Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	6 September 2016
Officer	Interim Director for Adult and Community Services
Subject of Report	**Fobbed Off – Some experiences of making a complaint about NHS Foundation Trusts in Dorset.**
Executive Summary	People's experiences of what happens when they raise a concern or complaint about a service they have received from the NHS has been of particular interest for the Healthwatch network nationally. In 2014 our national body, Healthwatch England, published "Suffering in Silence", setting out what people had told local Healthwatch around the country about their experience of making a complaint. It highlighted the importance of listening and learning when care goes wrong and handling complaints effectively. In 2015, responding to the work in this area done by Healthwatch, the Secretary of State for Health made clear his belief that more could be done on the local scrutiny of complaints handling. In that context Healthwatch Dorset approached the four NHS Foundation Trusts in Dorset with a proposal that we invite everyone who had brought a formal complaint against any of those Trusts in 2015 to share with us their experiences of the complaints process and to highlight any issues that some may have faced in that process. With the involvement of three Trusts our survey was carried out in the early months of 2016. This report sets out what those who responded to our survey told us. Before publication, we shared this report with the NHS Trusts concerned and invited each of them to respond to it. We reproduce their responses at the end of the report.

Impact Assessment:	Equalities Impact Assessment: NA
	Use of Evidence: Report provided by Healthwatch Dorset.
	Budget: NA
	Risk Assessment: NA – Not Dorset County Council report.
	Other Implications: None.
Recommendation	That the Committee consider and comment on the findings and recommendations contained within the report.
Reason for Recommendation	The work of the Health Scrutiny Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of all Dorset's citizens.
Appendices	1 Healthwatch Dorset report: Fobbed Off – Some experiences of making a complaint about NHS Foundation Trusts in Dorset
Background Papers	None.
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healthwatch Dorset

Appendix 1

Fobbed Off

Some experiences of making a complaint about NHS Foundation Trust services in Dorset

Table of Contents

PREFACE

Two years ago, in one of our very first reports – "Every One Matters" – we drew attention to the wide variation in the standard of care that local people reported to us. We said then, "At its best, the quality of…care in the NHS is second to none". But also, "At its worst… (it can end up) denying people…the most basic standards of care and dignity".

The causes of that disparity are many, not least the unprecedented pressures and challenges our NHS faces today, categorised most starkly by the juxtaposition of rising demand, cost and expectations with constrained resources.

Nevertheless, the fundamental principle of the NHS remains – that every single person should receive the best possible service, free at the point of delivery.

In any large, complex organisation there will inevitably be times when things go wrong. Some of the measures of an organisation are how willing it is then to listen, to empathise and not justify; how well and how quickly things are recognised and put right; and how speedily things are put in place to make sure it doesn't happen again.

People's experiences of what happens when they raise a concern or complaint about a service they have received from the NHS has, from the beginning, been of particular interest for the Healthwatch network nationally. In 2014 our national body, Healthwatch England, published "Suffering in Silence", setting out what people had told local Healthwatch around the country about their experience of making a complaint. It highlighted the importance of listening and learning when care goes wrong and handling complaints effectively.

In 2015, responding to the work in this area done by Healthwatch, the Secretary of State for Health made clear his belief that more could be done on the local scrutiny of complaints handling - something in which he hoped local Healthwatch would play "a strong, visible role".

So it is in that context that Healthwatch Dorset approached the four NHS Foundation Trusts in Dorset with a proposal that we invite everyone who had brought a formal complaint against any of those Trusts in 2015 to share with us their experiences of the complaints process and to highlight any issues that some may have faced in that process.

One of the Trusts felt unable to participate this time (the reasons for that are set out below), but with the involvement of the others our survey was carried out in the early months of 2016.

This report sets out what those who responded to our survey told us. Its findings are in line with other studies carried out by local Healthwatch around the country (and with other major national studies, including the Francis Enquiry, the Clwyd-Hart Review and reports from the Parliamentary and Health Service Ombudsman). In some cases, people's experiences of NHS complaints systems and processes are negative. In fact, we were so struck by the fact that a number of our respondents had, quite independently of each other, chosen a particular phrase to sum up their experience that we have made it the title of this report – "Fobbed Off".

This report sets out the facts of the feedback we received from our survey respondents. But we want to make it clear that we do not extrapolate from this to make definitive assumptions about the experiences of those who did not choose to take part. Nor does it allow us to make true comparisons between the NHS Trusts who participated. So we have refrained from suggesting that one Trust may be any better or worse than another in the way that it handles and learns from complaints. The issues are system-wide and not confined to any one organisation.

Before publication, we shared this report with the NHS Trusts concerned and invited each of them to respond to it. We reproduce their responses at the end of the report.

We want all NHS organisations to see complaints as "gold dust", a critical source of intelligence about how to improve services; feedback that should be welcomed as a way to improve how our services treat and care for people.

We look forward to continuing to work closely with our local NHS, to ensure that every person receives the standard of service that they not only deserve but have a right to expect.

We would like to thank all those who contributed to this investigation, in particular the survey respondents who gave their time and effort to tell us about their experiences and the NHS Trusts that took part.

July 2016

REPORT SUMMARY

Healthwatch Dorset has already previously undertaken work to investigate how easy it is for people to make a complaint about their health care (should they need to) and whether they receive the right information and support to do so. This report looks at the other end of the process and asks the question "what was it like to make a complaint?" with a specific focus on complaints made about services provided by the NHS Foundation Trusts in Dorset.

We wanted to find out how people felt about the process of making a formal complaint and whether that process was fit for purpose. We also wanted to be broad in our approach and give everybody who has brought a complaint against one of our NHS Foundation Trusts across Dorset in the previous year (2015) the opportunity to tell us about their experiences of the complaints system. Therefore, we approached all 4 NHS Foundation Trusts in Dorset, Poole and Bournemouth to ascertain their willingness to send out our survey to all patients who had made a formal complaint during 2015. Dorset County Hospital NHS Foundation Trust, The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust and Dorset HealthCare University NHS Trust were very happy to be involved, with one Trust responding "this will help us enhance our existing feedback methods". Poole Hospital NHS Foundation Trust Questionnaire Review Panel decided, after careful deliberation, that they were unable to be involved in a retrospective survey if complainants had not been advised in advance. However, they also stated they would be willing to participate in a prospective study in the future.

- 42% of those who responded to our survey told us that they were not satisfied with the actual process of making a complaint.
- 52% of respondents were not confident that making the complaint would have no adverse effect on any current or future care they might need.
- 78% were not made aware that they could have been supported through the complaints process by an independent advocate.
- 76% said they were not satisfied with the result of the complaint.

We hope that our findings will help our local NHS Trusts to focus on areas that could be improved in order to make people's experience of what can often be a stressful and difficult process a better one.

INTRODUCTION

Healthwatch is the national independent consumer champion for health and social care, established throughout England in 2013 under the provisions of the Health and Social Care Act 2012, with statutory powers to ensure that the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. Healthwatch exists in two distinct forms – local Healthwatch, and Healthwatch England at national level.

Healthwatch Dorset is one of 148 local Healthwatch organisations with a dual role to champion the rights of users of health and social care services and to hold the system to account for how well it engages with the public. The remit of local Healthwatch encompasses all publicly funded health and social care services for both adults and children. Healthwatch Dorset covers the area of the three local authorities of Dorset, Poole and Bournemouth.

Healthwatch Dorset collects feedback on services, from people of all ages and from all parts of the community, through attendance at community events; contact with community groups; comment cards and feedback forms which people send to us in the post; online through web site and social media; from callers to our telephone helpline; and through the Citizens Advice Bureaus in Dorset, Poole and Bournemouth, all of whom offer a face-to-face service. As part of the remit to gather views Healthwatch Dorset also has the power to “enter & view” services and undertake announced or unannounced visits.

BACKGROUND

Every patient has the fundamental right to complain if they are not happy with the care or treatment they have received from an NHS service, or if they have been refused treatment for a condition.

Following on from the report of the Francis Enquiry, much work has been done by various organisations including the Department of Health, Healthwatch England and the Parliamentary & Health Services Ombudsman (PHSO) to review the NHS complaints system and provide recommendations for improvement. We will not repeat or make lengthy references to that work here but have provided links in the References/Bibliography section at the end of this document. We undertook our work to establish the current picture in Dorset (for people making a complaint about care received from any of our NHS Foundation Trusts) and to highlight people's experiences, which we hope will help the Trusts to reflect on whether those recommendations made by organisations such as the PHSO have been actioned where necessary.

METHODOLOGY

After receiving agreement to be involved from 3 out of the 4 NHS Foundation Trusts in Dorset, we developed a survey, using questions already pre-tested and verified (our thanks go to colleagues at Healthwatch Isle of Wight for allowing us to use their survey as a starting point). The survey was developed using our accessible information guidelines. Trusts were invited to comment on the draft survey and their responses/amendments were incorporated into the final version where appropriate. Trusts' Clinical Audit and Information Governance teams were involved in agreeing to the work and we also spoke with the Director of Surveys at Picker Europe to ensure there were no concerns over ethics or confidentiality. The response from Picker was extremely positive with advice for Trusts to ensure they filtered data appropriately.

