healthwatch Plymouth

University Hospital Plymouth NHS Trust Patient Experiences of PALS Complaints Services

April - May 2023

Contents

Introduction

Healthwatch Devon, Plymouth & Torbay (HWDPT) are the three local independent consumer champions for people using health and care services across Devon. HWDPT listens to what people say about services - what works well and what could be improved and shares what we learn with those who have the power to make change happen.

An effective complaints system is a vital part of high-quality health and social care, helping services and individuals learn how to do things better when things don't go according to plan.

For people to speak up about their concerns, they need to be confident the system will act in response. In order to build trust, the NHS needs to consistently demonstrate that they are taking people's complaints seriously.

Background

In January 2020, our national partner Healthwatch England published a report around NHS Hospital Complaints called Shifting the mindset. They looked at whether hospitals are learning from complaints by searching the websites of 149 NHS acute trusts in England and looking for substantive reporting on complaints.

Their report found that:

- Local reporting on complaints is inconsistent and inaccessible
- Staff are not empowered to communicate with the public on complaints
- Reporting focusses on counting complaints, not demonstrating learning

Following the recovery of NHS Services after the Covid-19 pandemic, Healthwatch Plymouth held conversations with the Patient Advice and Liaison Service (PALS) manager at University Hospital Plymouth NHS Trust (UHP) in late 2022 to see how we could collaboratively work with them around the findings from the Healthwatch England report. It was agreed for HWP to independently interview individuals via telephone contact who had recently been through the complaints process at UHP and who had consented to be contacted by HWP. Questions to be asked were

agreed between UHP PALS and HWP Staff. HWP were provided with a total of 32 individuals to contact. The interview process took place during April and May 2023 with 22 individuals; the other 10 could not be contacted despite numerous attempts. Of these 22, one individual had not been fully through the complaints process and therefore their comments are only included up to Question 5.

Key findings

This Healthwatch Plymouth summary report draws on the experiences that we recorded during conversations with patients or relatives who had recently been through the complaints process at University Hospitals Plymouth NHS Trust. These conversations took place during April and May 2023 over the phone and consisted of a mix of binary Yes/No questions with the chance to expand on each of these responses. Whilst this is a relatively small number of interviews, the following key findings have been identified from this engagement activity that reflect some of the Healthwatch England 2020 report findings:

- Complainants felt that the process was not timely;
- They did not feel involved in the process;
- Individuals felt that their complaint was not always fully understood and subsequently the response was incomplete;
- They were unsure if, or were not confident that, the Trust had learnt from their experience.

Further observations can be found on page 25.

Our findings

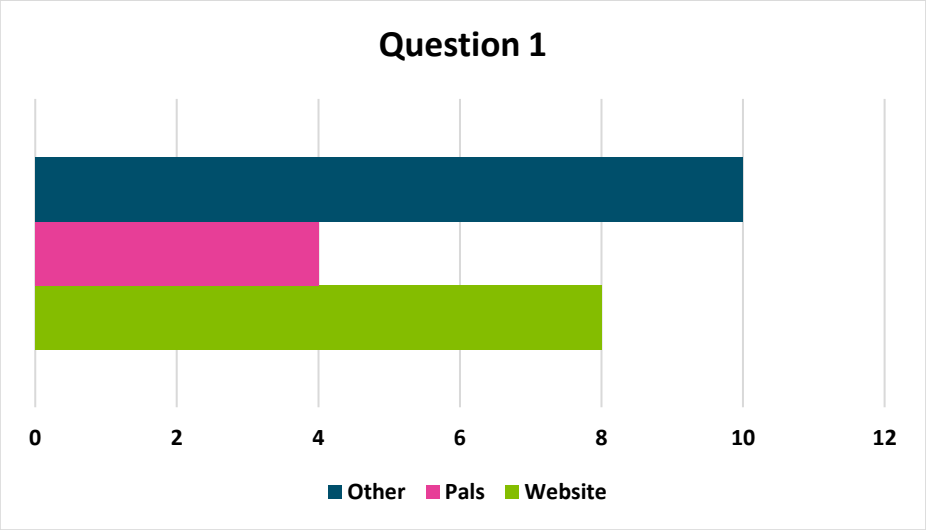
The following sections provides details for each of the conversational questions for the 22 individuals interviewed. One individual had not been fully through the complaints process and therefore their comments are only included up to Question 5. Two individuals were contacted for the same complaint; the mother and her son (the reason for this is that during the complaint process the son turned 18).

