HSE: Statutory Hospitals	4848
HSE: National Ambulance Service	58
HSE: Primary Care Reimbursement Fund	139
Total	**8281**

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

Complaints received to the HSE

Complaints received to the HSE	Total
Excluding Voluntary Hospitals and Agencies and Complaints under Part 2 of the Disabilities Act 2005 (from above table)	8281
Complaints under Part 2 of the Disabilities Act 2005 (Assessment of Need)	744
Total Complaints received to the HSE	**9025**

Table 3: Complaints received to the HSE

Complaints received to Voluntary Services

Complaints received to Voluntary Services	Total
HSE Voluntary Hospitals	7225
Other Voluntary Hospitals	398
Voluntary Agencies	3733
Total Complaints received to Voluntary Services	**11356**

Table 4: Complaints received to Voluntary Services

Total Complaints Received

Total Complaints received 2017	Total
Total Complaints received to the HSE	9025
Total Complaints received to Voluntary Services	11356
Total Complaints received 2017	**20381**

Table 5: Total Complaints received 2017

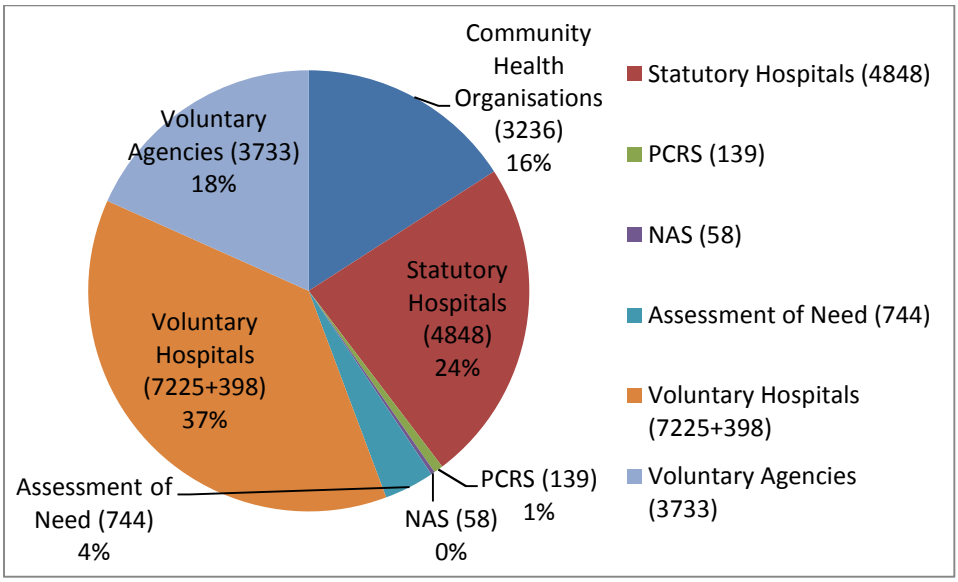


Figure 1: Breakdown of Complaints Received

Total Complaints Addressed 2017

Total Complaints addressed 2017		Total
Complaints resolved by Complaints Officers ≤30 working days formally	6233	
Complaints resolved by Complaints Officers ≤30 working days informally	10111	
Complaints resolved by Complaints Officers ≤30 working days (formally and informally)		16344
Complaints resolved by Complaints Officers over more than 30 working days		2948
Complaints entirely referred to another process	269	
Complaints withdrawn	470	
Anonymous complaints	72	
Complaints withdrawn, anonymous or referred to another process		811
Total Complaints addressed 2017*		**20103**

*Complaints resolved could include complaints carried over from the end of 2016

Table 6: Total Complaints Addressed 2017

Resolved/Withdrawn/Anonymous/Excluded

Complaints Handling 2017			
Withdrawn		470	2%
Anonymous		72	0%
Complaints resolved by Complaints Officers ≤30 working days (formally and informally)			
HSE Statutory Services: Health Act 2004 & Disabilities Act 2005 Part 3	6298		
HSE Statutory Services: Disabilities Act 2005 (Part 3)	6		
Voluntary Hospitals and Services	10040		
		16344	81%
Complaints resolved by Complaints Officers over more than 30 working days		2948	15%
Complaints excluded for investigation under Your Service, Your Say (Health Act 2004, Part 9)		269	1%
Complaints resolved or referred to another process in 2017		**20103**	**100%**

Table 7: Complaints Handling 2017

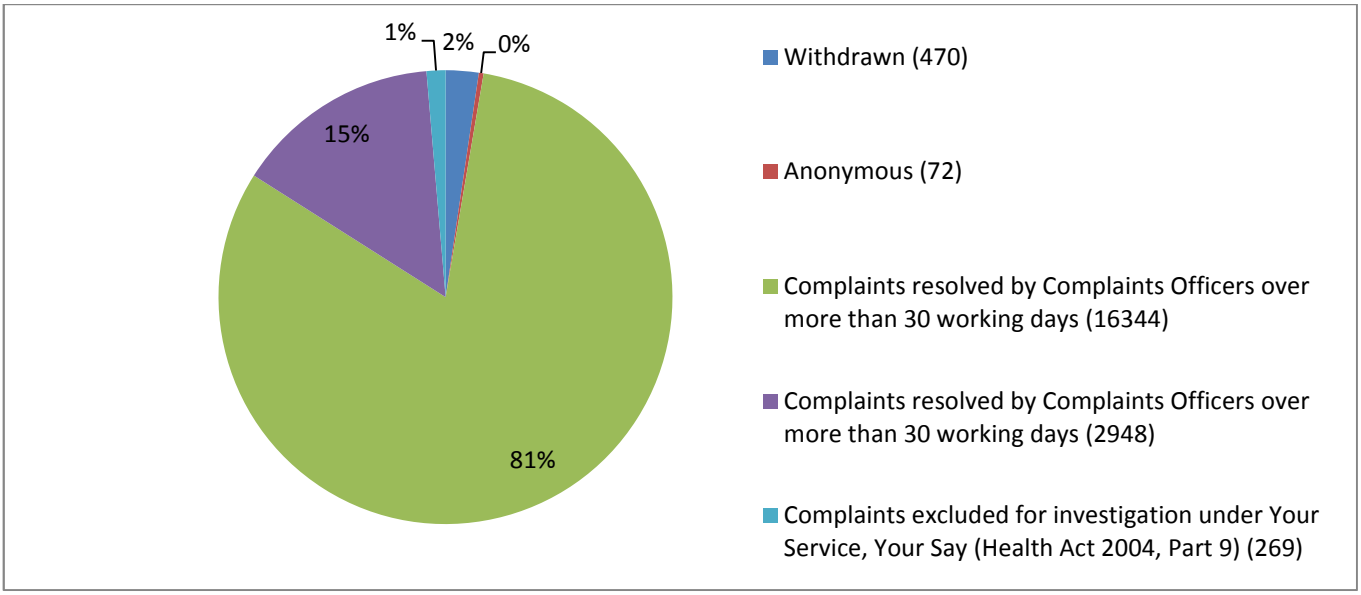


Figure 2: Breakdown of Complaints Resolved/Withdrawn/Anonymous/Excluded

Complaints resolved by Complaints Officers ≤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.

The following graphs for Hospital Groups and CHOs show that services are generally resolving complaints in line with the timeframes required.

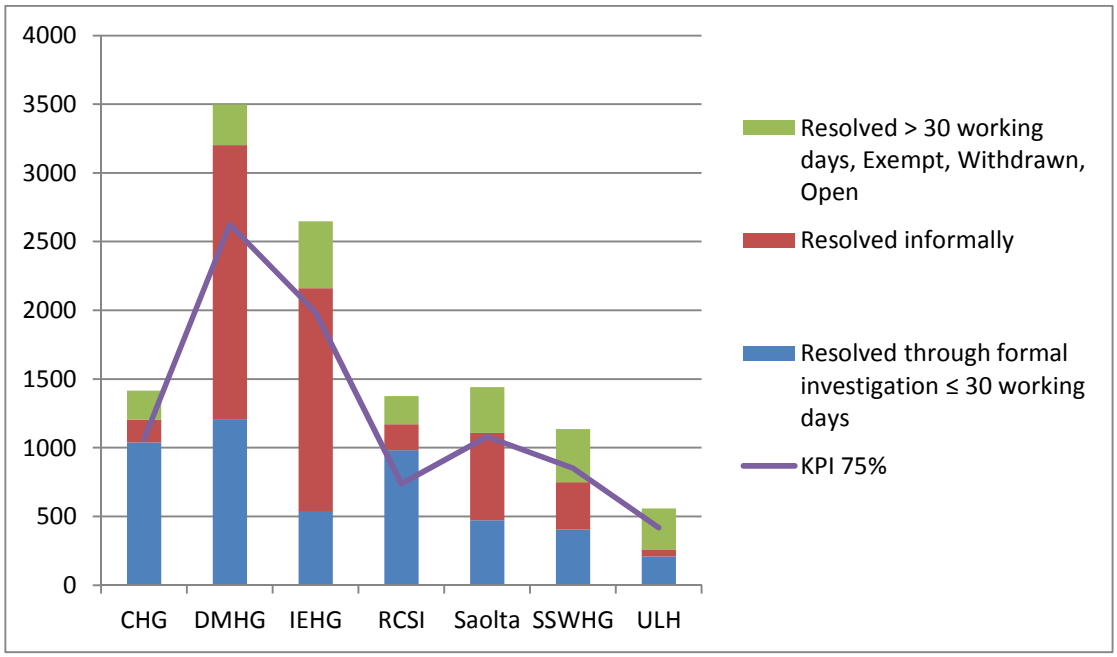


Figure 3: Hospital Groups: Complaints resolved by Complaints Officers either informally or formally within 30 working days against the target line of 75%

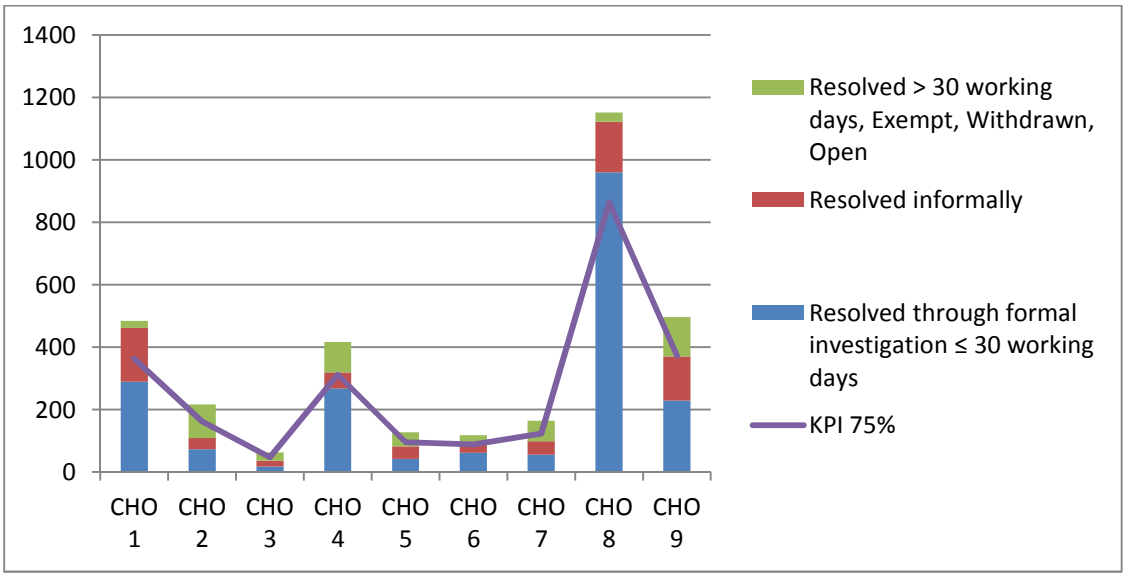


Figure 4: CHOs: Complaints resolved by Complaints Officers either informally or formally within 30 working days against the target line of 75%

HSE Hospital Groups (Statutory and Voluntary Hospitals)

Complaints reported by Hospital Group per 100,000 bed days

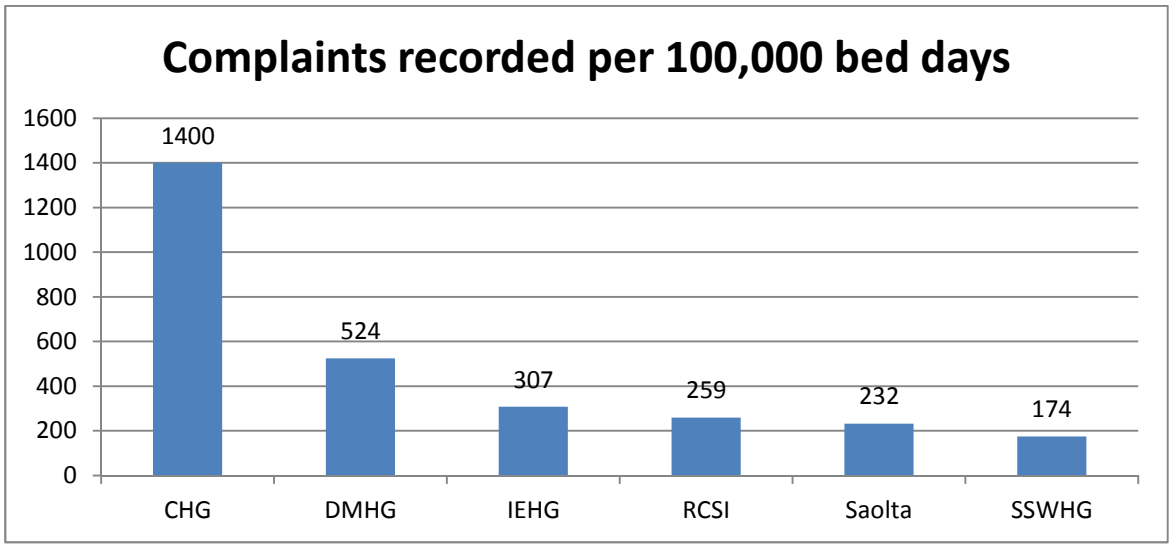


Figure 5: Complaints per 100,000 bed days received to Hospital Groups (Statutory & Voluntary)