The Trusts provided us with the number of patients who had made a formal complaint between Jan and Dec 2015. We requested numbers only for those patients whose complaint was now closed. It should be noted that the numbers do not cover EVERY complainant, only those where Trusts had postal addresses and relevant permissions for contact. (Numbers are shown in the Findings section).

The surveys, covering letters and freepost return envelopes were sent to Trusts pre-sealed and stamped in order that each Trust only had to print labels and post the envelopes on our behalf (Trusts could not share patient contact details with us due to data protection and client confidentiality). Healthwatch Dorset covered all costs for developing, printing and sending the surveys.

We also gave every person the opportunity for a phone interview should they wish and we offered home visits. (Note – no respondent requested either of these services). We have included the survey and covering letter as an appendix.

FINDINGS

SUMMARY

The full analysis (figures and percentages) of our survey findings can be found below. Here we provide a summary.

As noted above, it would be unfair to make true comparisons between the NHS Trusts concerned, due to the fact we did not receive exactly the same number of responses for each. We have, therefore, refrained from making any statement suggesting that one Trust may be better or worse than another. However, we have split responses (see the data after this summary) to show the feedback for each individual Trust, which inevitably highlights similarities and differences. Where issues are identified affecting more than one Trust we hope that those Trusts will work together where possible to identify actions for improvement.

1. A total of 764 surveys were sent. 158 people chose to respond (a response rate of 21%).

2. Most people said that their complaint related to quality of treatment, staff attitudes, the patient pathway or access to services.

3. 34% of people found out how to make the complaint by asking PALS (the Patient Advice and Liaison Service run by the NHS Trust). 56% said they were not aware of PALS before making the complaint.

4. 64% felt unable to raise their concerns with staff members before making the complaint.

5. 70% of people said that they were not offered the opportunity to discuss or meet with staff at any point during the process of making the complaint.

6. 51% told us that they found it very easy or easy to find information about how to make the complaint. 17% found it either difficult or very difficult.

7. 78% said that they were not made aware that they could be supported through the process by an independent advocate.

8. 52% told us they did not feel confident that making the complaint would have no adverse effect on any current or future care that they may require.

9. 92% of respondents advised they were able to make complaint in a way that suited them.

10. When asked if they felt concerns raised were being taken seriously from the beginning, 51% said No.

11. 19% told us they had a mutually agreed timescale for the complaint to be resolved, while 33% were given no timescales or dates. Where a timescale was given, 53% told us that those timescales were not met and 79% of those said that they were not provided with a satisfactory response as to why.

12. 54% said that they were kept informed of what was happening with the complaint during the investigation.

13. 74% received their response by letter, although 33% of people told us the method of response was not their chosen method.

14. When asked if the response directly addressed all aspects of the complaint, 61% said No but 65% were given the opportunity to provide their views on the response or to reply. However, 34% of people were not informed of how to proceed if they were not satisfied with the response.

15. 76% said that they were not satisfied with the result of the complaint. People told us they felt that complaints were still unresolved, not handled well and they were unsure if things would improve (this last is reflected in the answer to the question "were you given any information about how things would change so that other people's experiences would be better in the future?" – with 64% of respondents saying No and 91% of those saying they would have liked to receive that information).

16. When asked if they felt the complaint had been handled fairly, 59% said No and 41% said they did not feel they had been treated with kindness and compassion by the people dealing with the complaint.

17. However, 85% said that they would make another complaint in the future if they felt it was necessary.

18. 42% said they were not satisfied with the actual process of making the complaint.

19. When respondents were asked if they had any suggestions about how the process could be improved (full comments can be seen below), the main areas identified were:

    - The language and format of complaint letters.
    - Responses should be within timescales given.
    - Complainants should always be kept informed and complaints should be handled openly, frankly and in a transparent way.
    - Local independent bodies should handle complaints rather than NHS internal processes.
    - There should be more support for people through the process.
    - People would also appreciate being kept informed about actions taken to improve services.

DATA

A total of 764 surveys were sent. Overall response rate 21% (158 returns)

Royal Bournemouth and Christchurch NHS Foundation Trust (RBCH) - 315 sent, 86 returns – response rate 27%

Dorset County Hospital NHS Foundation Trust (DCH) - 230 sent, 36 returns – response rate 16%

Dorset Healthcare University NHS Foundation Trust (DHUFT) - 229 sent, 23 returns – response rate 10%

A number of responses were received that related to more than one Trust:

Combination Poole and RBCH – 4 responses

Combination – Poole, RBCH and DHUFT – 1 response

Combination DCH, Poole and RBCH – 1 response

Combination RBCH and DHUFT – 1 response

Combination DCH and DHUFT – 3 responses

Poole – 1 response received not in combination with other Trusts

Unknown provider – 2 responses received

For the following analysis results for Poole, Unknown and Combined have been amalgamated into the category "Combined"

Question 1. Which NHS Trust and service did the complaint refer to?

Royal Bournemouth and Christchurch NHS Foundation Trust (RBCH)	Service (where known)	No. of responses
	Physiotherapy	1
	Stroke Ward	1
	Haematology	1
	Dermatology	1
	Gastroenterology	1
	ENT	1
	Maternity	2
	Ophthalmology	2
	Oncology	3
	Endoscopy	3
	Cardiology	3
	Gynaecological Dept.	3
	Orthopaedics	4
	A&E	8
	Elderly Care	8
Dorset County Hospital NHS Foundation Trust (DCH)	Service (where known)	Number of responses
	Gynaecological Dept.	1
	Elderly Care	1
	Endoscopy	1
	Gastroenterology	1
	Orthotics	1
	A&E	2

	Urology	2
	Ophthalmology	3
Dorset Healthcare University NHS Foundation Trust (DUHFT)	Service (where known)	Number of responses
	CMHT	1
	Pain Clinic	1
	District Nursing	1
	Gynaecological Dept.	1
	Mental Health (Community Hospital)	2
	Elderly Care	2
	Podiatry	2
	CAMHS	3
	Prison Healthcare	9

Poole	Service (where known)	Number of responses
	Orthopaedics	1

Question 2. Was the complaint on behalf of yourself or someone else?

	RBCH	DCH	DHUFT	Combined	OVERALL
Yourself	71%	97%	65%	54%	**75%**
Someone Else	29%	3%	35%	46%	**25%**

Question 3. What was the nature of the complaint? (Note – respondents could tick more than one) Note – where respondents ticked the given option "other" and provided identifiable information – that information has been included in the figures below

	RBCH	DCH	DHUFT	Combined	OVERALL
Access to services	10%	12%	14%	11%	**11%**
Environment	2%	3%	2%	3%	**2%**
Equality	2%	1%	8%	0%	**3%**
Patient Choice	8%	6%	8%	5%	**7%**
Patient Pathway	11%	19%	10%	29%	**15%**
Staff attitudes	26%	26%	27%	21%	**25%**
Quality of treatment	28%	23%	23%	18%	**25%**
Safety	4%	1%	6%	5%	**4%**
Discharge	9%	9%	2%	8%	**8%**

Question 4. How did you find out about how to make the complaint? (Note – respondents could tick more than one)

	RBCH	DCH	DHUFT	Combined	OVERALL
Checked Trust website	21%	16%	18%	38%	**21%**
Checked leaflet/brochure	6%	11%	9%	15%	**8%**
Asked PALS	43%	35%	9%	15%	**34%**
Asked staff	7%	14%	41%	16%	**14%**
Wrote to CEO	10%	8%	0%	0%	**8%**
Other options	13% (largest 2% via social worker and 2% via legal advice)	16% (largest 5% via GP)	23% (largest 9% through being staff members)	16% (largest 8% through notice board and 8% through being staff member)	**15%**

Note "Other Options" – people told us they had found out via social workers, from GPs, from MPs, from CQC, though legal advice, through previous experience, by writing to the CEO, from Health Visitors, from dentists, through the Independent Monitoring Board, through hospital notice boards, from friends and from being a staff member themselves.

Question 5. Were you aware of the Patient Advice & Liaison Service (PALS) before you made the complaint?