Section 1 - Information

Questions 1 and 2 deal with information about making a complaint and how easy it was to raise concerns.

Question 1 - How did you find out information about making a complaint?

The aim of this question was to establish how and where individuals found information on how to complain.



When reviewing the additional commentary for website, this did not always relate to visiting the UHP Website and the PALS page but included internet searches:

"I went online to find NHS England which led me to Healthwatch. As a result, I went to PALS who put me in contact with the Service Line. The online information was clear."

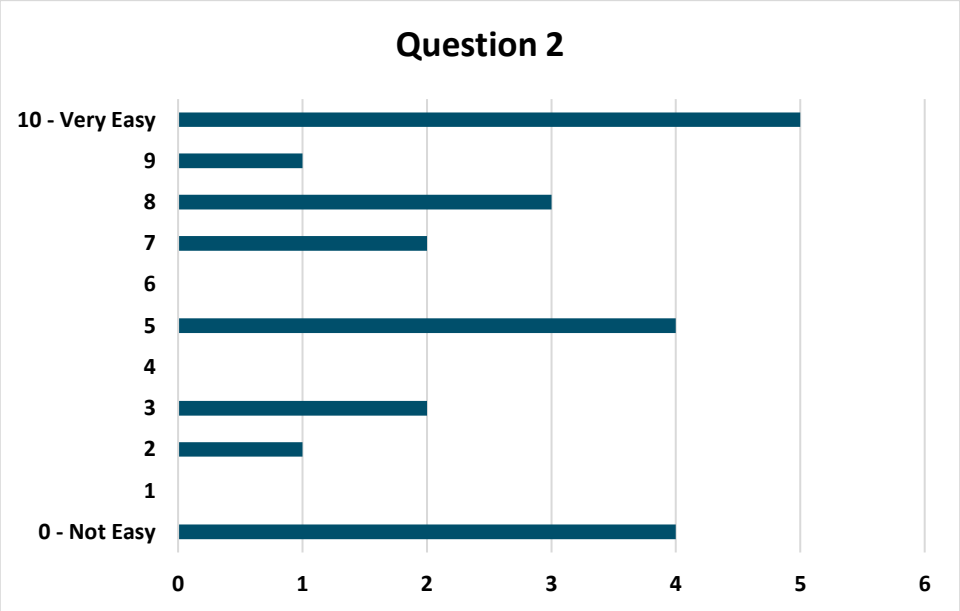
"Google search to find how to complain at Derriford."

'Other' includes being signposted by other Health Professionals, CQC or via relatives.

"Nursing staff provided a number for me to call to make a complaint and they we very helpful."

Question 2 - From 0-10, where 10 is very easy and 0 is not easy at all, how easy was it to raise your concerns?

This question was to understand after finding information on how to complain, how easy did individuals find it to raise their concerns.



Average rating is 5.7. Those that rated the process as 0 did not leave any comments. Other comments include:

"Easy once I had found the website." (**Rated as 8**)
"....and I am a trained lawyer" (**Rated as 3**)

"I found it difficult to word the letter of complaint prompts of how to word it and the information required would have helped." (**Rated as 5**)
"Did not realise there were 2 types of complaint. Was told later told it was an informal type and not formal." (**Rated as 3**)
"To raise the concern was easy, to write it out was harder because of the trauma it caused." (**Rated as 7**)
"Very easy to raise" (**Rated as 10**)

Section 2 – Initial process

Questions 3 through to 7 deal with the initial stages of the complaints process including acknowledgement by the service line and whether the concerns were discussed with the individual to ensure they were fully understood at the start of any investigation.

Q3 - Did you receive an acknowledgement via email or letter to your complaint once submitted?

Of the 22 Individuals spoken with, 21 said that they had received an acknowledgement generally via email or phone call. The one individual who said they had not received any acknowledgement also responded to Q4 with a comment of 4 weeks.

Q4 - If yes how long did it take to receive an acknowledgement?

Fifteen individuals (68%) stated that they received an acknowledgement within 7 days with 10 (66%) of these being within 48 hours.

Two individuals were unable to recall the time it took to receive an acknowledgement.