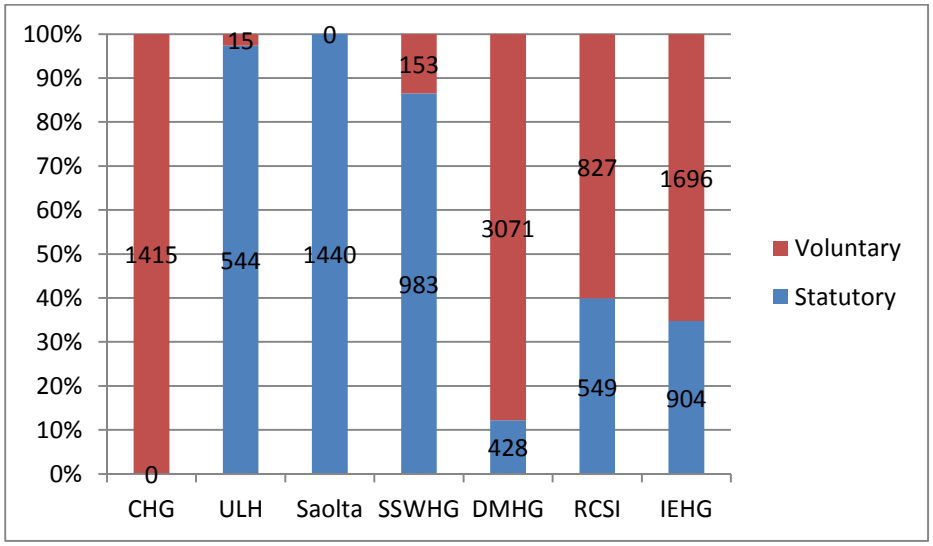


Figure 6: Complaints received to Hospital Groups: Statutory and Voluntary Hospitals

University Limerick Hospitals Group

Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
UHL Statutory	544	249	46%
UHL Voluntary	15	12	80%
UHL Total	**559**	**234**	**47%**

Table 8: ULH Reported Complaints 2017

South/South West Hospital Group

Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
SSWHG Statutory	983	623	53%
SSWHG Voluntary	153	125	82%
SSWHG Total	**1136**	**748**	**66%**

Table 9: SSWHG Reported Complaints 2017

Saolta Hospital Group

Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
Saolta Statutory (Total)	**1440**	**1109**	**77%**

Table 10: Saolta Reported Complaints 2017

RCSI Hospital Group

Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
RCSI Statutory	549	444	81%
RCSI Voluntary	827	727	88%
RCSI Total	**1376**	**1171**	**85%**

Table 11: RCSI Reported Complaints 2017

Ireland East Hospital Group

Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
IEHG Statutory	904	704	78%
IEHG Voluntary	1744	1458	84%
IEHG Total	**2648**	**2162**	**82%**

Table 12: IEHG Reported Complaints 2017

Dublin Midlands Hospital Group

Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
DMHG Statutory	428	350	73%
DMHG Voluntary	3071	2853	86%
DMHG Total	**3499**	**3203**	**84%**

Table 13: DMHG Reported Complaints 2017

The Children's Hospital Group

Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
CHG Voluntary (Total)	1415	1204	85%

Table 14: CHG Reported Complaints 2017

Other Voluntary Hospitals

Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
Other Voluntary Hospitals	390	331	85%

Table 15: Other Voluntary Hospitals Reported Complaints 2017

All Statutory and Voluntary Hospital

All Statutory and Voluntary Hospital	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
Total	12431	7876	63%

Table 16: Complaints resolved within 30 working days timeframe

Community Healthcare Organisations

Complaints Reported by County per 100,000 general population

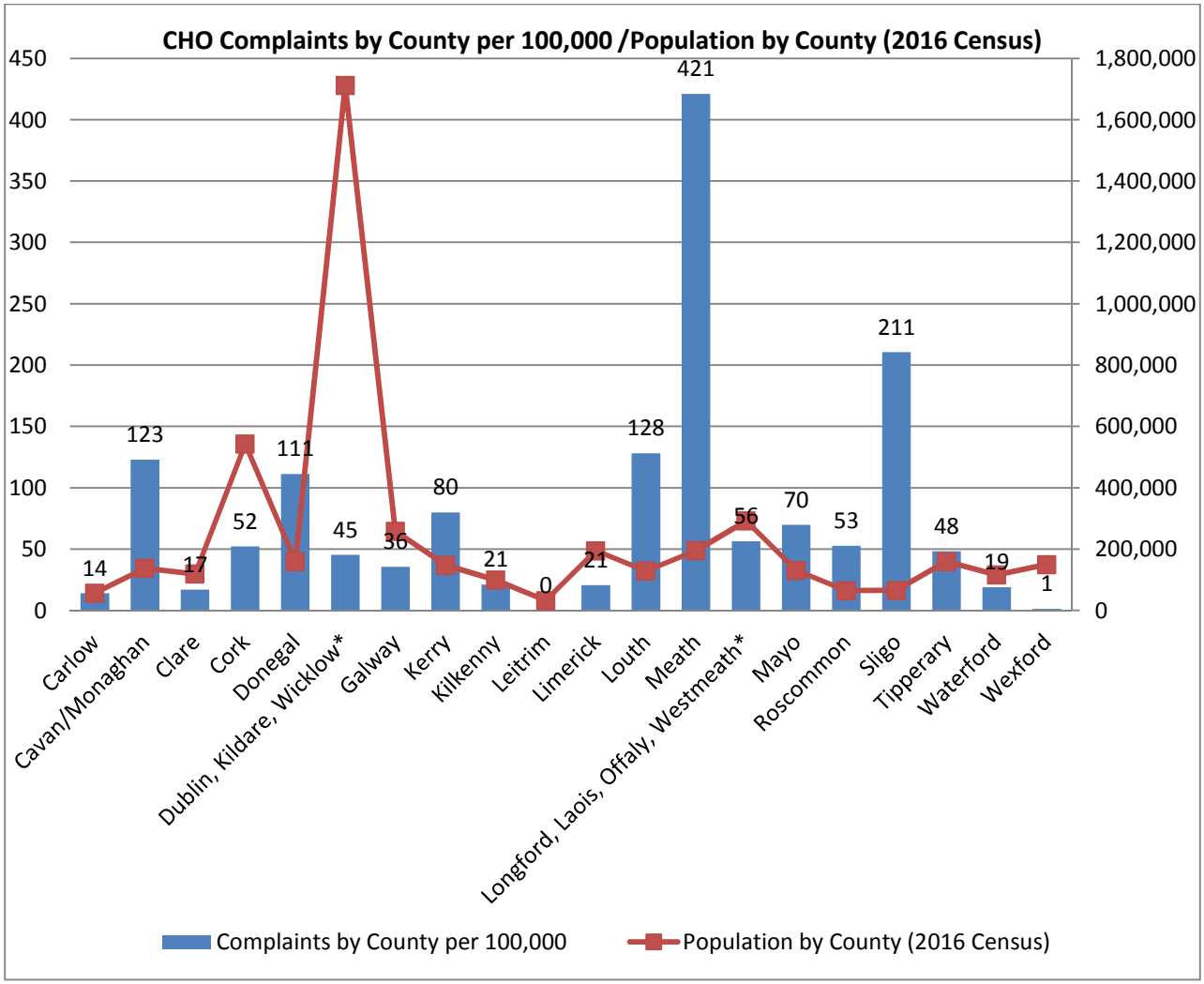


Figure 7:Breakdown of Complaints Received to Community Services per 100,000 general population / Population per County

Population data from 2016 Census, Central Statistics Office

Complaints Reported per CHO

CHO	Counties	Complaints received 2017	Resolved ≤30 working days by Complaints Officer (formally and informally)	% resolved ≤30 working days by Complaints Officer
CHO 1	(Donegal, Sligo, Leitrim, Cavan, Monaghan)	484	462	95%
CHO 2	(Galway, Mayo, Roscommon)	217	109	50%
CHO 3	(Clare, Limerick, North Tipperary)	63	36	57%
CHO 4	(Kerry, North Cork, North Lee, South Lee, West	416	319	77%

	Cork)			
CHO 5	(South Tipperary, Carlow, Kilkenny, Waterford, Wexford)	127	82	65%
CHO 6	(Wicklow, Dun Laoghaire, Dublin South East)	118	98	83%
CHO 7	(Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West)	164	99	60%
CHO 8	(Louth, Longford, Laois, Offaly, Meath, Westmeath)	1151	1122	97%
CHO 9	(Dublin North, Dublin North Central, Dublin North West)	496	370	75%
Total		**3236**	**2697**	**83%**

Table 17: Reported Complaints to CHOs 2017

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 2017
Access	3905	3505	7410
Safe & Effective Care	2667	3596	6263
Communication & Information	1414	3396	4810
Dignity & Respect	1094	1605	2699
Accountability	353	555	908
Clinical Judgement	191	261	452
Privacy	123	218	341
Improving Health	148	180	328
Safeguarding Vulnerable Persons	12	253	265
Participation	65	190	255
Pre-School Inspection Services	0	125	125
Nursing Homes / Residential Care for Older People (aged 65 and over)	50	31	81
Vexatious Complaints	5	45	50
Children First	0	49	49
Trust in Care	12	26	38
Nursing Homes / Residential Care (aged 64 and under)	5	14	19

Table 18: Complaints broken down by category **NOTE:** Explanation of Categories is available in Appendices

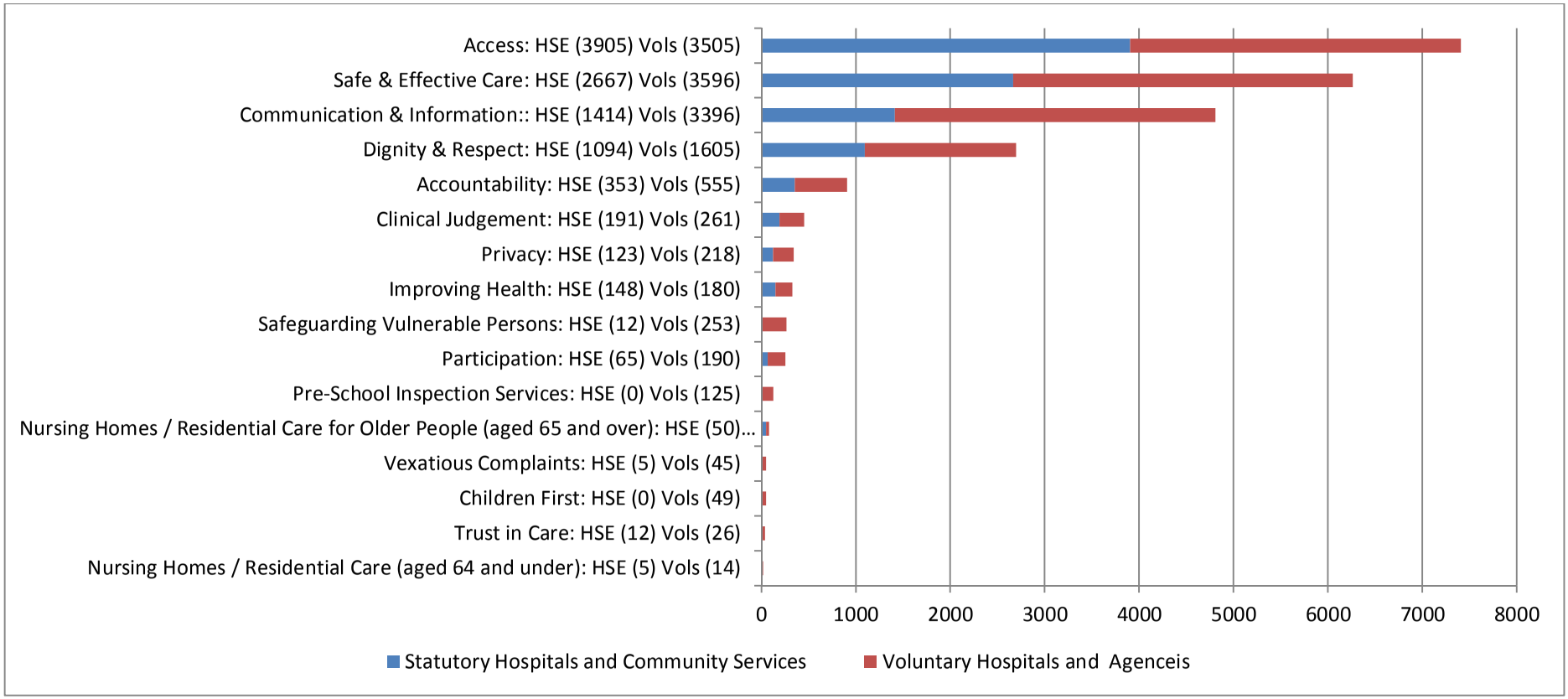


Figure 8: Categories of Complaints

Complaints by Divisions (per CHO)

Community Health Organisation (CHO)	Social Care	Primary Care	Mental Health	Health and Wellbeing
CHO 1	310	128	34	0
CHO 2	76	107	32	0
CHO 3	6	26	19	1
CHO 4	254	76	70	16
CHO 5	38	13	10	0
CHO 6	29	24	24	10
CHO 7	0	83	9	0
CHO 8	140	872	125	1
CHO 9	143	259	75	0
Total	**996**	**1588**	**398**	**28**