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	47%	42%	35%	46%	**44%**
No	53%	58%	65%	54%	**56%**

Question 6. Before deciding to make the complaint, did you feel you could raise the concerns with any staff members? (2 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	39%	30%	27%	46%	**36%**
No	61%	70%	73%	54%	**64%**

Question 7. Were you (or the patient you represented) offered the opportunity to discuss or meet with staff at any point during the process of making the complaint? (5 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	26%	33%	41%	31%	**30%**
No	74%	67%	59%	69%	**70%**

Question 8. How easy was it to find information about how to make the complaint? (1 no response)

	RBCH	DCH	DHUFT	Combined	OVERALL
Very Easy	29%	14%	8%	0%	**20%**
Easy	28%	34%	39%	31%	**31%**
Neither Easy nor Difficult	31%	35%	23%	46%	**32%**
Difficult	6%	17%	15%	23%	**11%**
Very Difficult	6%	0%	15%	0%	**6%**

Question 9. Did anyone make you (or the patient you represented) aware that you could be supported to make the complaint by an independent advocate? (2 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	23%	20%	31%	8%	**22%**
No	78%	80%	69%	92%	**78%**

Question 10. Did you feel confident that making the complaint would have no adverse effect on any current or future care you (or the patient you represented) may require? (6 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	48%	67%	36%	31%	**48%**
No	52%	33%	64%	69%	**52%**

Question 11. Were you able to make the complaint in a way that suited you (or the patient you represented) e.g. in writing, in person, email etc. (2 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	94%	97%	77%	92%	**92%**
No	6%	3%	23%	8%	**8%**

Question 12. Did you feel the concerns raised were being taken seriously from the time that you raised them? (7 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	51%	53%	45%	27%	**49%**
No	49%	47%	55%	73%	**51%**

Question 13. When raising the complaint were you provided with: (respondents could tick more than one) (7 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
A mutually agreed timescale for the complaint to be resolved	17%	13%	32%	18%	**19%**
A date by which the complaint should be resolved	50%	41%	36%	28%	**44%**
No timescales or dates	30%	41%	28%	45%	**33%**
Other	3%	5%	4%	9%	**4%**

Further to Question 13, respondents were given the option to provide any further comments. Comments have been redacted where necessary (e.g. to protect anonymity).

Trust	Comments
RBCH	No complaint procedure in place and confusing number of names and people involved
	Was informed 1-year time allowed. Felt delaying tactics were used. Replies postponed by letter.
	I made the complaint online and when I submitted the complaint I was told the person I addressed it to had left the trust and the complaint would be dealt with by another person. It wasn't and no reply was received.
	Not met, but kept informed.
	We were give one date by letter, but still had to chase this up as staff were on holiday.
	This date was not complied with or resolved by the due date. I did receive a number of letters telling me of further delays,
	Date was given but not complied with. 3 weeks after date, I emailed to ask for an update. I was told that a reply had been sent to me via email, except they couldn't even copy my correct email address. I did not receive the reply until I asked.
	Attempts of dates for a final review of the complaint has been made multiple times, but there were always problems to approve date and time. Eventually I gave up.
	Can't remember but I was told I would hear by post.
	They did not stick to the dates, fobbed off constantly
	Timescale was not met
	Timescale from RBH but not surgery, who took many weeks to respond
DCH	A meeting with the matron and someone else (which was very good of them)
	Took too long, then said I was informed each time it took too long

	The timescale lapsed for months. I received a phone call out of the blue, months after the complaint, although I received a letter with a date that someone would contact me.
DHUFT	A meeting was arranged without prior warning. Just me and two staff members, very uncomfortable.
	I'm not sure. I was confused with the whole process.
Combined	Both dates given were missed, no further information until I made two telephone calls. Blamed staff sickness for late reply.
	First concerns raised verbally and ignored; raised by my friend for me and listened to. Once in writing, I received a letter to say that Head of Dept. (name of Dept. redacted) was promoted and I will get a reply after a few weeks.

Question 14. Were you kept informed of what was happening with the complaint during the time it was being investigated? (4 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	57%	49%	47%	58%	**54%**
No	43%	51%	53%	42%	**46%**

Question 15. If you were provided with timescales, were these met? (42 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	49%	46%	50%	29%	**47%**
No	51%	54%	50%	71%	**53%**

Question 16. If No (to Question 15), were you provided with a satisfactory response as to why? (Note – 14 respondents did not complete question 15 but did answer Question 16)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	27%	25%	8%	0%	**21%**
No	73%	75%	92%	100%	**79%**

Question 17. How did you receive your response? (Respondents could choose more than one) (6 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
By Letter	78%	77%	59%	68%	**74%**
By Email	9%	0%	3%	16%	**6%**
By Phone	10%	15%	19%	11%	**13%**
In a face to face meeting	3%	8%	19%	5%	**7%**
Other	0%	0%	0%	0%	**0%**

Further to Question 17 respondents were given the option to provide any further comments. Comments have been redacted where necessary.

Trust	Comments
RBCH	Dorset advocacy also came to house
	Only had a letter acknowledging complaint, asking for date of birth.
	Sought by letter, received by delayed email. Not impressed.
	Satisfactory at first by letter but no meeting arranged until Ombudsman intervened
	I requested in my complaint letter, sent by me by email, that I receive a response by email. A paper letter was sent and then after I requested email version, one was sent.
	Received phone call from ward sister. Insisted I had reply from CEO. (redacted)

Question 18. Was this your (or the patient you represented) chosen method of response? (17 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	72%	70%	43%	77%	**67%**
No	28%	30%	57%	23%	**33%**

Question 19. Did the response directly address all aspects of the complaint? (8 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	36%	46%	52%	15%	**39%**
No	64%	54%	48%	85%	**61%**

Question 20. Were you (or the patient you represented) given the opportunity to provide your views on the response or to reply? (8 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	69%	69%	48%	66%	**65%**
No	31%	31%	52%	34%	**35%**

Question 21. Were you informed of how to proceed if you (or the patient you represented) were not satisfied with the response? (7 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	76%	53%	36%	66%	**64%**
No	24%	47%	64%	34%	**36%**

Question 22. Overall were you (or the patient you represented) satisfied with the result of the complaint? (7 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	22%	28%	33%	8%	**24%**
No	78%	72%	67%	92%	**76%**

Further to Question 22, respondents were given the option to provide the reason why they had answered "No". Comments have been redacted where necessary.

Trust	Comments
RBCH	Unresolved, loss of photos of injury, complaints officer unaware of complaints process (redacted).
	Because, in my view, the whole issue was handled appallingly
	Despite being informed all calls are recorded for training purposes, they are actually not. The staff member couldn't recall the contact or what she said. No evidence available.
	Part of reply was incorrect and when I corrected this via email I never received a reply/comment etc.
	The explanations forthcoming were not patient orientated, leaving some of the points raised unclearly explained.
	The complaint was effectively shut down. Inaccurate/dishonest reporting of staff action.
	Do not feel it fully addressed issues. Feel that same problem could happen again. Hospital will complain if patients do not attend appointments, but they cannot organise themselves.
	Quite honestly felt it was a fob off letter.
	Response was contradictory and did not adequately address concerns
	No way of being reassured that training had been given or improvements achieved
	It was a fob off and I am complaining to the Ombudsman
	I am still waiting for outcome
	I felt that the points I raised were not addressed directly, just a general rationalised given.
	They completely failed to address the fact myself and my Doctor saw the changes in my xxx and that the consultant should therefore have been concerned and referred me for a scan but instead just bleated on

	about how they could see nothing untoward, therefore they were not liable for my condition spreading. Made me very angry that they were rallying around and protecting their negligent colleague instead of addressing the view point of my Dr and myself. (redacted)
	Yes, and no because it did address all points but no because the doctor I complained about (his attitude and approach). Perhaps a statement or phone call from him would have been more personal. Instead I have to trust their word that he has taken on board my comments.
	Because of the lack of response initially, too long a period had passed for the complaint to be properly investigated.
	Letter just stated their failings. Staff were very unhelpful at the hospital, no empathy, blaming each other.
	Response did not address issues, late second opinion proved the response incorrect.
	The way I was treated was abhorrent. At no stage did I receive a personal apology for what happened. I was brushed aside several times and the response was unsatisfactory.
	Still felt the reply didn't take into account my true feelings
	We have now had to go via an advocate because we felt the complaint was put on people in the wrong area and brushed under the carpet.
	No, I felt they were not taken seriously.
	Almost all of my concerns were minimised and I felt that no changes for the better would be put in place. I still feel that vulnerable older people will be put at risk.
	After sending required date of birth information, I never heard another thing.
	Letter finally received was very bland, no real apology or response to the problems.
	Still not had a result

	I was greeted with a very aggressive response from Mr X at my next appointment at his clinic. (redacted)
	It was very much lip service, I felt and my family felt that the care was poor. My relative died while in hospital, but it is the care of others that is also my concern.
	I'm still waiting for an outcome from my complaint
	The letter had a usual standard response feel to it. There was no sympathy for my problem expressed.
	No, because I wanted to complain about treatment at Poole. Also, why a consultant took so long to do something (redacted)
	Various listed complaints were not addressed and the main fault became my wife's domain! Apparently, she should not have accepted my discharge, despite raising issues of extreme concern on the day.
	Because what was said by the persons involved was not true
	Not all issues were addressed and no apology
	I do not feel that the impact of the negligence on my life for 4 years was really considered. If I had been given appropriate medication following exam, I would have had 4 normal years.
	Felt the response was defensive, often inaccurate and since the health service ombudsman has got involved, the NHS has conceded points
	The investigating manager appointed didn't contact me when the investigation was delayed. The response didn't answer all my complaints. I was fobbed off.
	8 - 10 months and still waiting
	Time on letter for appointment was x, it was hour and half later before we saw a consultant. The excuse was mix up of paperwork due to change. (redacted)
	Not sure if anything will come from my complaint in regards to improvements
	Not all aspects of the complaint were addressed. Some aspects related to serious nursing practice which did

	not appear to have been addressed. No apology for tardiness of response.
	So biased, didn't address any of the major concerns I had raised. Ridiculously pathetic and subjective.
	Fobbed off- wasted our time on the day and again with response
	Complaint was never answered
	The letter only partly dealt with my concern.
	Trust offered no reassurances or practical actions that would be undertaken to avoid repetition.
	Don't feel it personally responded to all the issues raised. Feel the response was hiding behind guidelines.
DCH	The letter was from a third party at the trust saying Dr (redacted) was sorry. Sorry doesn't help now that I'm left with permanent disability (redacted)
	I went to the hospital to meet Mr X to have my complaint heard but was rushed through and the complaint never heard. (redacted)
	Does not appear to be a significant improvement
	Wasn't taken seriously, complaint was barely addressed. I was just given a series of excuses.
	It did not address the issue of how my medical records were incorrectly annotated and no additional checks made
	My concerns were not answered properly and I felt dismissed. Not happy at all!
	The consultant and his staff were completely exonerated by the CEO, who also reprimanded me for arguing with the consultant.
	Basically provided with a whitewash of my complaints!
	I felt nothing was achieved and attitudes would not change in XX, but a fully apologetic letter received from XX, which was frank and I appreciate that. (redacted)
	Would have liked a personal apology from member of staff involved.

