Complaint Handling in the Health Sector Seminar

Workshop Feedback

How can we optimise our structures and processes to improve the complaint handling experience?

Make clinicians pay for redress if they are at fault
Streamline processes
WG conducted a review of complaints processes but the report was never published – where is this? (ask AH from listening and learning group)
Put a process in place for monitoring clinician responses
Need to look inside organisation
Need input from people who can influence change
Need a national route for further consideration of
Links between networks
Give staff skills and permission to address concerns
Tendency for clinicians sometimes to engage more with formal and / or PSOW complaints rather than the informal or standard complaints process
Showing generic learning – there is a need to improve how this is done across the HB
HB structures can work against a smooth and streamlined learning
Often difficult to evidence and describe learning
Complaints often seen as a 'bolt on' for clinical staff; rather than part of the core element of jobs
Revalidation and appraisal – need to ensure that complaints are discussed
Promote and increase ownership
Ensure responses and investigations include any staff and their feedback/contribution
Final letter must reflect the statements / contribution of staff in the correct context

Can all shortfalls in complaint handling be address through attitude / communication and documentation
Offering meetings to address 'second responses'
Having insight and managing people individually or as individuals
Consistency within LA may have impact on health e.g. ABUHB has 5 different Las
One point of contact to simplify
Factsheets given to complainants at start of investigation

How can we learn from each other on improvements to complaint handling?

Being open and learning from each other
Sharing knowledge e.g. how many complaints is a good number for a complaint handler
Hold more events like this – need to get people in a room together to have discussions
Use QA groups internally
Through various groups – need to get the right level and have those involved who do the investigation not those who just sign off the complaint letter
Using similar cases as case studies (hot topics) – focusing on what body did to improve / how complaint was managed / how response was created / how effective it was
Having access to good complaint responses
Look at the listening and learning group – has it met its goal? What next for the group?
Cross border / boundary information sharing
What are we doing right and how can we replicate 'good'
Ensuring lessons learned across HBs
Dataset – communality fir subjects (Betsi/ABM/Velindre) – pilot coming to an end with a view to adopting across Wales
Merit for exchange between officers on different levels including those dealing with complaints

What are the barriers to preventing ground hog day?

Processes even internally are very different
Getting clinicians on board
Getting service buy in from all staff not just clinicians
Need a strong clinical/medical/nurse director team to lead/guide
Forward planning important
Culture and engagement of staff moving away from only letting complaints staff deal with complaints
How realistic is your target when you are dependent on 3rd party?
Culture
Control
Good investigation should involve staff – impact of deadline on staff involvement (records / staff absence)
Consistency of approach by health boards on grading concerns
Delay - explanations and reasons communicated / trying to document actions / contact
New IT system – action points sent to investigation
Too focused on complaints that have 'failed'
Cut backs / limited resources / staff delivering on multiple roles / clinical demands are increasing for frontline operational staff
Links with process and system – demands and monitoring / auditing rather than sorting the problem
Datix industry – impact on operational staff
It is about individual responsibility and managing people's expectations
Not enough staff delivering care
Too much emphasis on systems

Is it fear stopping us move forward – culture or is it a JDI?
Time/resource
Difficulty getting agreement of senior officers
Need to have volunteers /identify and allow different people the opportunity

What steps can we take to increase awareness and accountability for complaints throughout our services?

Clinicians need to take ownership
Agree questions at start of complaint
Ask clinical board to give response and draft letter
Decide who owns complaint
Reg. Requirements. Expected to put in to responses
Manage expectations
Length of complaint period
Impact on partiality – contact with complainants
How measure complaint response – quality v time
Set realistic targets
What happens if you know up front that it will take longer?
How you interpret regs 30 days / 6 months
Poor performance on complaints sits with complaints team not clinician
How realistic is your target when you are dependent on 3rd party?
Different attitude by clinicians to complaints
Underlying pressure

Ownership but no control
No pause button
How to regain control of complaints?
Escalation process
Does delivering PTR responses / investigations etc rest with those clinicians who are already delivering multiple roles and delivering care
Room for integrated responses – health / LA

Can the Scottish CSA approach work in Wales?

Depends on numbers
Networks have authority in Scotland but how would that work in Wales as it wouldn't have same power to change policies
Wales is in a different starting position as already has some networks and a model complaints policy (PTR)
Wales works to legislation; Scotland works to procedure which networks can change
There is a place for a strong concerns network in wales with WG rep sat on it but independent from WG
Network needs to provide benefit or be a vehicle for change or members won't prioritise it
Networks would work in Wales; there is a desire to develop – ownership / content / location / theme groups so correct people attend
Challenges of devolved government
Issues of consistency across Wales
Great if it could work but structural differences between health boards
Getting the right people in the room - how things are done / what works well/ what doesn't work well
Messages going back and power to implement

What each health board wants in clear terms of reference
Difference between how departments and health boards tackle complaints
Can share some practice to reach similar outcome if journey different
Need to decide what is good practice and how to recognise it
Good practice needs a bit of everything – quality / time / process
Tell people at beginning what to expect
Terms of reference for CSA set by sector (SPSO input) – PSOW wouldn't get involved
Should PSOW have a strong voice in the group? How involved should it get?
Process to capture info and share via CSA
PSOW have involvement when necessary
CSA is well supported but need to ensure it isn't just another level of bureaucracy
Relevance in terms of practice learning
Decision-making
Primary care- the current PTR process is not fit for purpose for the patient
Yes – all working to PTR in Wales but there is so much variation
Would an all Wales operational policy support standardisation of approach
Clarity/interpretation of WG reportable incidents to ensure standardised approach
Clarification of informal/formal – Cwm Taf triage process
Do we need to evaluate regs?
Has PTR benefited patients? Should look at Scottish model
PTR does give us a structure and process – it's not always wrong
Needs focus at the groups – listening & learning (Evans Review) / some sub-groups – discrete projects (inconsistency due to staff changes / too many issues / how HBs interpret regs)
Do we need consensus – board level buy in?

Working to regs causes complexity
NQS forum for widespread approval

What lessons can we take forward?

Need to have protected time for networks
Establish an online forum to discuss issues anonymously
Difficult to maintain momentum if no changes will come of the group
Forward planning is key – meeting dates
Need clear terms of reference / aims
Needs good communications around it
Work together – collaborative approach
Link between unhappy with process v unhappy with outcome
Difficulties with survey
SPSO survey an outcome