Table 19: CHOs Complaints by Division 2017

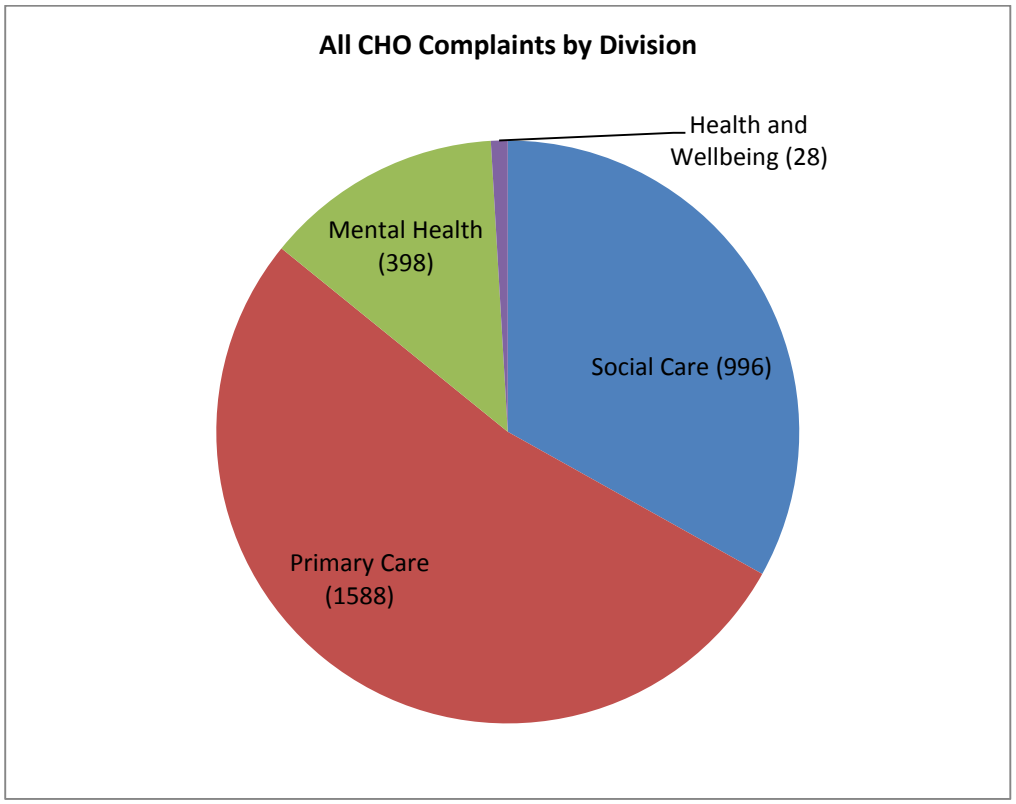


Figure 9: Complaints by CHO Service

Complaints relating to the Assessment of Need process

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

	Complaints received 2017	Complaints excluded under Part 9 of the Health Act 2004	Anonymous	Resolved informally	Withdrawn	Resolved through formal investigation ≤30 working days	Resolved through formal investigation ≥30 working days	% Resolved ≤30 working days	Resolved through Mediation
AoN	744	0	0	0	185	6	337	1%	0

Table 20: AoN Complaints resolved 2017

Percentage of Applications for Assessment of Need that result in a complaint per County

County	AoN complaints	% of AoN Applications that result in a complaint	County	AoN complaints	% of AoN Applications that result in a complaint
Carlow/Kilkenny	11	10%	Longford/ Westmeath	0	0%
Cavan/Monaghan	51	38%	Louth	9	6%
Clare	4	4%	Mayo	0	0%
Cork	468	49%	Meath	3	1%
Donegal	21	38%	Roscommon	1	3%
Dublin, Kildare Wicklow*	98	5%	Sligo/Leitrim	4	5%
Galway	0	0%	Tipperary	15	2%
Kerry	1	1%	Waterford	2	6%
Laois/Offaly	3	1%	Wexford	52	20%
Limerick	1	0%			

Table 21: Percentage of Applications for Assessment of Need that result in a complaint per County

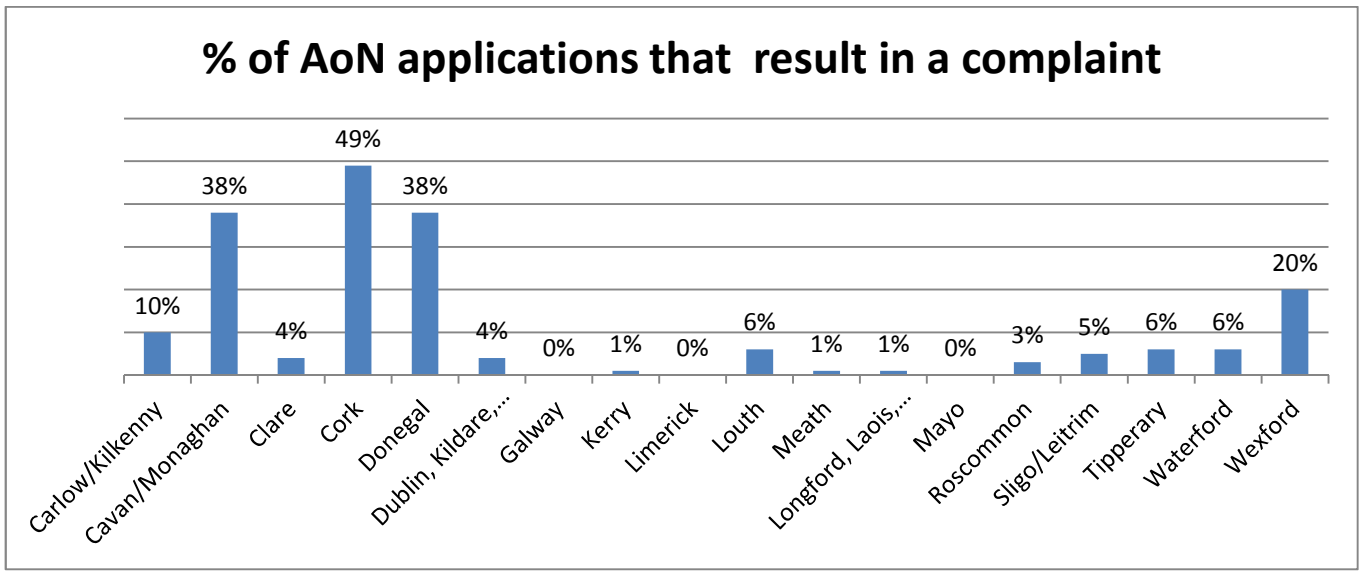


Figure 10: % of AoN applications that result in a complaint

Reviews & Recommendations

HSE Internal Review Total Reported

HSE Total 2017 (excluding voluntary agencies)	Internal Review				
	Review Request Received	Review Request Refused / Withdrawn	Review Conducted	Recommendations	
				Recommendations made arising from Review	Recommendations Implemented arising from Review
	101	4	93	48	30

Table 22: HSE Internal Review requests reported 2017

***Review conducted include Review requests received at the end of 2016**

Hospitals Groups

Hospital Groups 2017	Internal Review				
	Review Request Received	Review Request Refused / Withdrawn	Review Conducted	Recommendations	
				Recommendations made arising from Review	Recommendations Implemented arising from Review
Hospital Groups 2017	67	3	62	19	14

Table 23: HSE Internal Review requests to Hospital Groups reported 2017

Community Health Organisations

Community Hospital Group 2017	Internal Review				
	Review Request Received	Review Request Refused / Withdrawn	Review Conducted	Recommendations	
				Recommendations made arising from Review	Recommendations Implemented arising from Review
Community Hospital Group 2017	34	1	31	29	16

Table 24: HSE Internal Review requests to CHOs reported 2017

Part Two

Your Service Your Say Governance: National Action Plan returns to the Office of the Ombudsman

An Action Plan was devised to support the development and progress nationally and at local level, of **Recommendations** from the Ombudsman Report, '*Learning to Get Better*'.

The Ombudsman's 2015 investigation into how public hospitals handle complaints concluded with 36 recommendations in total. These 36 recommendations were grouped under five headings; *Access, Process, Response, Leadership* and *Learning,* and following a directive by the HSE Director General in May 2015 it was agreed that the findings and recommendations of the investigation report were to be reflected across all services division in the HSE, not just public hospitals.

On that basis, a template, for return on a bi-annual basis, was designed by the HSE in partnership with the Office of the Ombudsman to capture each service area's self-assessed level of compliance for 29 of those recommendations, that is, *non-compliant, partially compliant* or *fully compliant*. The remaining 7 recommendations are for specific action and response by either the Health Service Executive or Department of Health.

Following the return of these templates the feedback has been collated and is presented below.

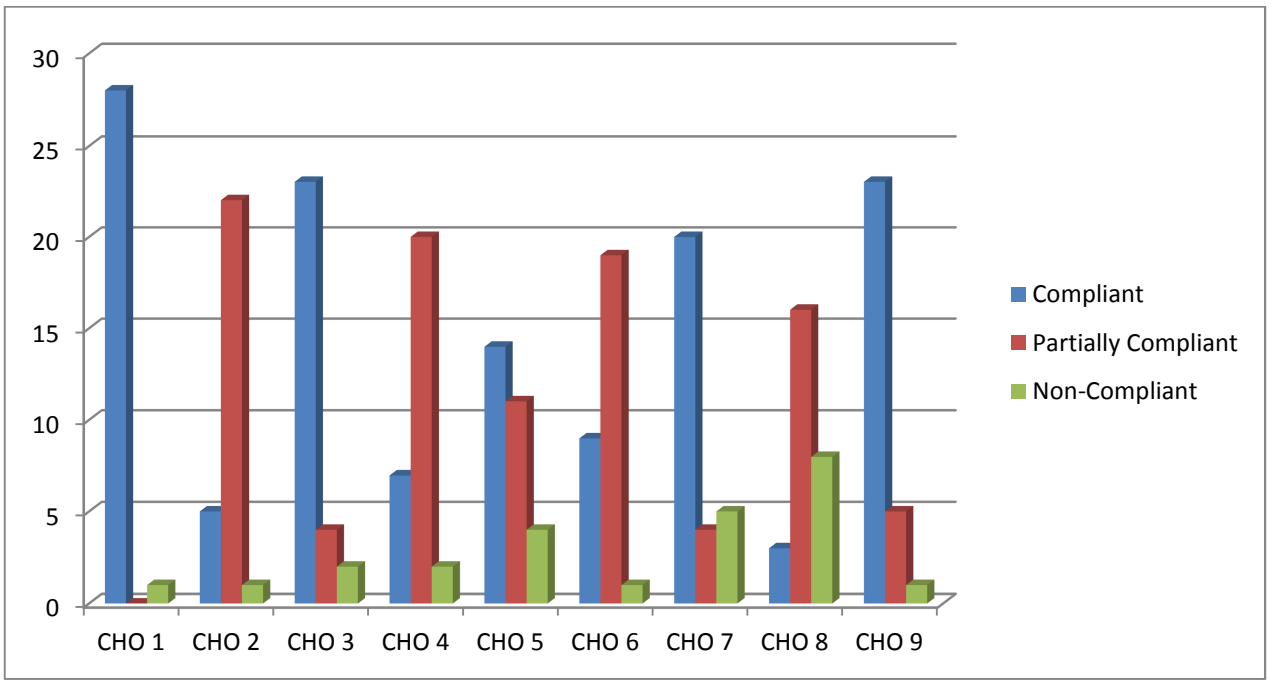
1. Community Healthcare Organisations

All 9 Community Health Organisations returned updated Action Plans:

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

The following table and graph shows the self-assessed compliance rating for each CHO area.

Recommendation	CHO 1	CHO 2	CHO 3	CHO 4	CHO 5	CHO 6	CHO 7	CHO 8	CHO 9
Compliant	28	5	23	7	14	9	20	3	23
Partially Compliant	0	22	4	20	11	19	4	16	5
Non-Compliant	1	1	2	2	4	1	5	8	1



* Please note CHO 8 measured against 27 recommendations only (no compliance rating entered against Action #3 or #19 – review of complaints system currently being undertaken)

Four of the nine Community Healthcare Organisations (CHOs) are reporting high levels of compliance, above 20 actions, with four reporting compliance below 10 actions. One CHO is approximately 50% compliant.

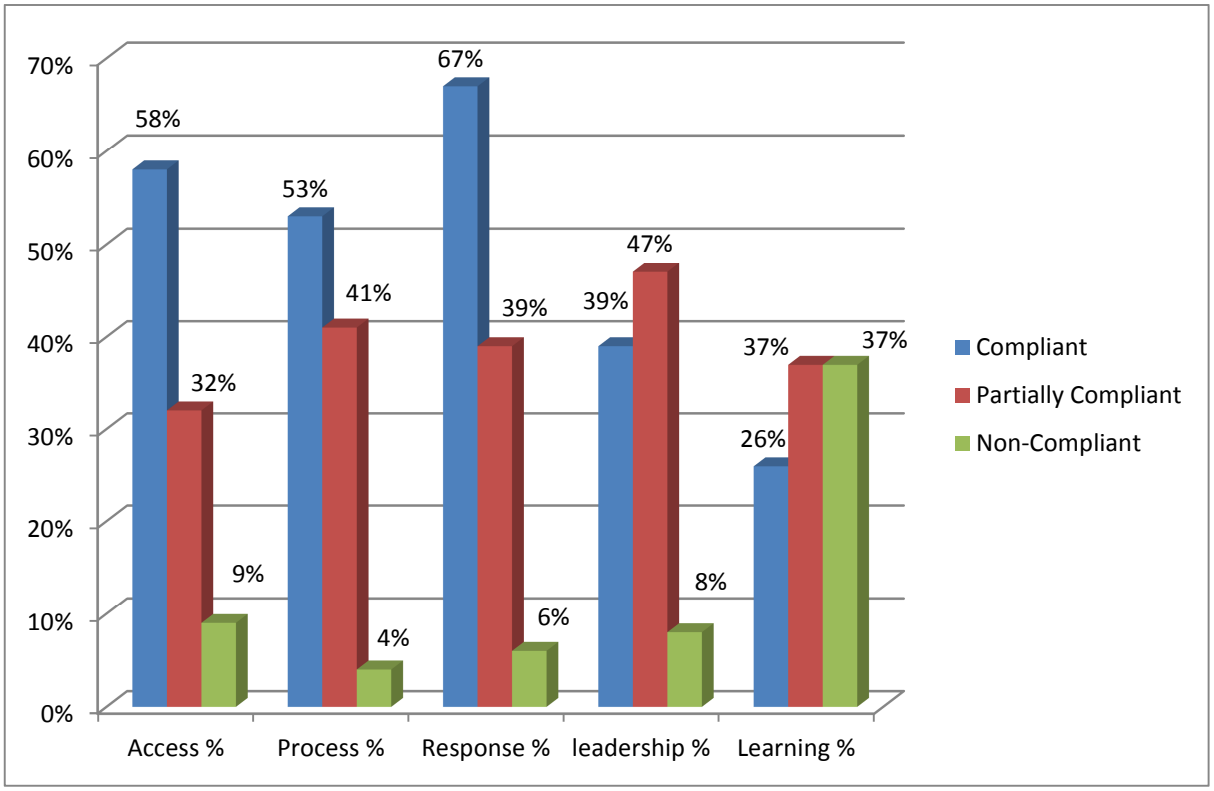
Of the four CHOs reporting compliance levels below 10 actions, high levels of partial compliance have been recorded.