	A delay of 39 days by PALS in responding to questions concerning complaints
	They did not cover the excessive time delay or the fact that a scan would have shown the seriousness of the situation (redacted)
	Because it was my word against theirs (redacted)
	It did not improve the service
	The letter stated that my claims would be looked into. I've heard nothing since.
	The elements of the complaint were brushed to one side. They were touched upon but it did nothing to resolve that the treatment of care would improve.
	After writing on I was sent a holding letter stating that I would receive a response in 4 weeks. I did not receive a response until 7 weeks later. No mention was made of the failed treatment issues (redacted)
	I felt the response was somewhat sarcastic, particularly one paragraph of the letter from the chief executive.
	Quite evident that the whole process was a 'cover our arse' exercise and in no way did it evidence the form of staff attitudes, approach to patient care or quality of care.
	But I feel that the night time discharge of elderly, single people will still go on.
	No one accepted responsibility for the poor service of the complaint
	Wasn't happy with outcome. I was told I would receive an apology from the member of staff. Never came.
	I feel a written apology should have been send direct to myself from the nurse.
DHUFT	Nothing has happened, nurses still treat patients as if they were screws not nurses!!
	I'm on pre-gablin, outside. When in XXX prison I wasn't given them, yet others get them. Now in XXX prison and I have not been given them even though I had an MRI scan and have proof of my back and nerve damage. Others get them here. (redacted)

	Initially the level of care improved but lapsed back to an unacceptable standard after a few weeks and had to complain again
	No one felt that it is appropriate to trust me, an offender with respect, i.e.; turning up 30 mins late to a meeting and not offer an apology.
	I felt that my complaint was the only thing they were interested in and not any mention of support. They simply washed their hands of me.
	The letter was defensive and focused on the process, not on the patient's needs.
	The response I got were empty words, nothing has improved. But then this is a prison HMP XX (redacted)
	I was never told why I had to wait 1 year between appointments
	Almost every issue I raised as being a significant area of concern was refuted. I felt taking the trouble to compose a letter was a complete waste of effort and time. Extremely disillusioned/disappointed
	It was coupled to another issue which made me very cautious and restricted in what I was able to say.
	They didn't take me seriously and still treated me with no respect, causing further distress
Combined	Response to complaint in one area regarding test results which contradicts information provided by the Doctor at the time in A&E. Considering taking complaint to the Ombudsman for further investigation.
	The response received appeared to vindicate the NHS but failed to address the fact that XX was left at risk of self-harm, and indeed did attempt suicide again within 24 hours of being discharged. (redacted)
	Matters raised were twisted and changed in the response received.
	We were placated rather than being listened to.

Question 23. Were you given any information about how things would change so that other people's experiences would be better in the future? (6 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	40%	40%	23%	15%	**36%**
No	60%	60%	77%	85%	**64%**

Question 24. If No, would you have liked that information? Of the 98 people who said they were given no information about how things would change, 93 responded to this question.

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	91%	100%	80%	90%	**91%**
No	9%	0%	20%	10%	**9%**

Question 25. Do you feel the complaint was handled fairly? (18 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	38%	42%	55%	40%	**41%**
No	62%	58%	45%	60%	**59%**

Question 26. Do you feel you (and/or the patient you represented) were treated with kindness and compassion by the people dealing with the complaint? (14 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	57%	66%	54%	66%	**59%**
No	43%	34%	46%	34%	**41%**

Question 27. Do you feel you would make another complaint in the future if you felt it was necessary? (3 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	92%	83%	68%	69%	**85%**
No	8%	17%	32%	31%	**15%**

Question 28. Were you satisfied with the actual process of making the complaint? (5 no responses)

	RBCH	DCH	DHUFT	Combined	OVERALL
Yes	54%	64%	54%	69%	**58%**
No	46%	36%	46%	31%	**42%**

If you have suggestions about how the process could be improved, please state:

Trust	Comments
RBCH	I was very pleased with the process, thank you.
	The process was fine. Hopefully action has been taken to ensure that similar oversights and mistakes do not happen in future
	Reports sent to patients for their information should be in a format and language comprehensive to everyone, not just hospital staff.
	The reply contained inaccurate and incomplete information. Omitted relevant facts. Drew illogical conclusions, protected their own interests and dismissed harm done to me as coincidence.
	Face to face meeting would be more respectful. Staff lied and we needed them to explain their actions with us present
	Hospital should respond in timescales given. They advised complaint had not commenced with an immediate investigation.
	When making a complaint, concerns maybe raised because it is made to an office at the hospital where your complaint is about. This could and would put people off making a complaint to PALS in the first place.
	If the complaints officer dealing with the complaint goes off sick but the complaint is not allocated to anybody else to handle for 6 weeks, this is not really efficient or respectful. In future if complaints officers do go off sick then complaints should be reallocated as soon as possible. I wasn't really treated with kindness or compassion. However the A&E staff member I rang after 6 weeks of no response was helpful in chasing it for me
	Taken seriously when concerned about treatment.
	I was informed at the time I could make a complaint, but not how to do so. In fact, I was adamant that I did not blame the overstretched staff, but the system which treated the patient

	I was dealing with 2 parts of the NHS. In the end they blamed one another and I was left in the middle. Less than an ideal situation I would suggest
	I think more pre-thought could have gone into the process. Everything appeared to be very cold and non-caring
	To be kept up to date with what's going on
	Timescale not met. No monitoring or procedure from manager. Lack of answers, just told to contact Ombudsman.
	To be invited in to talk in person would be so much better. Sometimes it's difficult to express in writing. A follow up to ensure a happy out come as some patients may feel too anxious to take further if they are not happy. Mine was a very emotional matter and face to face therefore would have been better
	The people who deal with complaints are probably first line of defence, therefore their job is to put people off but patients have the right to see justice. XX was uncaring, defensive and downright rude and I worry they could put people off as they'll worry that everyone is like that (redacted)
	I wrote to the CEO and he wrote back. I would have found a face to face conversation helpful as I would have been able to respond directly to his reply.
	The hospital to be frank, open and honest about what went wrong and why
	PALS service was not helpful-did not seem interested in helping. They were chatting about personal stuff when I asked for assistance and I was simply handed a leaflet while they continued their conversation.
	More transparency. Personal apology from the Doctor concerned.
	RBCH never addressed the points in the complaint. CEO was most rude and said they wouldn't answer future emails.
	Management should not ignore patient concerns and try to whitewash and cover up complaints - especially when patients are only trying to help the NHS make

	improvements - those making complaints should not be victimized.
	I do not wish to denigrate PALS. I am articulate enough to make my own representation directly. RBH do not anywhere display an email address for a complaint. I found that the national unit was very helpful in forwarding my complaint to RBH.
	My complaint was not dealt with within the agreed timescale and I continually received letters to extend saying 'they hadn't had time to investigate'. I was never spoken to, or invited to speak to anyone and I should have, considering the way I was treated in xx (redacted)
	It would have been nice to be considered as a human being and not as someone trying to cause problems. A phone call to acknowledge what was happening and not make excuses by letter for staff who cannot be bothered to help.
	Do not dismiss problems because patient is elderly. Do not make promises of action and then do nothing. (redacted)
	To be made aware of actual changes to the service rather than just stating a bunch of failings.
	Still fearful as to how I will be treated next time.
	An answer to my complaint would be good. Here we are 1 year later and I have not had any response to my complaint, apart from the acknowledging letter. My relative has since died.
	The website should be updated as soon as a different person is responsible for particular jobs. A redirection is not good enough.
	The letters received were dated sometimes as much as seven days prior to arrival. There was no discussion of how to improve the patient's care with respect to the complaint. Patient was given excuses.
	I hand delivered all letters to PALS post box outside their office. On one occasion it took 14 days to reach the officer in PALS Dept. I will be contacting the Ombudsman. I feel the whole process reflects that patient views are unimportant at RBH.