Overall there is a very low level of actions that are reported as non-compliant with some of those common to the majority of CHOs.

Compliance rating under the Five Themes

The following table and graph outlines the percentage of self-assessed compliance across the CHO areas for each of the themes: *Access, Process, Response, Leadership* and *Learning* under which the recommendations are grouped.

	Compliant	Partially Compliant	Non-Compliant
Access %	58%	32%	9%
Process %	53%	41%	4%
Response %	67%	39%	6%
Leadership %	39%	47%	8%
Learning %	26%	37%	37%



The main actions identified as non-compliant are as follows:

Actions 6[4], 10[2], 14, 16, 20, 22[2], 23, 25, 28, 29[2], 30, 32, 34[3], 35[3], 36[5]

* The superscript number indicates the number of CHOs that have recorded non-complaint against this action.

The common actions that are non-complaint are listed below:

Action	Theme	Description
10	Access	Access Officer
22	Process	Bi-monthly Audit
29	Leadership	Standardised Reporting on Complaints
6	Access	Volunteer Advocates
34	Learning	Standardised Learning Implementation Plan
35	Learning	Sharing Good Practice (CO Network)
36	Learning	Casebooks

2. Hospital Groups

In total, 4 out of 7 Hospital Groups returned updated Action Plans:

- Saolta University Healthcare Group
- South/Southwest Hospital Group
- UL Hospitals Group
- National Children's Hospital Group

***NOTE:**
Although returns from Ireland East and RCSI Hospital Groups were made, they were not submitted in the form requested by the Ombudsman or in a format that enabled analysis or comparison with other hospital groups.

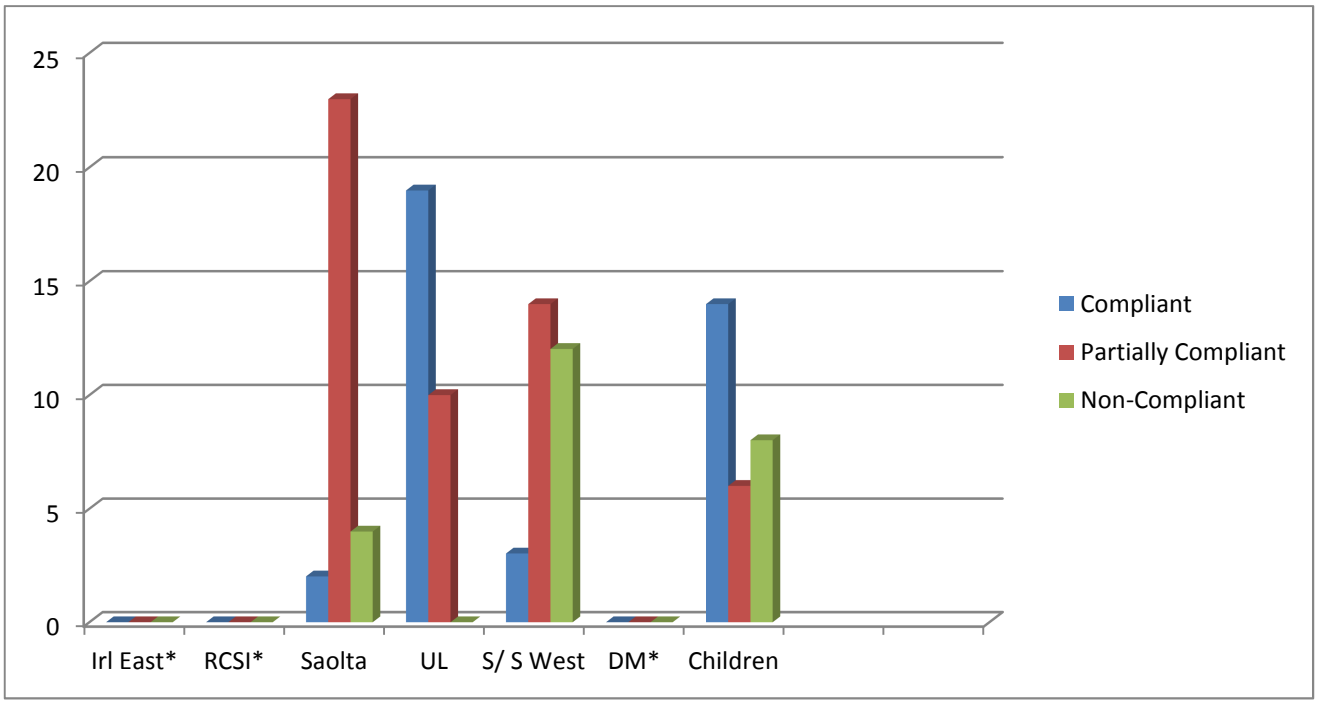
The Dublin Midlands Hospital Group submitted returns for 4 out of the 7 hospitals in that group. However, in these returns, not all recommendations had a compliance rating applied and so the return did not lend itself to analysis or comparison.

These Hospital Groups, as a result, have been omitted from the comparative analysis below.

The following table and graph outlines the percentage of compliance for each of the 5 groups of recommendations, across the 4 Hospital Groups returned.

Recommendation	Irl East*	RCSI*	Saolta	UL	S/ S West	DM*	Children
Compliant	0	0	2	19	3	0	14
Partially Compliant	0	0	23	10	14	0	6
Non-Compliant	0	0	4	0	12	0	8

* See note above.



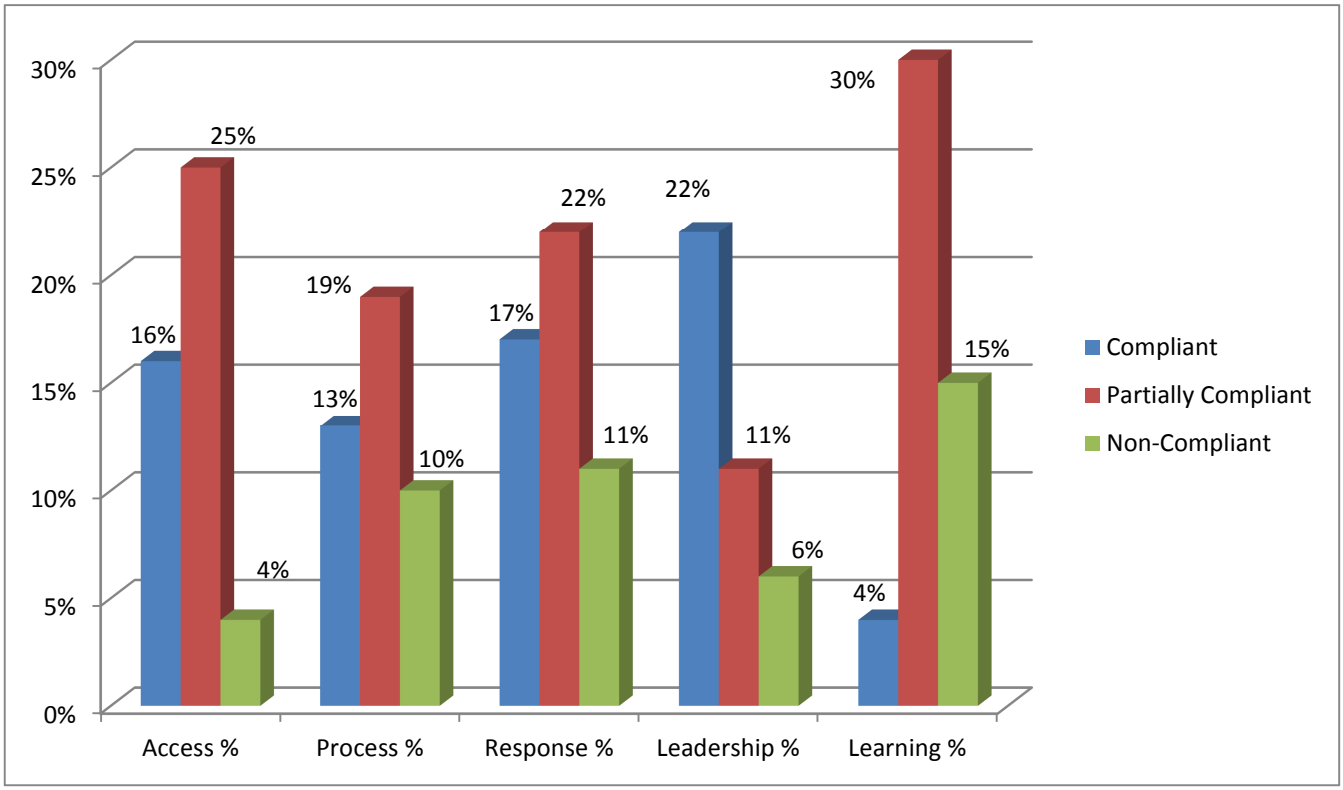
* See note above.

Out of the four Hospital Group returns only one HG is reporting a high level of compliance. It is worth noting that in the HGs reporting the lowest level of compliance, the level of partial compliance is high demonstrating significant progress towards achieving compliance. Two HGs show low to medium levels of non-compliance (between 8 and 12 actions).

Compliance rating under the Five Themes

The following table and graph outlines the percentage of self-assessed compliance across the Hospital Groups for each of the themes: *Access, Process, Response, Leadership* and *Learning* under which the recommendations are grouped. (Based on the four returns received)

	Compliant	Partially Compliant	Non-Compliant
Access %	16%	25%	4%
Process %	13%	19%	10%
Response %	17%	22%	11%
Leadership %	22%	11%	6%
Learning %	4%	30%	15%



The main actions identified as non-compliant are as follows:

Actions 3, 5, 6[2], 9, 12, 16, 17, 17, 20[2], 21, 22[2], 23[2], 24, 34, 35, 36

* The superscript number indicates the number of HGs (based on four returns) that have recorded non-complaint against this action.

The common actions that are non-compliant are listed below:

Action	Theme	Description
6	Access	Volunteer Advocates
20	Process	Mandatory Training for Complaints Officers
22	Process	Bi-monthly audit
23	Process	Independent Investigation

Key points

Recommendations:

- Community Healthcare Organisations recoded less instances of *non-compliance* against the recommendations compared to Hospital Groups.
- Both CHOs and HGs demonstrated good progress with implementing the recommendations with high levels of *partial compliance* recorded.
- Higher compliance rates were recorded by CHOs compared with HGs

Themes

- The CHOs returned high compliance ratings under all themes compared to the HGs.
- For CHOs compliance for **Access, Process and Response** all achieved over 50% as against the Hospital Groups who returned similar compliance rates for these themes but all of which were under 20%
- Compliance with **Leadership** and **Learning** proved challenging for both CHOs and HGs with **Learning** the most difficult. Worth noting that **Leadership** achieved the highest level of compliance out of all the themes for the HGs.

Part Three

The National Complaints Governance and Learning Team

The National Complaints Governance and Learning Team (NCGLT) is the national unit within the National Quality Assurance and Verification Division tasked with developing the systems and supports to deliver on the HSE's commitment to provide an enhanced feedback process that is accessible, flexible and responsive as well as ensuring that it is geared towards learning and quality improvement.

Pictured are members of the NCGLT Team

Back Row: *Ms Lisa McCormack, National Your Service Your Say Office; Ms Annie Kinsella, National Your Service Your Say Office; Ms Amy McQuillan, National Your Service Your Say Office.*

Front Row: *Ms Angela Kennedy, National Disabilities Complaints Officer; Ms Elaine Ahern, National Complaints Governance and Learning Team; Mr Christopher Rudland, National Complaints Governance and Learning Team; Ms Jean Glynn, National Disabilities Complaints Officers; Ms Suzanne Moloney, National Complaints Governance and Learning Team; Ms Shirley Murphy, National Complaints Governance and Learning Team; Ms Aoife Hilton, National Complaints Governance and Learning Team. (Absent: Ms Sinead Kelleher, National Complaints Governance and Learning Team)*

Governance

Complaints Managers

The appointment of named managers with responsibility for championing the feedback process, especially in relation to complaints within Community Healthcare Organisations, Hospital Groups and National Divisions was a mandated action by the HSE to ensure leadership and governance in this area.

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

Complaints Managers will also be responsible for assigning Review Officers to complaints following request for a review.