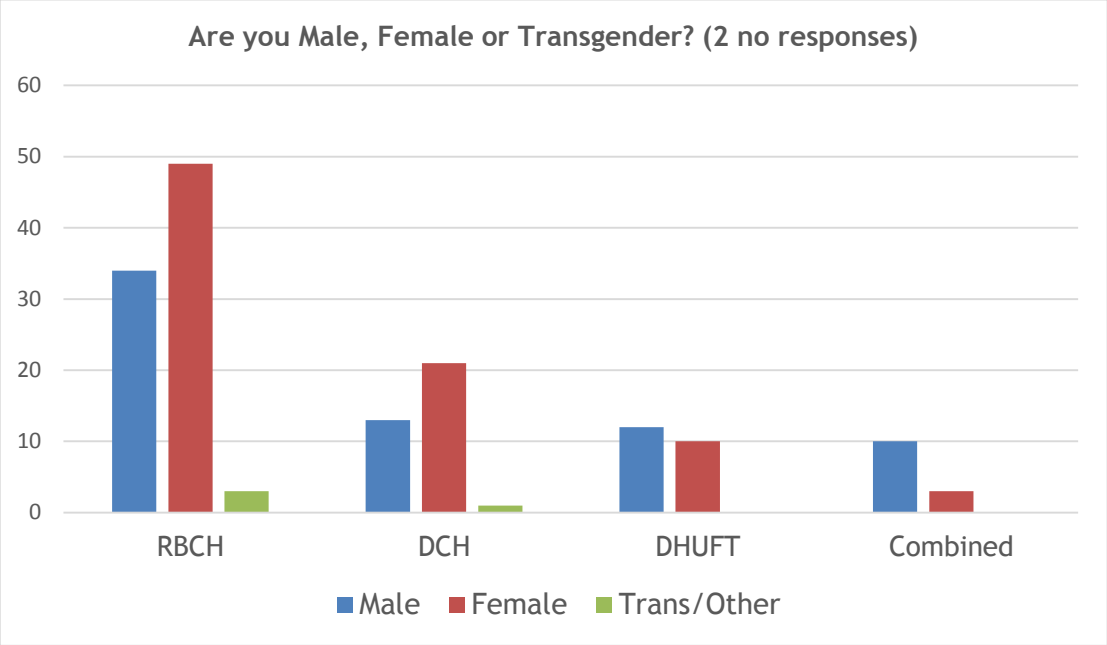
	I feel that the writers response to complaint should include a comprehensive information booklet explaining in detail what to do and when if you have a further complaint.
	I received an initial acknowledgement letter from the complaints manager which was helpful, personal and gave me detailed information about timescales and who would be investigating my complaint. When it was detailed the manager who should be investigating didn't keep me informed of the delay and let the process down.
	Investigating manager should telephone complainant when they are sent the complaint form. The complaints manager would make it more personal if they introduced themselves.
	Tell the truth!
	There should be a clear time limited staged complaints procedure. There should be a named complaints officer who should be responsible for all communications to prevent loss of vital evidence. There should be a reply within 10 days to confirm receipt and explain next steps and who is dealing with complaint
	It becomes the domain of complaints officer whose reply to begin with was offhand and inaccurate. The main most harmful points were left in the 'too hard' basket. More care needed in that department too
	I would have liked the opportunity to discuss the issues with someone - I wasn't offered this. I was cross with the response but did not feel I had the energy to take it any further, plus it caused emotional distress in the family.
	All staff need to be aware of how intimidating it is to patients and relatives asking for help and information. Instead of going to reception. Not knowing who to talk to and being ignored.
DCH	I was incredibly impressed with the matron and other staff member present at our fault finding meeting. Everything was very thorough and dignified. Thank you!

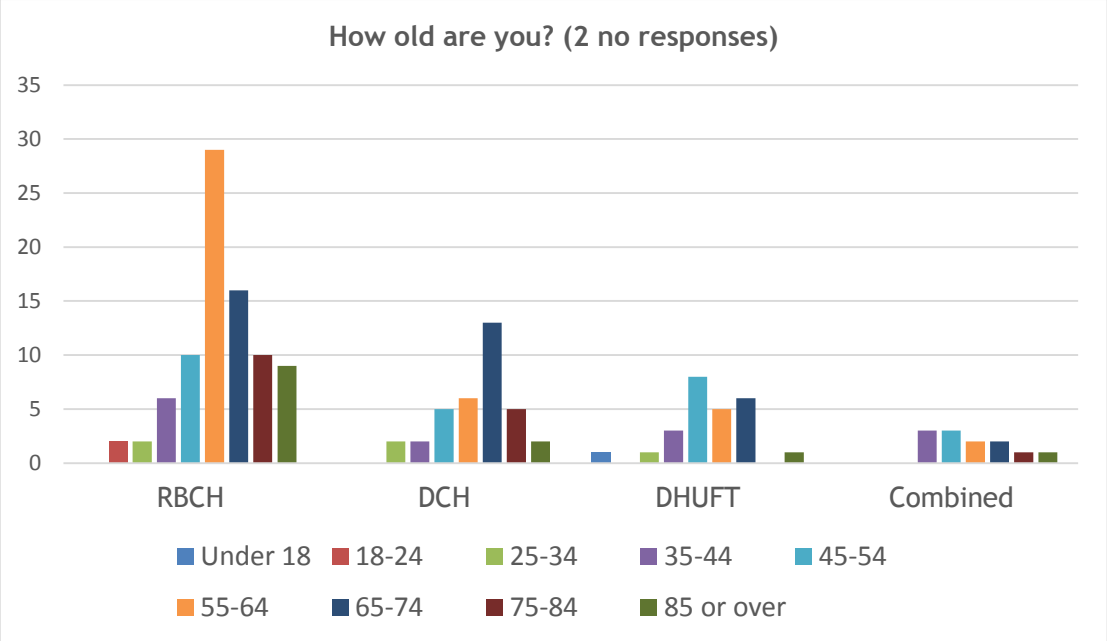
	Staff should understand and respect the severity of complaints. Follow up from staff should also be provided for support.
	I complained in writing and all my complaints were addressed - However, I only have one's word that the issues I had suffered would be put into practice and no one else would be treated like I was, even though I had complained
	My complaint was never heard. I felt that I was not taken seriously and they never addressed my concerns. XX (redacted) was arrogant, rude and showed no concern. The nurse who brought patients into see XX was very unprofessional. The whole event has left me feeling despair and unimportant.
	Because of the complaint I have felt unable to continue treatment. My condition continues and I never self-medicate, however I do not know if my condition deteriorates what I will do. The process was a travesty.
	The whole process needs to be taken out of hospital control and in this so called transparency, the patient given responses (copies) from staff and before a final outcome is reached, allowed to see the details, as points may have been missed or not addressed fully. Needs to stop being a 'cover our arse' exercise and more a real 'patient care' exercise to constantly improve standards.
	The meeting I had, after disagreeing with letter I was sent, would have been better if I could have had the person I complained about present. I think it would be better to be able to face the person, if wanted.
	Speedier response at all stages
	The letter sent giving the response appear to be generic. It did not say what new procedures, if any, would be put in place. Write the letter for my view point and not defensively.
	By answering the complaints in the initial letter we submitted.
	Nurses to show care and compassion. I was treated like a leper. I feel someone should have telephoned me with a follow up appointment to discuss my concerns.

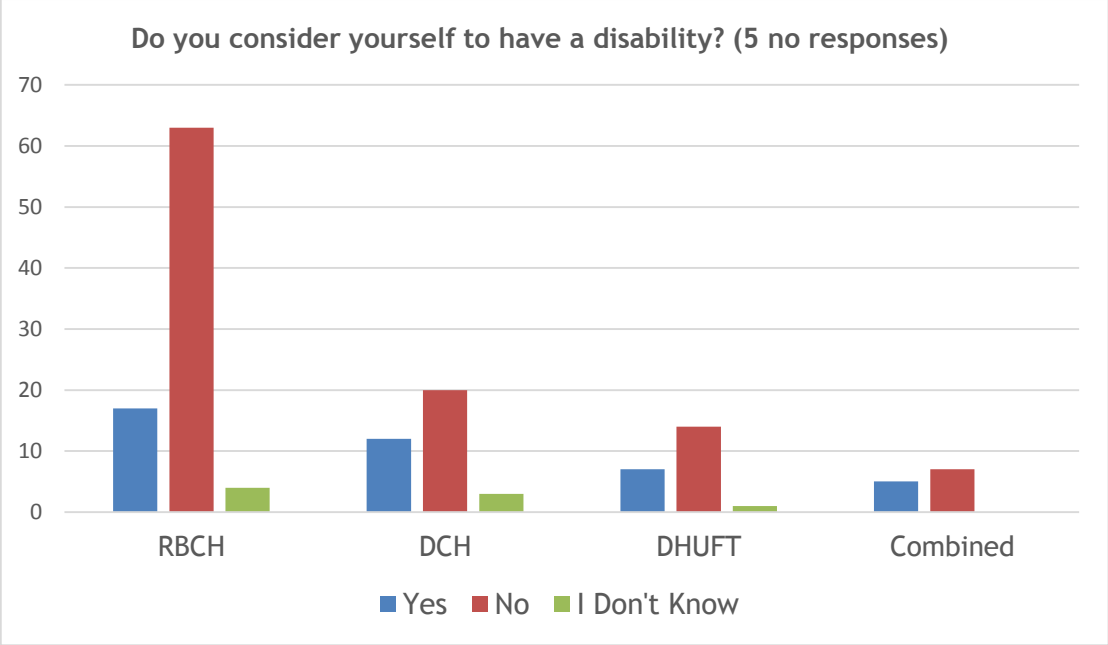
	The progress was ok but the time scales so long it made me feel that complaint was dealt with summarily and not too seriously as no action appeared to be taken except for corporate apology
DHUFT	To engage with imb (Independent Monitoring Board) so complaints got dealt with in the prison service and patients were treated as patients not criminals as their punishment has nothing to do with their health!
	The focus is on the process, not on the outcomes. The complaints are judged against policy and procedure, not against the specific needs of the patient. Funding is a critical issue, but ignored.
	I was certainly listened to. Only one staff member (not from the complaints team), was rude and dismissive.
	Employing consultants who are honest and prepared to accept complaints regarding their practice and during discussion with CEO have the sincerity and patient respect to own up to their failings and apologise. The practitioner involved blatantly lied.
	I'm diagnosed with various mental health disorders, yet was discharged from the CMHT after my complaint. I am left with no support and nowhere to go.
	My complaint was somewhat unusual in that I had been led to believe that a member of staff had discussed my medical history/treatment with an unauthorised person. Upon investigation by XX (redacted), the allegation was found to be untrue, so I withdrew the complaint. XX was extremely professional and kind and handled the whole process excellently.
	How about having a really novel idea of having independent community adjudicators, who have no bias, one way or the other looking at complaints! Makes sense to me!
	The process could be better communicated, dealt with in a timely and impartial way. I had no confidence that any complaint about staff would be treated fairly and was proved right, unfortunately.
	Understand that prisoners are people too. Just because some of us have done bad things, it is not a

	reason for your doctors, in this case, one particular doctor, to consider themselves superior to us and to treat us like some form of sub human life form. Also, stop management staff messing around with things when they are working okay.
	Agree timescale for complaint procedure. Feedback at end of complaint to confirm action taken and agreement to measures put in place.
Combined	Though I saw evidence of an investigation into my complaint, I felt nevertheless that the process was more interested in protecting the NHS and its staff from recognising the very real danger that my relative was left in and the distress caused to the family. We had no interest in playing the blame game, only in ensuring that vulnerable people were better cared for.
	I decided to complain to help improve xxx experience for other people in a similar situation (living in Bournemouth, required care in Poole). I do not think there was any improvement in communication within NHS. There is technology available to exchange information! (redacted)

DEMOGRAPHICS







Respondents were asked to consider which ethnic group they belonged to (from a choice). 97% answered White (British, Irish or any other white background). The remaining 3% considered themselves to be Chinese, Mixed or Any other ethnic group. There were 6 no responses to this question.

CONCLUSIONS & RECOMMENDATIONS

1. Many people told us they were not aware of the PALS service prior to making their complaint and many did not feel able to raise their concerns with staff before making a complaint. If PALS information had been readily available and accessible, it is possible that people could have resolved their concerns at a much earlier stage and been supported and encouraged to talk with staff. In our experience, most people do not wish to make a formal complaint and it can be a difficult and stressful decision to make.

   We recommend that Trusts review the information available to patients, families and carers about PALS, to ensure that from the perspective of patients and families that information is readily available and accessible throughout all services provided by the Trust.

   We also recommend that all staff receive training so that they fully understand the role of PALS. In many circumstances, staff are likely to be already aware that a patient or their relative/carer is unhappy with aspects of their care and they should be empowered to work with patients and families to resolve issues, wherever possible, "in real-time".

2. People said that they weren't given the opportunity to meet with staff during the process.

   We recommend that Trusts consider how they could be more proactive both in giving patients and families the opportunity to meet with staff at the very beginning of the complaints procedure and in supporting and encouraging them to do so. Trusts should be aware that sometimes the complaints process comes across to people as being process-driven rather than person-centred. Some people feel that Trusts "hide behind" procedure. Most people simply want an acknowledgement that something went wrong and an apology for what has happened, and to know that the Trust has learned from it and taken action to ensure that it doesn't happen to someone else.

If this happened more often, we believe that many complaints could be dealt with more quickly, be less stressful for all concerned and would ensure a higher level of satisfaction.

3. Many people told us that they were not informed that they could receive support from an independent advocate.

   We recommend that Trusts not only provide all complainants with information about available independent advocacy services, but also actively ensure that complainants have seen and read that information and have confirmed that they are aware of the support available, should they choose to use it.
   We also recommend that Trusts meet with Dorset Advocacy (the provider of the "Help with NHS Complaints" service in Dorset) to develop an effective process of referral and to discuss how awareness of the advocacy service can be raised.

4. People told us that they did not feel that their concerns were taken seriously. This could reflect the fact that timescales were not met, people were not kept informed as to the progress of the investigation or their chosen method of communication was not used. This causes frustration at an already stressful time and leads to a feeling that Trusts are not being as open and as transparent as they could be.

   We understand that investigating a complaint can sometimes be complicated, with many staff and professionals involved and timescales can slip due to various factors.
   However, **we recommend** that Trusts take steps to ensure that people are always be kept informed as to the progress of their complaint, by their chosen method of communication. If timescales are not going to be met, there should be further communication with the complainant with full and frank reasons for delays made clear.

5. Most people said that they were not told how to proceed if they were not satisfied with the result of their complaint. In fact, the NHS Constitution gives people the right to take their complaint to the Ombudsman if they are not satisfied with the way their complaint has been dealt with by the NHS.

> **We recommend** that Trusts review their procedures to ensure that all complainants are provided with information about what options are open to them if they are not satisfied with the result o*f their complaint, (specifically, information about* the Parliamentary & Health Service Ombudsman).

6. A high percentage of people told us that they felt their complaint had not been handled fairly and they had not been treated with kindness and compassion during the process. We understand that not everyone will be happy with the outcome of their complaint for whatever reason but everyone should be satisfied that the process was fair and everyone should always be treated with kindness, respect and compassion during what is likely to be a very emotional time.

> **We recommend** that staff with any responsibility for handling complaints should be provided with additional/ongoing/updated training in interpersonal and communication skills, to ensure that patients and families receive effective and appropriate support and communication. People will then be more likely to feel that their complaint was fairly handled. Effective ongoing communication at every stage of the process will also go a long way to ensuring that people feel that they are dealing with staff who really care and that their complaint is taken seriously.

WEBSITES REVIEW

Finally, we undertook a review of each Trust's website to establish if information is easy to access, current and comprehensive.

	RBCH	DCH	DHUFT
Where is the information about how to make a complaint found on the site?	Bottom of Home page - "Leave feedback". Bottom of that page "When things don't go to plan". Another click from there to complaints information. Typing in "Complaints" to the site search engine takes you to the "When things don't go to plan" page. You can also get to the same information from the Home page under the tab "Patients and Visitors" then clicking on "Tell us what you think"	Home page - there are 2 tabs "Patients" and "Visitors" both of these have a further link to "Tell us what you think"	Home page - under the tab "Your feedback" then a link to "Compliments & Complaints"
What type of information is provided? Very Basic (e.g. "speak to Practice	Brief Summary. Basic in terms of advised to talk to staff in first instance or to	Comprehensive. Brief info on PALS with a link to their own page. Complaints info	Comprehensive. Page has brief information about PALS and if patient needs

Manager") Brief Summary (e.g. "Write to Practice Manager" with maybe a sentence about the Ombudsman for example) or Comprehensive (a full explanation with possibly a link to a leaflet and details of advocacy or other support)	PALS. If want to make formal complaint email or write to Complaints Manger - email and address provided	provides guidance on how to make a complaint, who to contact and what info to provide. Timescales are given. They also document what they will do after receiving the complaint. Info is given about what to do if patient is not happy with the outcome with references to Dorset Advocacy and to the Parliamentary & Health Services Ombudsman. Full and current contact details are provided for the CEO, for PALS for Dorset Advocacy, PHSO, Healthwatch Dorset and for CQC	help to make a complaint to contact the Patient Experience & Complaints Team (full details provided for both). There's a link to "have your say leaflet" which gives more information on what happens with the complaint and relevant timescales. Although the info doesn't directly say about other sources of info there are links to Dorset Advocacy site, to PHSO, NHS Choices, CQC and SEAP. There is also a statement advising information is available in other formats.
Is there a link to a leaflet?	Yes	No	Yes
Is the information provided up to date?	Yes, apart from the leaflet which has ICAS info which has been out of date for 2/3 years. However, the	Yes	Yes

	leaflet does have a review date of April 2016.		
Is there information about independent sources of advice? E.g. NHS England Health Ombudsman, Dorset Advocacy	No	Yes apart from details for NHSE	Yes apart from details for NHSE
Does documentation say when complaint should be acknowledged?	No	Yes	Yes
Does documentation say when complainant should receive a response?	No	Yes	Yes
Does documentation say what time period complainant has to make a complaint?	Yes, but wording could be felt to be defensive.	Yes	Yes

Additional	There is an easy read version of the leaflet, a link to the latest Complaints Annual Report 2014/15 and a link to "Learning from Complaints Dec/Jan 16" with 4 examples giving "Problem was xxx" and "We did xxx"	Nothing additional	There are links to "Complaints Lessons Learnt" for 2012/13 and links to "Complaints Overviews" from 2012 through to Sept 2015. There is also a link to a YouTube video advising with a "signer for the deaf" and subtitles, how to make a complaint.