National Complaints Managers Governance and Learning Forum

NCGLT, to support Complaints Managers in their role, established a National Complaints Managers Governance and Learning Forum. 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 area to exploring areas for development to ensure the continuous evolvement of our feedback processes. Matters identified or arising from this Forum are shared with both local and senior management for consideration.

A key feature of the shared learning aspect of the Forum is the standard agenda item of a case study presentation. These presentations are based on anonymised complaints where the Complaints Manager feels that from the management of the complaint learning has been identified that would benefit members.

An example of such a case study presentation, where the complainant kindly agreed to attend in person to relate his experience is outlined below.

Learning Case Study

A father of a young child attended a National Complaints Managers Governance and Learning Forum meeting to share his family's particular experience with the HSE.

The father's daughter, then 7 months old, attended a routine check-up with her Public Health Nurse. As a result of this appointment, it became apparent that a referral for a routine X-ray, made during her initial new-born paediatric check, had not transpired. The family contacted the relevant referral hospital who had no record of the initial referral. An appointment for an X-ray was subsequently arranged, after which the child was diagnosed with hip dysplasia, which meant that she would have to undergo a procedure, while under anaesthetic, and wear a cast on her lower body for at least 12 weeks. Sometime later the family contacted the HSE to query the initial delayed referral. The father described his hesitancy to complain during subsequent and on-going treatment; however, concerns that similar issues could affect another family prompted his decision.

The father described a mixed experience with the HSE once the decision was made to complain formally. What transpired during the complaints process, which involved two hospitals, was a system failure regarding the method of referral by fax machine from one hospital to another, and a difference of opinion between the hospitals regarding this system failure. Unhappy with the HSE's response to their complaint, the family formally lodged a complaint with the Ombudsman for Children's Office (OCO), who identified a systemic failure of the referral pathway between the two hospitals. A review of 2077 cases over a 16-month period found a total of 20 patients whose faxed referral had been lost. The Ombudsman subsequently alerted the HSE Director General and both hospitals committed to a range of improvements, including:

- Discontinuation of referrals by Fax Machine
- Review of use of Fax Machines
- Development of cross-site Standard Operating Procedure
- Quarterly Audits
- Agenda Item at Hospital Group level
- Formal communication pathway agreed

Lessons to be learned

Issues and observations from the patient's perspective:

- Disparity of contact from the two hospitals
- No apology offered from one hospital until a face to face meeting
- Excellent medical care provided throughout the experience
- HSE should admit when it's obvious something is wrong/not working
- Persisting with a complaint is worthwhile
- The complaints process was more difficult than it should have been
- Not everyone is going to take legal action

Case Study continued.

From the HSE's perspective:

- The family was thanked for their patience throughout the duration of their experience with the HSE.
- Apologies were given to the family.
- Standard Operating Procedures were put in place to deal with Hip Referrals between hospitals.
- HSE approach for the future involves Patients – 'Patients as partners in their healthcare'
- Faxes are no longer used as methods of referral
- The National Lead for Outpatient Services is focused on improving systems, such as 'referrals' across all acute sites.

HSE Service wide Improvement

A Patient Safety Alert was issued by the HSE and circulated as appropriate to ensure that all services referring patients to external agencies e.g. inter-hospital, community to hospital, are aware of the requirements of the Electronic Communication Policy particularly as it relates to the use of fax machines.

Where fax machines are currently used as a method for communicating referrals, the use of an alternate and more reliable means of communication is to be considered.

Where there is no alternative but to use a fax machine, to ensure that the checks outlined in the Electronic Communications Policy are carried out prior to and following transmitting the information.

Such case studies are an integral part of the learning platform that is fostered and facilitated at the Forum. The key messages are taken back from the Forum and shared with Senior Management Teams at CHO and HG level for consideration and action as appropriate.

The National *Your Service Your Say* Policy

To formalise efforts to embed a culture that is open and welcoming to feedback, a Steering Committee was established in 2015 tasked with reviewing and updating the Your Service Your Say Feedback Policy which had been in existence for 15 years.

The Committee comprised of representatives of staff, service users, various community groups, patient and service user advocacy groups, the Department of Health and the Office of the Ombudsman. See Appendix 1 for the full listing of the Steering Committee. They examined the processes that were in place using the Ombudsman's report as a benchmark and following extensive consultation including with the Health Service Trade Unions, proposed a revised Policy to be supported by a comprehensive online Guidance Manual for all those involved in and interacting with our feedback processes and in particular our complaints management process.

Pictured: Some members of the National Steering Committee at the official launch of the revised Your Service Your Say Policy in the Mansion House in November 2017

The new Policy, ***Your Service Your Say, the Management of Service User Feedback for Comments, Compliments and Complaints, 2017***, has embraced five principles as the foundation of its revised feedback process.

- We will **Enable** you to provide feedback.
- We will **Respond** to your feedback promptly.
- We will **Support you** and **Support staff** through the process.
- We will commit to **Learning** from feedback and use it to **Improve** services and make them **Accountable**

The Policy sets out clearly the HSE's intention to provide and to support a system that encourages and enables feedback from service users.

Enable

The updated Policy strongly reflects the Ombudsman's call for a *No Wrong Door* approach by ensuring access to the greatest extent possible by patients and service users wishing to provide a comment, compliment or a complaint.

Respond

Point of Contact: The Policy places a great emphasis on trying to resolve complaints at the point of contact. This means that all staff are encouraged and supported to try to manage a complaint to resolution at the time of it being made or within 48 hours (two working days). If the complaint cannot be resolved by the staff member receiving it, the complaint can be escalated to their Line Manager. Where the complaint proves complex or beyond the scope of the Line Manager to resolve it, then it can be sent to a Complaints Officer who again will make every effort to resolve the complaint informally.

Formal Investigation: When a complaint progresses to formal investigation, the Complaints Officer will advise the Complainant of their rights and expectations including the timeframes involved. At all times, the Complainant will be kept updated on the investigation. A written report detailing the investigation, the findings and any resulting recommendations will be issued to the Complainant along with their rights to request a HSE internal review and/or an independent review from the Ombudsman / Ombudsman for Children.

Feedback: Complaints Management Pathway

Clearer pathways for the management of complaints have also been set out in the revised Policy. This will ensure that a concern raised will be directed to the most appropriate avenue for response in a timely manner. This is especially important where issues of clinical judgment are involved.

Support: *Patients/Service Users*

The HSE is committed to encouraging and enabling patients and service users to engage with the Health Service in relating their experience. Multiple routes for providing feedback have been put in place. Staff will assist anyone wishing to provide feedback and can advise them of their options and explain the process involved. Staff can also advise of the advocacy supports available locally that can support a patient/service user in making their concern known and in guiding them through the feedback process.

Support: *Staff*

All healthcare staff play a vital part in realising a culture where feedback is proactively welcomed and handled appropriately so as to maintain and build public trust and confidence in our services.

It is important therefore that they are supported in their role in the feedback process and training is central to this.

The Policy sets offers greater clarity on the roles and responsibilities of the various staff involved from frontline workers up to Chief Executive Officers for Hospital Groups and Chief Officers for Community Healthcare Organisations including right up the Leadership Team of the HSE. Everyone has a part to play in supporting and learning from feedback

The Guidance Manual developed to accompany the revised Your Service Your Say Policy provides a comprehensive guide to the feedback process.

The updated Policy and Guidance also outlines management responsibility in guiding and supporting staff through the complaints management process. Staff should be made aware of their rights within the process and be supported throughout. Line Managers need to be mindful of the welfare of their staff and ensure that the various mechanisms for assistance such as the Employee Assistance Programme, referral to Occupational Health and use of the ASSIST ME Model etc., are utilised as needed.

In addition to this Consumer Affairs are delivering awareness sessions on the operation of the Your Service Your Say Policy to staff with more detailed training sessions provided to Complaints Officers.

Train the Trainer Programme for Consumer Affairs

NCGLT developed a Train the Trainer Programme to assist Consumer Affairs staff in delivering training to staff and Complaints Officers on the newly revised Your Service Your Say Policy.

This two day train the trainer programme was held on the 23rd & 24th October 2017 and was delivered by NCGLT staff. The purpose of this programme was to provide attendees with the necessary skills required to enable them to roll out a one day Complaints Officer training programme within their own areas of remit. Participants learned about the importance of effective complaints management, developed an in depth understanding of the revised Feedback Policy and Guidance Manual and learned key skill sets required to manage complaints effectively. A number of guest speakers presented at this event including representatives from the Office of the Ombudsman and the Office of the Ombudsman for Children.

A total of 15 staff from across the HSE were trained and received their Train the Trainer certificates.

Since the Train the Trainer programme in October the following training session have been delivered by Consumer Affairs:

Consumer Affairs Area	Staff Awareness Sessions	Complaints Officer Training
HSE West	No data returned	No data returned
HSE South	No data returned	No data returned
HSE Dublin North East	No data returned	No data returned
HSE Dublin Mid Leinster	No data returned	No data returned

Review Officer Training

The National Complaints Governance and Learning Team provided a number of complaint training courses for Review Officers in 2017. These courses helped develop and enhance attendee's knowledge of the key elements within the complaints legislation and policy for the management of complaints at internal review stage. Participants learned how to identify key considerations when reviewing a complaint from initial receipt through to the issuing of recommendations. The course focused on the review process steps including guidance on how to conduct an investigation. Representatives from the Office of the Ombudsman also attended and presented at each of these training days.

A total of 104 staff attended Complaint Review Officer training in 2017.

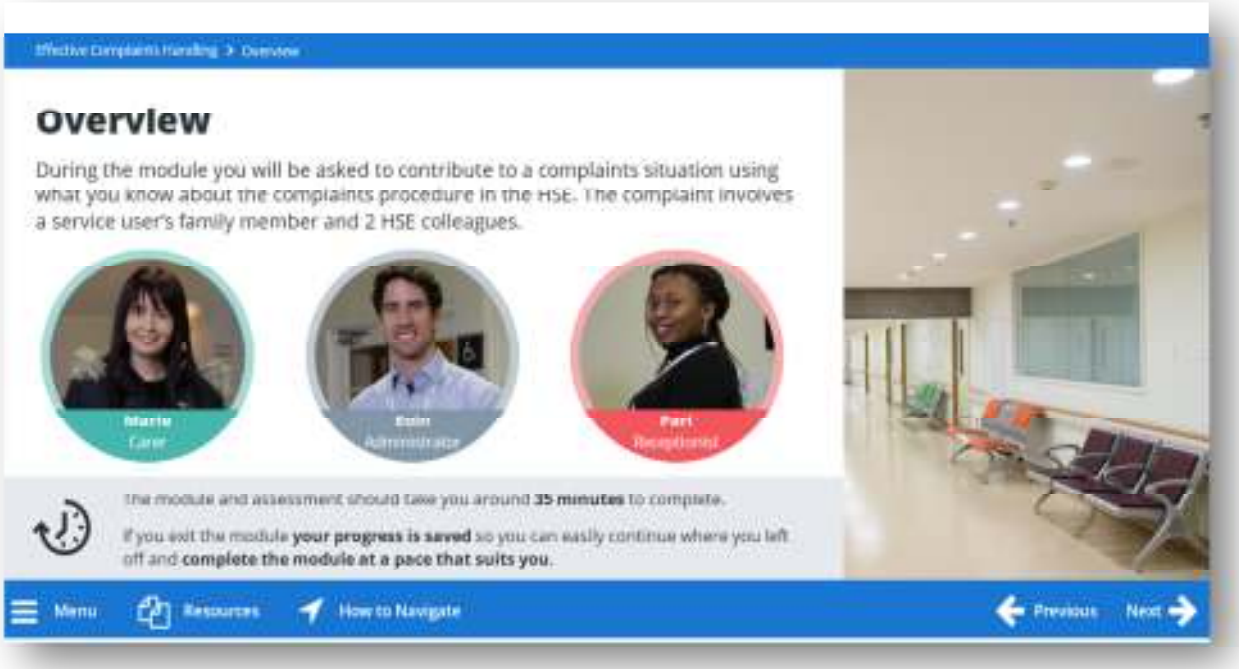
eLearning

In March 2017 work commenced on establishing a steering group for the development of an e-learning HSELanD complaints module. This steering group consisted of a number of key stakeholders including representatives from the Office of the Ombudsman. The aim was to develop an interactive on-line complaint handling e-learning tool, hosted through the HSELanD portal. This tool consists of two modules.

Module 1 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.

Module 2 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.

This e-learning tool covers a number of videoed scenarios encompassing both **stage 1** and **stage 2** (formal & informal) of the Your Service Your Say complaints policy. The participating online staff member will have to choose an appropriate pathway from a number of scenarios. This e-learning tool allows mistakes to be made in a safe environment, whilst also allowing the participant an opportunity to recover and learn from choosing an incorrect pathway. These modules will be available in early 2018.



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).

Additional supports

The Your Service Your Say Policy document along with a comprehensive guidance manual on the operation of the policy is available online at www.hse.ie/yoursay along with other supports such as letter templates and other useful guidance notes.

Learning

The majority of people complain not for any financial reward but to simply ensure that what happened to them does not happen to anyone else. Therefore learning and accountability are critical for an effective feedback process. This means that more than ever we need to ensure that recommendations arising out of complaint investigations are implemented and that learning, ideas and experiences can be shared across services, Hospital Groups and Community Healthcare Organisations.

The Policy is clear on its intent to use complaint data to ensure lessons are learned from feedback and in particular complaints and to use the data as a service improvement tool.