RESPONSES FROM THE NHS FOUNDATION TRUSTS

Before its publication, we shared our report with the three NHS Trusts concerned and invited them to respond to it.

Below are their responses, as we received them.

Dorset County Hospital NHS
NHS Foundation Trust

We would like to thank Healthwatch for carrying out the survey and those people who raised a concern with Dorset County Hospital (DCH) that participated in the survey. We appreciate receiving feedback about our services so that we can continually make improvements. We have carefully read the report and would like to assure Healthwatch and our patients, staff, carers and public of our processes and use of the recommendations in the report to make service improvements.

Wherever possible we resolve concerns and complaints in real time at local level, in order to be person-centred and less process-driven. In order to achieve this, we train our staff in person-centred complaint handling so that staff across the Trust can resolve issues as quickly as possible, without involving PALS (Patient Advice and Liaison Service) and taking people through a formal procedure. This approach has seen a 44% reduction in formal complaints in the Trust in the year 2015/16. However, we also acknowledge that some people prefer to use the PALS service as PALS staff are not directly involved in care. With this in mind we have designed stickers with contact details of PALS which are being distributed throughout the Trust, particularly to highly visible areas like patient lockers.

We invite all people raising concerns to meet with staff in the acknowledgement letter that they receive within 72 hours of raising a concern, but in order to make this more explicit we will highlight it in the letter. In this letter and our complaints leaflet we also make people aware of Dorset Advocacy who offer independent support to help people raise concerns, but again we will make this more explicit. We are pleased that many people found it quite easy to get information on how to complain and hope that our sticker campaign will raise awareness even more.

We are pleased that the majority of people responding about DCH felt that raising concerns would not affect their care, however we

acknowledge that for some people this may still be an anxiety. In order to support them, we give people the opportunity to feedback during regular sister and matron rounds and have appointed a volunteer independent of the clinical areas to seek patient and carer views, the volunteer will be supported to escalate any concerns that may be raised.

We are pleased that most of our respondents were able to raise concerns in a way that suited them, but recognise that further assurances need to be given that their concerns are being taken seriously. With this in mind we developed complaints standards, in which all people raising a formal concern are contacted by telephone by senior staff to keep people informed, mutually agree timeframes, the chosen method of response, and what aspects of their concern they would like addressed. We think that this will provide a more person-centred, compassionate and kind service and over time this will improve satisfaction with the process being fair, the outcome of the complaint and the timeliness of our responses.

It is important that people feel able to provide their views on the response and we are pleased that so many of our respondents felt able to do so. However, we also recognise the importance of letting people know how we are using their feedback to improve services, especially as all our respondents who did not receive this information would have liked it and therefore we will make sure that this is more explicitly included in our responses. Although every response contains details of the Parliamentary and Health Service Ombudsman if people wish to take their complaint further, we recognise that this too needs to be more explicit and we will ensure that it is highlighted in future. We want people to feel cared for when raising a concern and that to do so is worthwhile and they would do so again if they needed to. We appreciate that this report has given us greater insight into the experience of people raising concerns at DCH, and think that the service improvements we have identified and implemented as a result will ensure that everyone has a similar experience to one of our respondents who commented that:

“I was incredibly impressed with the matron and other staff member present at our fault finding meeting. Everything was very thorough and dignified. Thank you!”

With regards to the website, we are pleased we are pleased to see the report showed that DCH’s complaints process, contact information (including external organisations), and the procedure for dealing with complainants who are not happy with the outcome, were thoroughly documented and easy to navigate. Nonetheless, recommendations from

the report, including those given to DUHFT and RBH, have been incorporated into DCH's Patient Experience webpages.

Several additions made to the PALS webpage include:

- Link to the PDF version of the "Comments, Complaints, Concerns & Compliments" leaflet added
- Link to the PDF Easy Read version of the "Comments, Complaints, Concerns & Compliments" leaflet added
- NHS England's contact information (including, telephone, email, website, and opening hours) added as an additional independent source for advice and method of complaining. The information was placed near the information for Dorset Advocacy, Healthwatch Dorset, the Parliamentary and Health Service Ombudsman, and the Care Quality Commission (CQC).
- A paragraph regarding providing feedback on the DCH complaints process and a copy of the "Complaints Experience Questionnaire" added
- Link to Parliamentary Health Service Ombudsman's website added (in addition to full contact details that are provided later in the page).
- Updated 'You said, we did' page with recent comments.
- Updated News, Awards and Recognitions page with recent events

Page	Item	Action
18 and 19	Timescales	All acknowledgement letters contain timescales. RBCH are aware that timescales require improving and are working on this currently. This is a priority, with improvement trajectories set and accountabilities clearer to focus on the improvement needed.
23	Complainant view on the response	**All** responses state that the complainant may get in touch if they wish to as a standard template.
23	PHSO	**All** responses give details of the PHSO as a standard template.
24,25,26	Apologies	Concerning that people were not being given apologies. Quality assurance is now strengthened for responses to ensure style and responses are appropriate.
31	Kindness and Compassion	This may have been due to team structure and vacancies for which we sincerely apologise. There is a robust system now in place to ensure responses are of higher quality, and demonstrate appropriate personalisation and empathy.
41	Conclusions and recommendations.	1. PALS is now fully staffed and active within the Trust. PALS has increased its hours of opening in the last three years and also the resources for the team have been increased twice in the last three years. 2. All wards have leaflets for PALS. Holographic information is in the main foyer as is the PALS office. There is a dedicated page on the website which is being revamped and information is given on the back of many other leaflets. 3. Meetings to facilitate early resolution to complaints where appropriate is welcomed and often now offered as we recognise it is often much easier to talk through concerns.

Page	Item	Action
		4. All acknowledgement letters give information on Advocacy as a standard template. The complaints leaflet is currently being updated* with the correct advocacy contact on it and advocacy information is being added to the website, also currently being updated. 5. All acknowledgement letters contain timescales. RBCH are aware that timescales need improving and have a plan in place which is being reviewed at our internal quality board and reported to the Board of Directors. New PALS and Complaints management is in place and this is a priority. 6. All response letters contain information regarding the PHSO as a standard template. This will also be contained in the updated complaints leaflet* 7. New management and quality assurance processes are now in place. While 51% of responders felt that their complaint had not been handled fairly a high percentage of these complainants will not have had the outcome they wished for therefore may be unhappy with the process. * The complaints leaflet is currently being reviewed with a plan to have the information in the leaflet also included on the reverse side of the letter of acknowledgement and subsequent correspondence.
44	Website review	The website is also being reviewed. Plans are: • To raise the position of the Complaints link on the main page to give it greater prominence. • Rewrite the complaints page to be fully comprehensive. • Change out of date information re advocacy. • Ensure information regarding the PHSO is more prominent. • Include timescales within the complaints information – acknowledgement, response, and time period to make complaint. • To include the complaints procedure link on the complaints page.

Dorset HealthCare
University NHS Foundation Trust

This report serves as an important opportunity for us to learn from the experiences of our patients and as a reminder of the importance of responding effectively and compassionately to the complaints we receive. From the feedback within the report we can identify a larger proportion of complaints from our prison services and we have worked really hard to make the complaints process easier to use and more responsive, however acknowledge that further improvements need to be made. Our own review of our complaints process – involving feedback from patients – suggests a more positive picture but we can always improve how we work. We have already been doing this and recently made a series of changes to align our complaints process to the best practice principles outlined by the Parliamentary and Health Service Ombudsman. We would like to thank Healthwatch Dorset for undertaking this important piece of work on behalf of local people and patients.

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- Department of Health (2013) *The NHS Constitution: The NHS belongs to us all*, [online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf [Accessed March 2014]

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APPENDIX

LETTER INVITING PEOPLE TO TAKE PART AND THE SURVEY

Freepost RTJR-RHUJ-XBLH
Healthwatch Dorset
896 Christchurch Road
Bournemouth
BH7 6DL

Tel: **0300 111 0102**
Email: **enquiries@healthwatchdorset.co.uk**
Web: **www.healthwatchdorset.co.uk**

Hello

Healthwatch Dorset is the independent watchdog for everyone who uses health or social care services in Dorset.

We're contacting people who raised a formal complaint about NHS services in Dorset during 2015, to ask if they would take part in a survey we're carrying out (enclosed), to tell us what they think about the way their complaint was handled and whether they think it could be improved. This letter has been sent to you by the NHS organisation involved in your complaint, on our behalf. We do not have your name or address and those organisations will not see your replies.

You do not have to reply to this survey, but we would very much appreciate it if you do. Your reply will come directly to us and will not go to the NHS, your answers will be treated as confidential and they will not be passed on to anyone in the NHS or to anyone else responsible for providing you with health care or other help.

What we learn from your replies will help us to make recommendations to our local NHS organisations about how they could improve their complaints systems and make them better for people who may have cause to make a complaint in the future.

Once we have the responses to our survey, we will write a report summarising what people have told us in the survey and share it with everyone who has taken part and with the NHS organisations in Dorset, Poole and Bournemouth. Our report will not identify any individuals who have taken part in our survey and any information you give us will be used anonymously. Your feedback really can help to improve the way complaints about health care are handled and resolved.

Once you have completed the survey, please return it to us in the enclosed envelope (no stamp needed) by 31st March.

If you would like, you can ask a friend or a relative to help you complete the survey. Alternatively, we can arrange for someone to go through the survey with you over the telephone. We also have a limited number of home visits available if you would like someone to come out to your home to help you with the survey. Please call us on 0300 111 0102 for further information on those options, or if you would like to receive the survey in another format.

Thank you very much for your time.

Yours sincerely,

Joyce Guest, Chair

If you have any suggestions about how the process could be improved, please put them here:

Answering the next few questions is not obligatory. But any answers you give will be treated in confidence and will help us to make sure that we have a balanced understanding of respondents to our survey. If you represented a patient, please complete the questions on their behalf where possible.

Are you male, female or transgender? Please tick ☑ one box:

☐ Male ☐ Female ☐ Transgender

How old are you? Please tick ☑ one box:

☐ Under 18 ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54
☐ 55-64 ☐ 65-74 ☐ 75-84 ☐ 85 or over

Do you consider yourself to have a disability? Please tick ☑ one box:

☐ **Yes** ☐ **No** ☐ **I don't know**

To which of these groups do you consider you belong? Please tick ☑ one box:

☐ White (British, Irish, any other white background)
☐ Mixed (White and black Caribbean, White and Black African, White and Asian, any other mixed background)
☐ Asian or Asian British (Indian, Pakistani, Bangladeshi, any other Asian background)
☐ Black or Black British (Caribbean, African or any other Black background)
☐ Chinese
☐ Arab
☐ Any other ethnic group

Thank you for helping us by filling in this survey.

Now please put the completed survey in the envelope provided (no stamp needed) and post back to us.

If you would like to receive a copy of our report once it is available, please enter your contact details here: Either

Email:

Postal address:

healthwatch Dorset

Complaint Survey

1. **Which NHS Trust and service did the complaint refer to?** (you should be able to find the name of the Trust on the correspondence you had). If the complaint was about more than one Trust, please indicate below.)

Trust	Service
Dorset County Hospital NHS Foundation Trust	
Poole Hospital NHS Foundation Trust	
The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust	
Dorset HealthCare University NHS Foundation Trust	

If you are not sure what to put in the box above, please just put in the box below where and what service the complaint was about. For example, "physiotherapy at Blandford Hospital", "Community Matron care at home", "mental health treatment at St Ann's Hospital".

2. **Was the complaint on behalf of? Please tick ☑ one box:**
   a. ☐ **Yourself** b. ☐ **Someone else**
   If the complaint was made by you on behalf of someone else, please state why. (For example, you may be the advocate or relative of someone with a learning difficulty or for someone with dementia.)

3. **What was the nature of the complaint? Please tick ☑ all relevant:**
   ☐ Access to a service (e.g. opening hours, waiting times, distance to a service)
   ☐ Environment (e.g. buildings and facilities, car parking, equipment, transport)
   ☐ Equality (e.g. discrimination regarding age, faith, gender etc.)
   ☐ Patient Choice (e.g. choice of where to have treatment, time and date of treatment)
   ☐ Patient Pathway (e.g. access to information, admissions, appointments, co-ordination of services, diagnostics)
   ☐ Staff Attitudes (e.g. doctors, consultants, nurses, midwives, health visitors and how they communicated)
   ☐ Quality of treatment (e.g. cleanliness and infection control, confidentiality and privacy, consent to treatment, dignity and respect, food and water, medicines)

☐ Safety (e.g. safe care of patient with mental health concerns or learning difficulties)
☐ Discharge (e.g. transfer of care when leaving hospital, whether to home, to nursing care or care home or to a community hospital)
☐ Other (please describe)

4. How did you find out about how to make the complaint? Please tick ☑ all relevant:

☐ You asked a member of staff
☐ You asked PALS (Patient Advice & Liaison Service)
☐ You checked the information leaflet/brochure
☐ You checked the Trust's website
☐ Other (please specify)

5. Were you aware of the PALS (Patient Advice & Liaison) service before you made the complaint? ☐ **Yes** ☐ **No**

6. Before deciding to make the complaint, did you feel you could raise the concerns with any staff members? ☐ **Yes** ☐ **No**

7. Were you (or the patient you represented) offered the opportunity to discuss or meet with staff at any point during the process of making the complaint? ☐ **Yes** ☐ **No**

8. How easy was it to find information about how to make the complaint? Please tick ☑ one box:

☐ Very easy ☐ Easy ☐ Neither easy or difficult ☐ Difficult ☐ Very Difficult

9. Did anyone make you (or the patient you represented) aware that you could be supported to make the complaint by an independent advocate? ☐ **Yes** ☐ **No**

10. Did you feel confident that making the complaint would have no adverse effect on any current or future care you (or the patient you represented) require? ☐ **Yes** ☐ **No**

11. Were you able to make the complaint in a way that suited you (or the patient you represented) e.g. in writing, in person, by email, by phone ☐ **Yes** ☐ **No**

12. Did you feel the concerns raised were being taken seriously from the time that you raised them? ☐ **Yes** ☐ **No**

13. When raising the complaint were you provided with - please tick ☑ all relevant:

☐ A mutually agreed timescale for the complaint to be resolved
☐ A date by which the complaint should be resolved
☐ No timescales or dates
☐ Other (please explain below)

14. Were you kept informed of what was happening with the complaint during the time it was being investigated? ☐ **Yes** ☐ **No**

15. If you were provided with timescales, were these met? ☐ **Yes** ☐ **No**

16. If No, were you provided with a satisfactory response as to why? ☐ **Yes** ☐ **No**

17. How did you receive your response? Please tick ☑ all relevant:

☐ By Letter
☐ By Phone call
☐ By Email
☐ In a face to face meeting
☐ Other (please specify)

18. Was this your (or the patient you represented) chosen method of response?
☐ **Yes** ☐ **No**

19. Did the response directly address all aspects of the complaint? ☐ **Yes** ☐ **No**

20. Were you (or the patient you represented) given the opportunity to provide your views on the response or to reply? ☐ **Yes** ☐ **No**

21. Were you informed of how to proceed if you (or the patient you represented) were not satisfied with the response? ☐ **Yes** ☐ **No**

22. Overall were you (or the patient you represented) satisfied with the result of the complaint? ☐ **Yes** ☐ **No**
If no - why?

23. Were you given any information about how things would change so that other people's experiences would be better in the future? ☐ **Yes** ☐ **No**

24. If No, would you have liked that information? ☐ **Yes** ☐ **No**

25. Do you feel the complaint was handled fairly? ☐ **Yes** ☐ **No**

26. Do you feel you (and/or the patient you represented) were treated with kindness and compassion by the people dealing with the complaint? ☐ **Yes** ☐ **No**

27. Do you feel you would make another complaint in the future if you felt it was necessary?
☐ **Yes** ☐ **No**

28. Were you satisfied with the actual process of making the complaint?
☐ **Yes** ☐ **No**

If you have any suggestions about how the process could be improved, please put them here:

Answering the next few questions is not obligatory. But any answers you give will be treated in confidence and will help us to make sure that we have a balanced understanding of respondents to our survey. If you represented a patient, please complete the questions on their behalf where possible.

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☐ Arab
☐ Any other ethnic group

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If you would like to receive a copy of our report once it is available, please enter your contact details here: Either

Email:

Postal address:

DISTRIBUTION LIST FOR THIS REPORT

- Dorset Clinical Commissioning Group
- Dorset, Poole & Bournemouth NHS Foundation Trusts
- Dorset Healthcare University NHS Foundation Trust
- Dorset Health & Well-Being Board
- Bournemouth & Poole Health & Well-Being Board
- Dorset, Bournemouth and Poole Health Scrutiny Committees
- CQC (Care Quality Commission)
- Healthwatch England
- NHS England Wessex Area Team
- Dorset Advocacy
- Dorset Community Action
- Poole Council for Voluntary Service
- Bournemouth Council for Voluntary Service

Other formats, easy read etc. available upon request. Report will be published on the www.healthwatchdorset.co.uk website.

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