A number of new reporting templates have been developed and are designed to assist staff capture learning from handling complaints. There are as follows:

- **Point of Contact Resolution Form** - to be completed by all staff who resolve a complaint within the 48 hours, point of contact timeframe, and sent to Line Manager for analysis.
- **Point of Contact Escalation Form** – to be completed by the Line Manager where complaint could not be resolved within the point of contact timeframe (48 hours) and needs to be examined by a Complaints Officer. Copy retained by Line Manager for analysis.
- **Anonymised Learning Notification Forms** – completed by both Complaints Officers and Review Officers following investigation/review to capture any learning resulting. Forwarded to Complaints Manager for analysis.
- **Learning Summary Casebooks**. (1) Compiled quarterly by Complaints Officer for their area and sent to Complaints Manager. (2) Generated and published quarterly by Complaints Managers from all learning forwarded by Complaints Officers and Review Officers

Complaints Management System (CMS)

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

As a result, a new online database, the Complaints Management System, was developed in conjunction with the State Claims Agency and will, for the first time, facilitate the capture of comprehensive complaints data to enable analysis and comparison. This will support learning from complaints and ensure evidence based best practice can be shared across services

Leads for the Complaints Management System have been identified in each CHO and HG and will be 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 2017	**2017**
Hospital Groups	
CHG	0
ULH	4
Saolta	33
SSWHG	31
DMHG	13
RCSI	19
IEHG	12
Community Health Organisations	
CHO 1	3
CHO 2	1
CHO 3	0
CHO 4	60
CHO 5	18
CHO 6	28
CHO 7	6
CHO 8	44
CHO 9	16
Corporate	
PCRS	0
NAS	2
	290

Analysis of 1000 complaints recorded on Complaints Management System

2017 was the first year that Complaints Officers commenced recording complaints data on the Complaints Management System. A random sample of 1000 such records allowed the NCGLT the opportunity to take a more in depth look at the causes of complaints using a more detailed classification system.

While nothing definite can be drawn from this random selection, it is important to demonstrate that the move from the old spreadsheet data collection method to the new national standardised Complaints Management System will improve our understanding, throughout the Health Services, of the factors that influence service users to make complaints.

It is also possible to demonstrate, for the first time, how many recommendations arose from issues investigated through the complaints process, i.e. 146.

- 1000 complaints
  - 727 Closed (73%)
  - 578 Upheld/partially upheld (79% of complaints investigated were upheld)
- 375 complaints were indicated as closed within recommended timeframe, (on examination many more complaints were closed within timeframe but had not been recorded as such on the CMS)
- 146 recommendation or some other action arose from the complaint investigation

1	**Safe & Effective Care**	**352 recorded issues in complaints received**		
		Top 3 causes	1	Unsatisfactory treatment or care
			2	Failure / delay in treatment / delivery of care
			3	Diagnosis - delayed diagnosis
2	**Access**	**227 recorded issues in complaints received**		
		Top 3 causes	1	Appointment - delay in issuing appointment
			2	Admission - delay in admission process
			3	Treatment
3	**Communication & Information**	**211 recorded issues in complaints received**		
		Top 3 causes	1	Insufficient and inadequate information
			2	Failure / delay in communicating with relatives
			3	Inadequate listening and response
4	**Dignity and Respect**	**170 recorded issues in complaints received**		
		Top 3 causes	1	Lack of respect shown to patient during examination / consultation
			2	Alleged inappropriate behaviour by a patient
			3	Patient's dignity not respected
5	**Accountability**	**51 recorded issues in complaints received**		

		Top 3 causes	1	Bill dispute
			2	Insurance cover
			3	Unhappy with income collection process
6	**Improving Health**	**13 recorded issues in complaints received**		
		Top 3 causes	1	Patient / family preference discounted / disrespected
			2	Food quality
			3	Non-compliance (visitor, patient, staff smoking)
7	**Privacy**	**9 recorded issues in complaints received**		
		Top 3 causes	1	Breach of patient confidentiality
			2	Hospital Facilities (Privacy)
			3	Lack of privacy during consultation/discussing condition
8	**Participation**	**3 recorded issues in complaints received**		
		Top 3 causes	1	Opinion discounted - family / relatives / advocate / next of kin
			2	Excluded from decision making process - family/ relatives/ advocate/ next of kin
			3	Consent

Complaints Management System (CMS) Steering Group

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

CMS leads have been appointed within each Community Healthcare Organisation and Hospital Group and meet as a group to further progress the development of the CMS existing module for Stage 2 complaints and the future 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

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?*

NCGLT are commencing the first phase of a national project in conjunction with the London School of Economics. **Phase 1** will involve the systematic analysis of all complaints in a given time period in a selected Hospital Group using HCAT. The purpose of phase 1 of the project is to analyse:

- The types and severity of healthcare complaints made about care in an acute hospital
- Whether the types and severity of healthcare complaints share similarities with other international studies conducted by the LSE.

This analysis is currently in progress.

Further phases of the project will extend this analysis nationally to samples from all Hospital Groups

This will also eventually extend to CHOs

Policy Launch

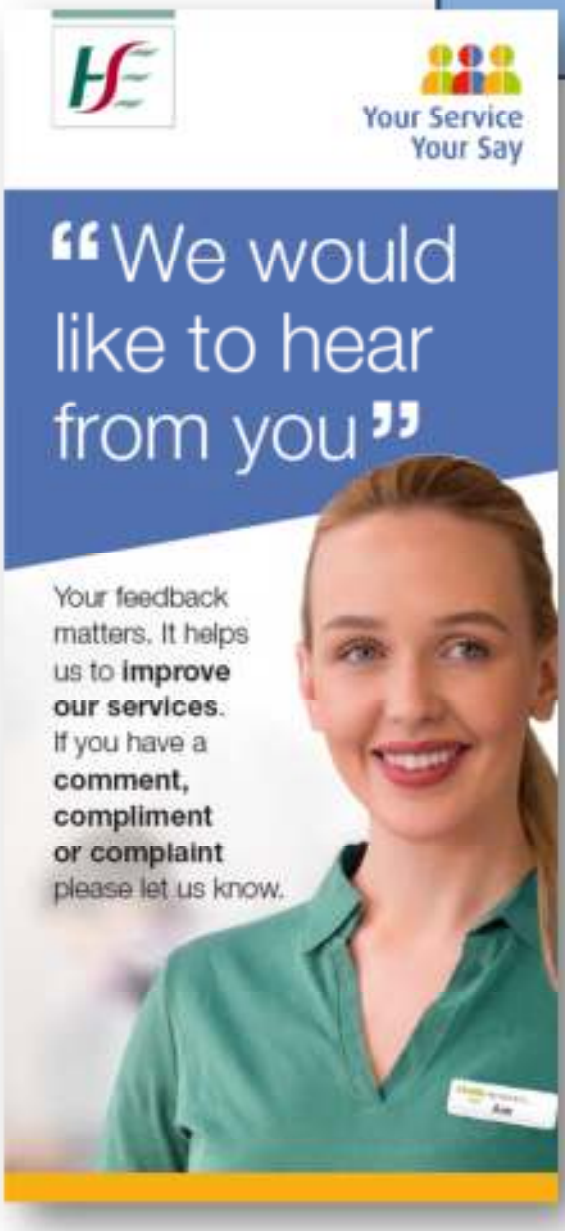
The **National HSE *Your Service Your Say, The Management of Comments, Compliments and Complaints*** Policy was formally launched on 15th November 2017 in the mansion House in Dublin by Mr Tony O'Brien, Director General, HSE with an address by Mr Peter Tyndall, Ombudsman.

Mr O'Brien in welcoming the revision of the Your Service Your Say Policy stated, *"Our intention with* Your Service Your Say *is to ensure that the HSE is an organisation that proactively welcomes, encourages and embraces feedback from all of our service users. I hope that this newly revised policy will reaffirm the commitment of the HSE to respond to service users when things go wrong and that we will do so in a way that empowers them and gives them trust in our effort to put things right".*

Pictured (L to R)Mr Christopher Rudland, Assistant National Director, National Complaints Governance and Learning Team; Mr Tony O'Brien, Director General, HSE; Mr Peter Tyndall, Ombudsman; Mr Patrick Lynch, National Director, National Quality Assurance and Verification Division

Mr Peter Tyndall, Ombudsman, acknowledged the very positive steps taken by the HSE in addressing some of the key issues that were identified in Learning to Get Better and recognised the shared commitment to improving services and to put the patient experience at the fore of service delivery. He welcomed the revision of Your Service Your Say policy and hoped that, "patients and their families will feel empowered to bring their concerns to the attention of the health service, so that services can improve through learning".

"An incredible amount of work has gone into the development of the Your Service Your Say policy and it is only right that it is part of the overall health system. This assessment and handling of vital feedback provided by users of the service will help the HSE to proactively identify areas of good practice and areas of concern, ultimately enhancing patient involvement and patient safety". **Sheila O'Connor, Founder & National Coordinator of Patient Focus**



"It's nice to give positive feedback. It is equally important for Patients and Family's "to have no fear "in raising concerns with the system through Your Service Your Say. *The HSE is fully committed to open disclosure when things go wrong. This is a good policy for both present and future patients."*
Stephen McMahon, Director of The Irish Patients Association

Supporting Initiatives

Materials

A number of materials have been developed to support the revised Your Service Your Say Policy. These include:

- **Guidance Manual** – this will be available online at www.hse.ie/yoursay and will be structured in a format that gives control to the user, accessing the type, level and depth of information and will contain a number of links to other sections and resources that may be browsed if needed.
- **A3 Poster**
- **Adult Feedback Leaflet**

Materials in development and for distribution in early 2018

- **A4 Poster**
- **A4 Irish poster**
- **Children's information leaflet.** Being developed in partnership with the Ombudsman for Children's Office, TUSLA, the Youth Advisory Council
- **Plain English and Easy Read** versions of the Policy

Distribution

All CHOs and HGs were advised of the new Policy, Guidance Manual, poster and leaflet and were requested to identify named contacts to take responsibility for receiving the materials and arranging for distribution throughout their area ensuring appropriate display in all relevant settings. Distribution was completed in November 2017.

HSE Website

The feedback section of the HSE website was updated to reflect the new Policy, particularly in relation to the new YourSay section and is home to a myriad of resources, training materials, template letter packs as well as various other supports including the Guidance Manual. The online guidance manual offers detailed procedural information on our feedback process as well as comprehensive resources and supports and is tailored to the specific requirements of the visitor, be that a service user making a comment, compliment or complaint, a Complaints Officer managing a complaint or a staff member involved in a complaint.

This is an ongoing project with expected completion in 2018.

Awareness

In 2018, NCGLT will offer briefing sessions to CHOs, HGS and National Divisions to update management on the revised Policy and its key provisions.

The National Your Service Your Say Office

The National Your Service Your Say Office based in Millennium Park in Naas offers those who use our services a dedicated contact point for giving feedback or seeking advice on how to provide feedback. The service operates five days a week, Monday to Friday from 9am to 5pm and can be contact on 1890 424 555. 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 1850 24 1850.
People can also email the Your Say Team on yoursay@hse.ie if preferred.

Complaints received through the Director Generals Officer or from the Department of Health are also channelled through this office.

The office ensures that all feedback, including complaints, are routed to the appropriate service for examination and response.

Pictured (L to R): Ms Lisa McCormack, Ms Annie Kinsella and Ms Amy McQuillan of the National Your Service Your Say Team.

The National Your Service Your Say Office Activity 2017								
2017	YSYS emails	Complaints via Director General's Office	Complaints via Department of Health	QAV Letters	Reviews	YSYS office calls	YSYS office missed calls	Total Interactions
January	473	12	165	9	4	114	32	809
February	512	10	146	7	7	179	26	887
March	532	5	151	8	6	210	29	941
April	424	6	90	13	5	121	15	674
May	516	13	132	12	3	240	19	935
June	475	8	136	5	8	80	10	722
July	453	3	122	6	3	102	23	712
August	452	11	140	8	1	184	30	826
September	549	9	170	6	2	246	16	998
October	528	4	152	8	4	269	35	1000
November	542	12	167	6	5	210	15	957
December	396	6	127	6	5	156	22	718
Total 2017	5852	99	1698	94	53	2111	272	**10179**
Total 2016	6360	89	1485	141	155	1582	95	9907
Total 2015	7374	118	1786	198	194	n/a	n/a	9670
Total 2014	5011	87	1790	166	222	n/a	n/a	7276
Estimate 2018	5676	144	1980	108	48	1368	384	9708

Overall the National Your Service Your Say Call Team has experience d an increase in the number of contacts from people wishing to provide feedback with a 2.7% increase since 2016. Calls to the Your Service Your Say Team have increased by 33.4% with missed calls, given the small team size operating the service, increasing by 186%.

National Disability Complaints – Assessment of Need

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 were being delivered.

There is currently a significant backlog of complaints regarding Assessment of Need services to be addressed. The NCGLT recruited an additional dedicated Disabilities Complaints Officer in September 2017 to address this backlog. This expanded the team of Complaints Officers to two.

Please see part 2 for information on complaints addressed by this office.

New Developments for 2018

I. **Managing Unreasonable Behaviour by Complainants within the Your Service Your Say Process**
To support staff fully in dealing with complaints and with complainants NCGLT will establish a multi-disciplinary steering group to examine unreasonable behaviour by complainants with the Your Service Your Say process and to develop a policy based on evidence and International best practice that will provide a structure and process to assist staff in managing the behaviours and expectations of complainants as well as what to do when behaviours escalate to being classed as unreasonable. Completion date is expected for Q3 2018.

II. **Complex Complaints**
Feedback from Complaints Officers and Complaints Managers have identified a number of complaints that do not fall neatly within our processes and take up considerable resources across multiple services. An expert working group, which will operate as a sub group of the *Managing Unreasonable Behaviour by Complainants Policy and Guidance Development within the Your Service Your Say Process* steering group, will be set up to examine such cases and to explore what structures and processes could be developed to assist in the management and conclusion of these. Completion date expected for Q3, 2018.

III. **Complaints Officers Governance and Learning Forum**
Consumer Affairs to establish a Forum for Complaints Officers similar to that for Complaints Managers to provide an opportunity for sharing practice and learning as well as networking. Any issues arising can be escalated to the Complaints Manager who can raise with local management or bring to their forum for further input and discussion.

Appendices

Appendix One: 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.

In 2017 Complaints Data relating to HSE Statutory Hospitals was through 2 alternative methods:

1. HSE Statutory Complaints data was collected monthly and collated quarterly by each Consumer Affairs region with the exception of ULH. Complaints Data relating to ULH was collected by the Hospital Group
2. HSE Statutory Complaints data was extracted through statistical reports created from complaints recorded on the Complaints Management System.

University Limerick Hospitals Group (ULH) Statutory Hospitals	(University Hospital Limerick, University Maternity Hospital, Croom Hospital, Nenagh Hospital, Ennis Hospital)	**RCSI Statutory Hospitals**	(Our Lady of Lourdes Hospital, Drogheda, Connolly Hospital, Cavan General Hospital, Louth County Hospital, 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)

Hospital Groups

Hospital Groups (Statutory)	Complaints received 2017	Complaints excluded under Part 9 of the Health Act 2004	Anonymous	Resolved informally	Withdrawn	Resolved through formal investigation ≤30 working days	Resolved through formal investigation ≥30 working days	% Resolved ≤30 working days	Resolved through Mediation
DMHG Statutory Hospitals	428	11	3	192	2	158	76	82%	0
IEHG Statutory Hospitals	904	0	5	459	6	245	171	78%	2
RCSI Statutory Hospitals	549	2	3	174	14	270	88	81%	1
Saolta Statutory Hospitals	1440	1	0	637	31	472	236	77%	4
SSWHG Statutory Hospitals	983	34	2	343	8	280	475	63%	0
ULH Statutory Hospitals	544	0	0	50	0	199	242	46%	0
Total	**4848**	**48**	**13**	**1855**	**61**	**1624**	**1288**	**72%**	**7**

Table 25: Complaints reported: Statutory Hospitals within Hospital Groups 2017

National Ambulance Service

National Ambulance Service	Complaints received 2017	Complaints excluded under Part 9 of the Health Act 2004	Anonymous	Resolved informally	Withdrawn	Resolved through formal investigation ≤30 working days	Resolved through formal investigation ≥30 working days	% Resolved ≤30 working days	Resolved through Mediation
Total	58	2	0	0	2	26	2	45%	2

Table 26: Reported complaints National Ambulance Service

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	96	39	136	113	3	3	4	56
IEHG Statutory Hospitals	107	101	616	111	9	6	12	33
RCSI Statutory Hospitals	125	116	197	81	3	8	5	21
Saolta Statutory Hospitals	518	165	583	318	10	28	28	101
SSWHG Statutory Hospitals	349	94	311	245	9	15	5	53
ULH Statutory Hospitals	135	71	177	105	3	5	19	25
Total	**1330**	**586**	**2020**	**973**	**37**	**65**	**73**	**289**

	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
IEHG Statutory Hospitals	8	0	0	0	0	0	0	0
RCSI Statutory Hospitals	25	0	0	0	0	0	0	0
Saolta Statutory Hospitals	6	0	0	0	0	0	0	0
SSWHG Statutory Hospitals	1	0	0	0	0	0	0	0
ULH Statutory Hospitals	43	1	0	0	0	0	0	0
DMHG Statutory Hospitals	0	0	0	0	0	0	0	0
Total	83	1	0	0	0	0	0	0

Table 27: Categories of Complaints reported: Hospital Group Contd.

National Ambulance Service

National Ambulance Service	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
Total	21	39	35	7	0	0	0	2

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

Table 28: Categories of Complaints reported: NAS.

In 2017 Complaints Data relating to Community Health Organisations was collected and collated bi-annually by each Consumer Affairs region with the exception of CHO 3. Complaints Data relating to CHO 3 was collected and collated by the National Complaints Governance and Learning Team.

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)	**AoN**	Complaints relating to Assessment of Need Nationally (across all CHOs)

Complaints Received/Resolved: CHOs

Community Health Organisation (CHO)	Complaints received 2017	Complaints excluded under Part 9 of the Health Act 2004	Anonymous	Resolved informally	Withdrawn	Resolved through formal investigation ≤30 working days	Resolved through formal investigation ≥30 working days	% Resolved ≤30 working days	Resolved through Mediation
CHO 1	484	6	2	289	4	173	28	95%	0
CHO 2	217	3	2	73	4	36	29	50%	31
CHO 3	63	0	0	18	4	18	17	57%	0
CHO 4	416	15	1	268	8	51	66	77%	0
CHO 5	127	0	1	42	5	40	18	65%	0
CHO 6	118	6	0	62	4	36	4	83%	0
CHO 7	164	3	2	56	15	43	35	60%	0
CHO 8	1151	0	10	960	24	162	68	97%	0
CHO 9	496	7	2	229	15	141	85	75%	2
Total	**3236**	**40**	**20**	**1997**	**83**	**700**	**350**	**83%**	**33**

Table 29: CHOs Complaints resolved 2017

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

Assessment of Need Nationally (across all CHOs)	Complaints received 2017	Complaints excluded under Part 9 of the Health Act 2004	Anonymous	Resolved informally	Withdrawn	Resolved through formal investigation ≤30 working days	Resolved through formal investigation ≥30 working days	% Resolved ≤30 working days	Resolved through Mediation
Total	744	0	0	0	185	6	337	1%	0

Table 30: AoN Complaints resolved 2017

Percentage of Applications for Assessment of Need that result in a complaint per County

County	AoN complaints	% of AoN Applications that result in a complaint	County	AoN complaints	% of AoN Applications that result in a complaint
Carlow/Kilkenny	11	10%	Limerick	1	0%
Cavan/Monaghan	51	38%	Longford/ Westmeath	0	0%
Clare	4	4%	Louth	9	6%
Cork	468	49%	Mayo	0	0%
Donegal	21	38%	Meath	3	1%
Dublin	93	5%	Roscommon	1	3%
Galway	0	0%	Sligo/Leitrim	4	5%
Kerry	1	1%	Tipperary NR	6	2%
Kildare/Wicklow	3	1%	Waterford	2	6%
Laois/Offaly	3	1%	Wexford	52	20%

Table 31: Percentage of Applications for Assessment of Need that result in a complaint per County

Applications for Assessment of Need by CHO

CHO	LHO	Total for2017
AREA 1		271
	Cavan/Monaghan	136
	Donegal	55
	Sligo/Leitrim	80
AREA 2		318
	Galway	118
	Mayo	160
	Roscommon	40
AREA 3		464
	Clare	90
	Limerick	204
	Tipperary N.R	170
AREA 4		1054
	Kerry	106
	Cork North	73
	Cork North Lee	438
	Cork South Lee	404
	Cork West	33
AREA 5		497
	Carlow/Kilkenny	114
	Tipperary S.R	91
	Waterford	33
	Wexford	259
AREA 6		214
	Dublin South East	22
	Dublin South	26
	Wicklow	166
AREA 7		1218
	Dublin South City	149
	Dublin South West	479
	Dublin West	211
	Kildare/West Wicklow	379
AREA 8		666
	Laois/Offaly	217
	Longford/Westmeath	63
	Louth	158
	Meath	228
AREA 9		1137
	North Dublin	770
	Dublin North Centre	36
	North West Dublin	331
Total		**5839**

Table 32: Applications for Assessment of Need (Social Care)

PCRS	Complaints received 2017	Complaints excluded under Part 9 of the Health Act 2004	Anonymous	Resolved informally	Withdrawn	Resolved through formal investigation ≤30 working days	Resolved through formal investigation ≥30 working days	% Resolved ≤30 working days	Resolved through Mediation
Total	139	0	0	12	43	84	0	69%	0

Table 33: PCRS Complaints resolved 2017

Complaint Categories: CHOs

Community Health Organisation (CHO)

Community Health Organisation	Access	Dignity and Respect	Safe and Effective Care	Communication and Information	Participation	Privacy	Improving Health	Accountability
CHO 1	227	72	81	95	9	7	21	15
CHO 2	124	34	48	24	4	2	4	3
CHO 3	16	18	7	8	0	0	0	3
CHO 4	94	74	146	50	10	16	39	12
CHO 5	79	10	12	5	0	3	0	2
CHO 6	29	31	30	20	1	2	4	2
CHO 7	36	38	41	50	0	6	3	0
CHO 8	905	111	104	93	1	5	2	10
CHO 9	163	81	143	89	3	17	2	15
Total	**1673**	**469**	**612**	**434**	**28**	**58**	**75**	**62**

Community Health Organisation 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
CHO 1	11	1	8	0	0	2	0	1
CHO 2	6	0	4	1	0	2	0	1
CHO 3	0	0	0	0	0	0	0	0
CHO 4	22	1	36	3	0	6	0	8
CHO 5	2	0	0	0	0	0	0	0
CHO 6	6	1	0	0	0	0	0	0
CHO 7	3	0	0	0	0	0	0	0
CHO 8	20	0	2	0	0	0	0	1
CHO 9	38	1	0	1	0	2	0	1
Total	**108**	**4**	**50**	**5**	**0**	**12**	**0**	**12**

Table 34: CHOs Complaints Categories 2017

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	744	0	0	0	0	0	0	0
Assessment of Need Nationally (across all CHOs) 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**
AoN	0	0	0	0	0	0	0	0

Table 35: AoN Complaints Categories 2017

Primary Care Reimbursement Service (PCRS)

Breakdown not supplied by PCRS

Complaints by Divisions: CHOs

Community Health Organisation (CHO)	Social Care	Primary Care	Mental Health	Health and Wellbeing
CHO 1	310	128	34	0
CHO 2	76	107	32	0
CHO 3	6	26	19	1
CHO 4	254	76	70	16
CHO 5	38	13	10	0
CHO 6	29	24	24	10
CHO 7	0	83	9	0
CHO 8	140	872	125	1
CHO 9	143	259	75	0
Total	**996**	**1588**	**398**	**28**

Table 36: CHOs Complaints by Division 2017

Complaints Reported per CHO by Service

Assessment of Need Nationally (across all CHOs) 2017

Assessment of Need Nationally (across all CHOs)	Social Care	Primary Care	Mental Health	Health and Wellbeing
AoN	744	0	0	0

Table 37: AoN Complaints by Division 2017

Primary Care Reimbursement Service (PCRS) 2017

Primary Care Reimbursement Service	Social Care	Primary Care	Mental Health	Health and Wellbeing
PCRS	0	139	0	0

Table 38: PCRS Complaints by Division 2017

Voluntary Hospitals and Agencies Complaints Data

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.

In 2017 Complaints Data relating to Voluntary Hospitals was collected and collated bi-annually by each Consumer Affairs region.

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)

Complaints Received/Resolved: Voluntary Hospitals

Voluntary Hospitals within Hospital Groups	Complaints received 2017	Complaints excluded under Part 9 of the Health Act 2004	Anonymous	Resolved informally	Withdrawn	Resolved through formal investigation ≤30 working days	Resolved through formal investigation ≥30 working days	% Resolved ≤30 working days	Resolved through Mediation
CHG Voluntary Hospitals	1415	0	0	167	0	1037	181	85%	0
DMHG Voluntary Hospitals	3071	1	10	1802	4	1051	151	93%	0
IEHG Voluntary Hospitals	1744	1	0	1164	15	294	248	84%	2
RCSI Voluntary Hospitals	827	0	0	15	4	712	77	88%	0
Saolta Voluntary Hospitals	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
SSWHG Voluntary Hospitals	153	4	0	1	2	124	19	82%	1
ULH Voluntary Hospitals	15	0	0	3	2	9	1	80%	0
Total	**7225**	**6**	**10**	**3152**	**27**	**3227**	**677**	**88%**	**3**

Table 39: Complaints reported: Voluntary Hospitals within Hospital Groups 2017

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	490	39	414	340	12	30	19	53
DMHG Voluntary Hospitals	1197	225	1358	1104	21	36	39	176
IEHG Voluntary Hospitals	566	86	470	928	12	10	11	80
RCSI Voluntary Hospitals	451	64	338	289	6	18	6	48
SSWHG Voluntary Hospitals	47	34	60	36	2	6	1	11
ULH Voluntary Hospitals	2	7	6	0	0	0	0	0
Total	**2753**	**455**	**2646**	**2697**	**53**	**100**	**76**	**368**

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	88	0	0	0	0	0	0	0
DMHG Voluntary Hospitals	0	0	0	0	0	0	0	0
IEHG Voluntary Hospitals	26	0	0	0	0	0	0	1
RCSI Voluntary Hospitals	33	0	0	0	0	0	0	0
SSWHG Voluntary Hospitals	0	0	0	0	0	0	0	0
ULH Voluntary Hospitals	0	0	0	0	0	0	0	0
Total	**147**	**0**	**0**	**0**	**0**	**0**	**0**	**1**

Table 40: Complaints Categories reported: Voluntary Hospitals within Hospital Groups 2017

Other Voluntary Hospitals & Agencies

In 2017 Complaints Data relating to Voluntary Hospitals & Agencies was collected and collated bi-annually by each Consumer Affairs region. A number of large national agencies returned data directly to the National Complaints Governance and Learning Team.

Other Voluntary Hospitals & Agencies	Complaints received 2017	Complaints excluded under Part 9 of the Health Act 2004	Anonymous	Resolved informally	Withdrawn	Resolved through formal investigation ≤30 working days	Resolved through formal investigation ≥30 working days	% Resolved ≤30 working days	Resolved through Mediation
	4131	173	29	3095	69	566	294	89%	83

Table 41: Complaints reported: Other Voluntary Hospitals and Agencies 2017

Complaints Categories: Other Voluntary Hospitals & Agencies

Other Voluntary Hospitals & Agencies	Access	Dignity and Respect	Safe and Effective Care	Communicat-ion and Information	Participation	Privacy	Improving Health	Accountability
	752	1150	950	699	137	118	104	187
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 Vulnerable Persons**
	114	45	31	14	125	26	49	252

Table 42: Complaints Categories reported: Other Voluntary Hospitals and Agencies 2017

Hospital Groups

Complaints received by Hospital Group per 100,000 bed days

Hospital Group	Complaints reported 2017	Bed Days	Complaints per 100000 bed days
Childrens Hospital Group	1415	101102	1400
University Limerick Hospital Group	559	255500	219
Saolta Statutory Hospital Group	1440	621890	232
South/South West Hospital Group	1136	651820	174
Dublin Midlands Hospital Group	3499	667463	524
RCSI Hospital Group	1376	570963	241
Ireland East Hospital Group	2648	861555	307

Table 43: Complaints received by Hospital Group per 100,000 bed days

2017 Bed Days per Hospital

Hospital	Bed Days
Bantry General Hospital	18586
Beaumont Hospital	230974
Cappagh National Orthopaedic Hospital	27541
Cavan General Hospital	77971
Children's University Hospital Temple Street	29295
Connolly Hospital - Blanchardstown	93087
Coombe Women and Infants University Hospital	54672
Cork University Hospital	197585
Cork University Maternity Hospital	55033
Croom Hospital	8250
Ennis Hospital	20859
Galway University Hospitals	244903
Letterkenny University Hospital	106425
Lourdes Orthopaedic Hospital Kilcreene	4803
Louth County Hospital	59
Mallow General Hospital	16790
Mater Misericordiae University Hospital	294845
Mayo University Hospital	90514
Mercy University Hospital Cork	67189
Midland Regional Hospital Mullingar	64372
Midland Regional Hospital - Portlaoise	43594
Midland Regional Hospital - Tullamore	61516
Naas General Hospital	66588
National Children's Hospital at Tallaght Hospital	11849
National Maternity Hospital	39481
Nenagh Hospital	17645
Our Lady of Lourdes Hospital Drogheda	120543
Our Lady's Children's Hospital, Crumlin	59958
Our Ladys Hospital - Navan	32698
Portiuncula University Hospital	50848

Roscommon University Hospital	18483
Rotunda Hospital	48329
Royal Victoria Eye and Ear Hospital	5223
Sligo University Hospital	110717
South Infirmary/Victoria University Hospital Cork	24264
South Tipperary General Hospital	61519
St. Columcille's Hospital	36661
St. James's Hospital	238708
St John's Hospital	23963
St. Luke's Hospital Kilkenny	79325
St. Luke's Radiation Oncology Network	42537
St. Michael's Hospital	22933
St. Vincent's University Hospital	189550
Tallaght Hospital - Adults	159848
University Hospital Kerry	70675
University Hospital, Limerick	154704
University Hospital Waterford	135376

Table 44: Bed days per Hospital

2017 Complaints Reported per 100,000 Bed Days per Hospital

Bed Days	Hospital	Complaints Reported	Complaints reported per 100,000 bed days
294845	Mater Misericordiae University Hospital	1472	499
244903	Galway University Hospitals	937	383
238708	St. James's Hospital	1378	577
230974	Beaumont Hospital	736	319
217142	Sligo Letterkenny University Hospital	210	97
197585	Cork University Hospital	117	59
189550	St. Vincent's University Hospital	0	0
159848	Tallaght Hospital - Adults	1531	958
135376	University Hospital Waterford	616	455
120543	Our Lady of Lourdes Hospital Drogheda	324	269
93087	Connolly Hospital - Blanchardstown	63	68
90514	Mayo University Hospital	180	199
79325	St. Luke's Hospital Kilkenny	188	237
77971	Cavan General Hospital	134	172
70675	University Hospital Kerry	96	136
68926	Wexford General Hospital	87	126
67189	Mercy University Hospital Cork	83	124
66588	Naas General Hospital	121	182
64372	Midland Regional Hospital Mullingar	161	250
61519	South Tipperary General Hospital	28	46
61516	Midland Regional Hospital - Tullamore	193	314
59958	Our Lady's Children's Hospital, Crumlin	894	1491
55033	Cork University Maternity Hospital	110	200
54672	Coombe Women and Infants University Hospital	104	190

50848	Portiuncula University Hospital	78	153
48329	Rotunda Hospital	91	188
43594	Midland Regional Hospital - Portlaoise	114	262
42537	St. Luke's Radiation Oncology Network	58	136
39481	National Maternity Hospital	109	276
36661	St. Columcille's Hospital	21	57
32698	Our Lady's Hospital - Navan	447	1367
29295	Children's University Hospital Temple Street	301	1027
27541	Cappagh National Orthopaedic Hospital	48	174
24264	South Infirmary/Victoria University Hospital Cork	70	288
22933	St. Michael's Hospital	26	113
18586	Bantry General Hospital	5	27
18483	Roscommon University Hospital	35	189
16790	Mallow General Hospital	6	36
11849	National Children's Hospital at Tallaght Hospital	220	1857
5223	Royal Victoria Eye and Ear Hospital	89	1704

Table 45: Complaints reported per 100,000 bed days per Hospital

NOTE: Returns for University Hospital Limerick are not included in the above list as an Amalgamated return was made inclusive for including UHL, Croom, Ennis, Nenagh, University Maternity Hospital

Bed Days	Hospital	Complaints Reported	Complaints reported per 100,000 bed days
255500	University of Limerick Hospital Group	559	219

2016 Census Data: General Population

State	4,761,865
Carlow	56,932
Dublin	1,347,359
Kildare	222,504
Kilkenny	99,232
Laois	84,697
Longford	40,873
Louth	128,884
Meath	195,044
Offaly	77,961
Westmeath	88,770
Wexford	149,722
Wicklow	142,425
Clare	118,817
Cork	542,868
Kerry	147,707
Limerick	194,899
Tipperary	159,553
Waterford	116,176
Galway	258,058

Leitrim	32,044
Mayo	130,507
Roscommon	64,544
Sligo	65,535
Cavan	76,176
Donegal	159,192
Monaghan	61,386

Table 46: 2016 population census - County

Community Health Organisations

Complaints received to Community Services per 100,000 general population

County	Area	Complaints received/ recorded	Population	Complaints per 100,000
Carlow	CHO 5	8	56,932	14
Cavan/Monaghan	CHO 1	169	137,562	123
Clare	CHO 3	20	118,817	17
Cork	CHO 4	283	542,868	52
Donegal	CHO 1	177	159,192	111
Dublin, Kildare, Wicklow*	CHO 6 / CHO 7 / CHO 9	778	1,712,288	45
Galway	CHO 2	92	258,058	36
Kerry	CHO 4	118	147,707	80
Kilkenny	CHO 5	21	99,232	21
Leitrim	CHO 1	0	32,044	0
Limerick	CHO 3	40	194,899	21
Louth	CHO 8	165	128,884	128
Meath	CHO 8	821	195,044	421
Longford, Laois, Offaly, Westmeath*	CHO 8	165	292,301	56
Mayo	CHO 2	91	130,507	70
Roscommon	CHO 2	34	64,544	53
Sligo	CHO 1	138	65,535	211
Tipperary	CHO 3 / CHO 5	77	159,553	48
Waterford	CHO 5	22	116,176	19
Wexford	CHO 5	2	149,722	1
* Amalgamated local return				
** 15 complaints unassigned to county by CHO 4				
Complaints recorded/reported by CHOs				

Table 47: Complaints received to Community Services per 100,000 general population

Complaints reported by County per CHO Division per 100,000 general population

County	Population by County (2016 Census)	CHO Complaints by County per 100,000	Social Care - Complaints per 100,000	Primary Care - Complaints per 100,000	Mental Health - Complaints per 100,000	Health & Wellbeing - Complaints per 100,000
Carlow	56,932	14	0	2	0	0
Cavan/Monaghan	137,562	123	89	28	6	0
Clare	118,817	17	3	8	3	0
Cork	542,868	52	31	9	8	3
Donegal	159,192	111	68	39	4	0
Dublin, Kildare, Wicklow*	1,712,288	45	10	21	6	1
Galway	258,058	36	6	25	3	0
Kerry	147,707	80	58	8	17	0
Kilkenny	99,232	21	4	1	2	0
Leitrim	32,044	0	0	0	0	0
Limerick	194,899	21	1	8	7	0
Louth	128,884	128	33	26	68	1
Meath	195,044	421	48	373	0	0
Longford, Laois, Offaly, Westmeath*	292,301	56	1	38	13	0
Mayo	130,507	70	29	31	10	0
Roscommon	64,544	53	34	5	17	0
Sligo	65,535	211	119	43	29	0
Tipperary	159,553	48	22	2	2	1
Waterford	116,176	19	0	8	6	0
Wexford	149,722	1	0	0	0	0

Table 48: Complaints reported by County per CHO Division per 100,000 general population

Breakdown of % Variance of complaints from 2016 to 2017

Service	Complaints	Excluded	Anonymous	Resolved informally	Withdrawn	Formal ≤30 wds	Formal ≥30 wds	% Resolved ≤30 wds	Mediation	2016	% Change from 2016
DMHG Statutory Hospitals	428	11	3	192	2	158	76	82%	0	485	**-12%**
IEHG Statutory Hospitals	904	0	5	459	6	245	171	78%	2	1253	**-28%**
RCSI Statutory Hospitals	549	2	3	174	14	270	88	81%	1	533	**+3%**
Saolta Statutory Hospitals	1440	1	0	637	31	472	236	77%	4	1310	**+10%**
SSWHG Statutory Hospitals	983	34	2	343	8	280	475	63%	0	1033	**-5%**
ULH Statutory Hospitals	544	0	0	50	0	199	242	46%	0	405	**+34%**
CHG Voluntary Hospitals	1415	0	0	167	0	1037	181	85%	0	1376	**+3%**
DMHG Voluntary Hospitals	3071	1	10	1802	4	1051	151	93%	0	2566	**+20%**
IEHG Voluntary Hospitals	1744	1	0	1164	15	294	248	84%	2	2060	**-15%**
RCSI Voluntary Hospitals	827	0	0	15	4	712	77	88%	0	919	**-10%**
SSWHG Voluntary Hospitals	153	4	0	1	2	124	19	82%	1	32	**+378%**
ULH Voluntary Hospitals	15	0	0	3	2	9	1	80%	0	151	**-90%**
CHO 1	484	6	2	289	4	173	28	95%	0	516	**-6%**
CHO 2	217	3	2	73	4	36	29	50%	31	256	**-15%**
CHO 3	63	0	0	18	4	18	17	57%	0	155	**-59%**
CHO 4	416	15	1	268	8	51	66	77%	0	472	**-12%**
CHO 5	127	0	1	42	5	40	18	65%	0	148	**-14%**
CHO 6	118	6	0	62	4	36	4	83%	0	196	**-40%**
CHO 7	164	3	2	56	15	43	35	60%	0	224	**-27%**
CHO 8	1151	0	10	960	24	162	68	97%	0	1542	**-25%**
CHO 9	496	7	2	229	15	141	85	75%	2	475	**+4%**
AoN	742	0	0	0	185	6	337	1%	0	1119	**-34%**
NAS	58	2	0	0	2	26	2	45%	2	92	**-37%**
PCRS	139	0	0	12	43	84	0	69%	0	63	**121%**
Other Vol Hospitals & Agencies	4131	173	29	3095	69	566	294	89%	90	5705	**-28%**

Table 49: Summary Table of Variance 2017 to 2016

Complaint Categorisation

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
	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
		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
	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
	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
	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 50: Complaints Classification

Appendix Two: National Steering Committee Members for Your Service Your Say Policy

Ms June Boulger	National Lead for Patient and Public Partnership, Acute Hospitals, Division, HSE
Mr Gerry Clerkin	Head of Quality and Safety, National Social Care Division, HSE
Ms Emer Doyle	Investigator, Office of the Ombudsman
Ms Geraldine Doyle	Operations Manager, Prosper Fingal
Ms Ursula Galvin	Corporate Administration Manager, St. Michael's House
Ms Carol Hickey	Business and Performance Information Manager, Quality Assurance and Verification Division, HSE
Ms Aoife Hilton	Senior Manager, National Complaints Governance and Learning Team, Quality Assurance and Verification Division, HSE
Ms Deirdre Hyland	Mental Health Information Officer, Mental Health Commission
Ms Sinead Kelleher	Senior Manager, National Complaints Governance and Learning Team, Quality Assurance and Verification Division, HSE
Ms Loretta Jenkins	National Patient Safety Office, Department of Health
Ms Debbie Keyes	Regional Manager, Consumer Affairs, HSE
Ms Deirdre McNamara	National Complaints Governance and Learning Team, Quality Assurance and Verification Division, HSE
Mr Stephen McMahon	Irish Patients Association
Ms Anne McMenamin	National Clinical Strategy and Programmes, HSE
Ms Eleanor Mann	Complaints Officer/Business Manager, UL Hospital Group, HSE
Ms Caitriona Meehan	Communications Manager, Saolta University Health Care Group, HSE
Ms Suzanne Moloney	Senior Manager, National Complaints Governance and Learning Team,
Ms Shirley Murphy	Project Manager, National Complaints Governance and Learning Team, Quality Assurance and Verification Division, HSE
Ms Ciara Norton	National Patient Safety Office, Department of Health
Ms Sheila O'Connor	Patient Focus
Ms Anne Marie Oglesby	National Quality and Patient Safety Manager, National Ambulance Service, HSE
Mr Liam Quirke	Regional Manager, Consumer Affairs, HSE
Ms Susan Reilly	National Patient Safety Office, Department of Health
Mr Christopher Rudland	Executive Lead, National Complaints Governance and Learning Team, Quality Assurance and Verification Division, HSE
Ms Angela Tysall	National Lead for Open Disclosure, Quality Improvement Division, HSE

Special thanks to the Health Service Trade Unions who consulted with the HSE on the development of the Your Service Your Say Policy and associated Guidance Manual.