Three individuals responded to Q4 with comments of 2 weeks, 2 months, and 6 months. However, it is not clear whether they were referring to the whole process or acknowledgement of their complaint.

Q5 - Did the investigating office contact or meet with you at the start of the investigation to discuss your concerns, to agree the points for investigation, how you would like to receive the findings and the timescale required?

Seven individuals stated they were contacted about their complaint by the service line investigating. Five individuals stated that contact was via phone call, one had a meeting, and one was not clear on the method.

Of the 15 individuals who responded to Q5 with 'No', one stated that '*they would like to have had a meeting*' and a further person stated that '[*Although my name is on all the records, and I was allowed to visit my father*] *they refused to let me raise a complaint as my father had not signed a document for me to be his official representative. I thought this was a convenient reason not to let me complain*'.

Q6 - If yes – was that conversation/meeting helpful?

For those that answered 'Yes' to Q5, comments include:

"Phone calls only carried out, but they were helpful and sorted out plan."
"Someone phoned to talk about what was happening. Stated they would be overseeing the complaint very helpful."
"She was really empathetic spoke to members of staff and replied 3/4 weeks later."
"The meeting was helpful as it moved up the chain."
"A conversation with head of nursing."
"Had a telephone call early and talked about what they would do about it. No time scale given. Talked about the thing to be investigated."

Q7 - If no – would you have liked that opportunity at the beginning of the process?

For those that answered 'No' to Q5, comments include:

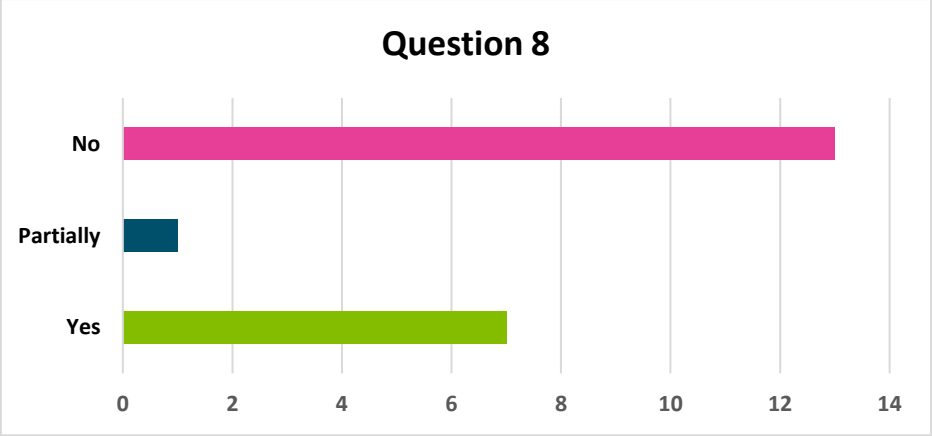
"That is what I was hoping for. If this had been done it would not have wasted so much of my time and theirs."
"It might have been better."
"I would say my complaint was full and detailed. It would have been polite thing to do and would have saved time as there were some key issues."
"I would explain myself verbally better than in writing or by email."
"I want to have investigation of exactly what the issue was that I was complaining about. Also, a form to fill in at the beginning of the process, to guide you when writing the complaint, would help."
"Would have liked a better chance at start to have complaint heard."
"Yes, to sort it all through."
"Would have like a conversation face to face."
"Would have liked a meeting."
"To clarify the points and better understand timelines."
"Not sure what it would have achieved. Not sure it would have achieved anything."

Section 3 – Being involved and being kept informed

Questions 8 through to 10a look at whether individuals were kept informed, did they feel involved and included and was the complaints process timely.

Q8 - Were you kept informed of progress throughout the investigation?

Thirteen people (62%) stated they were not kept informed whilst 7 (33%) said they were:

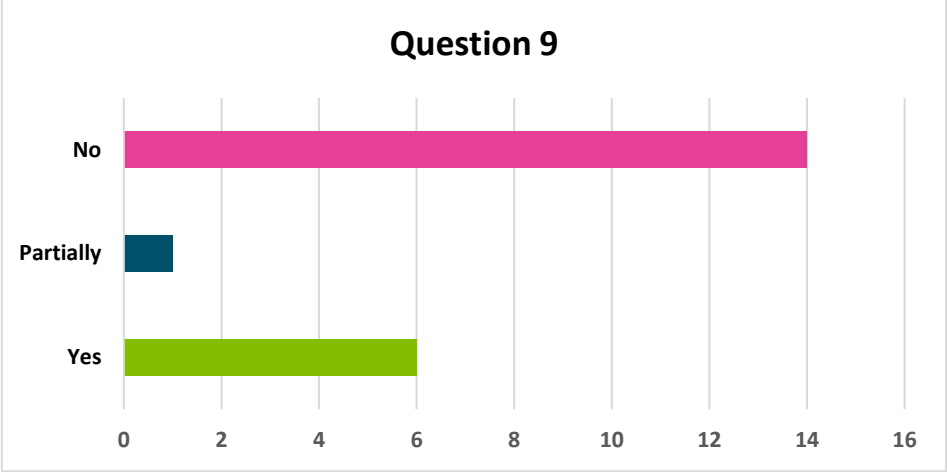


Comments included:

***"Yes** - but only after a second gentleman took over the complaint and started to help me. (originally it seemed that their phone system keeps you going from one answer phone to another)."*
***"Yes** - by a couple of letters from Derriford."*
***"No** - I had to send emails to ask if they had replied."*
***"Partially** - Only to some degree but they did explain timescale."*
***"No** - just an email afterwards."*
***"Yes** - Someone from the office kept up to date through email or phone call."*
***"No** - they were very busy and difficult to get in touch with."*
***"No** - in the initial email they said they would investigate the next email was the completion of the investigation."*
***"No** - Not until a final letter came through."*

Q9 - Did you feel involved and included in the process?

In response to feeling involved in the process, 14 people (66%) stated 'No' with 6 (29%) saying 'Yes':

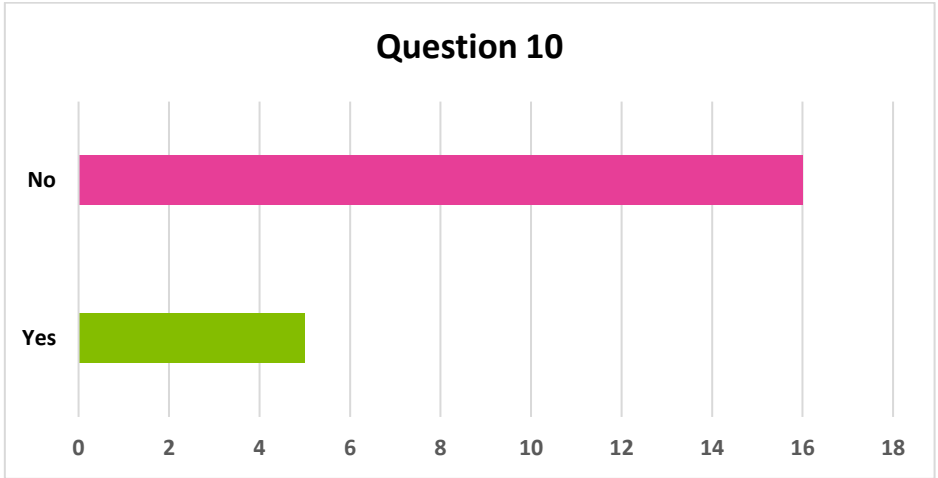


Comments included:

***"Yes** - when I finally got through to this (second) gentleman, he was very good. He gave me a direct number with an email address. He kept telling me how the process was going."*
***"No** - I had to keep chasing a reply in fact I complained about not being informed."*
***"No** - Not at all."*
***"Yes** - but only in a little way."*
***"Partially** - partly a call with an A&E consultant."*

Q10 - Did you think this was a timely process?

Sixteen respondents (76%) thought that the process was not timely.



Q10a - If not, why not?

Of those that answered 'No' to Q10, comments include:

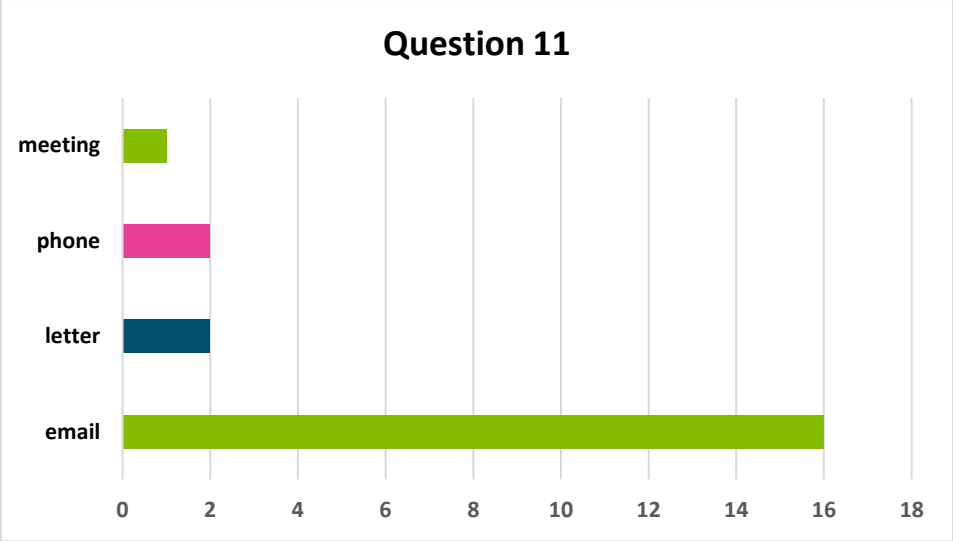
"Because it did not run smoothly, it shouldn't have been difficult and wasn't 'timely'."
"It could have been dealt with a lot more efficiently."
"Kept having to remind them. I didn't know if anything had been done."
"There seemed to be a lack of staff perhaps a dedicated person."
"Started in March replies later in July then September sorted."
"It took 6 - 8 weeks before response."
"Took longer than it needed to."
"It took several months to get a reply Issues were important because the experience was dreadful."

Section 4 – Response to the complaint

Questions 11 through to 15a looks at how the response to the complaint, was shared, whether an alternative to a letter would have been better, the quality of the response and whether in the complaint's view it answered the complaint and the accessibility of the information in the response.

Q11 -How were the findings shared with you?

The response to this question indicated that the majority (16 / 76%) received the findings of their complaint via email:

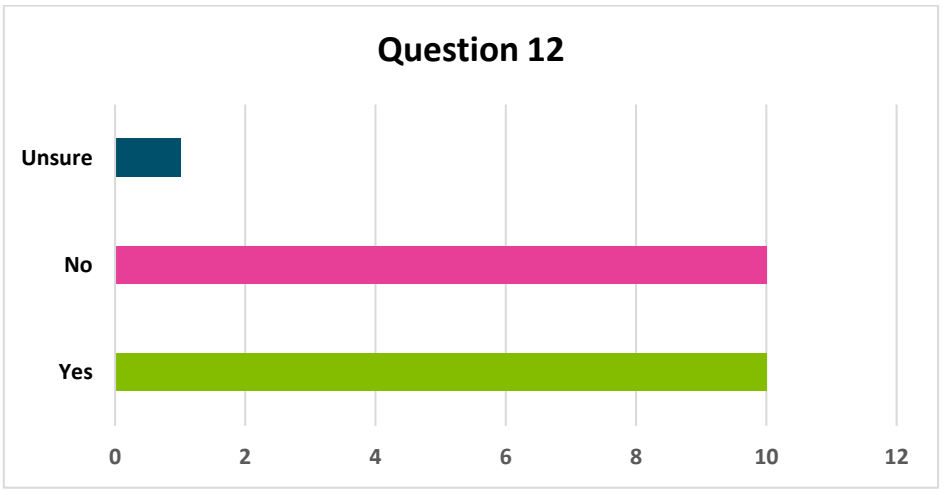


Additional comments include:

"No findings just an email letter although I asked for a letter. They apologised and said it would not happen again."
"Findings by letter about what had happened."
"Phone call confirmed by email."
"In a phone call the registrar."
"I received an apology via an email."

Q12 - Would you have liked an alternative to a letter/meeting?

The response to this question was evenly split.



Q12a - If yes – what would have helped?

Q12a, looked to complainants to identify other options. Of those who answered 'Yes' to Q12, the majority commented that in addition to a letter that gave the findings of the investigation, a face-to-face meeting to discuss those findings would have also been welcomed. Comments include:

"A meeting as I felt they did not fully understand the problem."
"A meeting with the people I made the complaint about with the investigative team."
"The letter did not cover all of the points and ignored some of the issues."
"Telephone call at least to explain issues."
"A meeting would have been nice."
"A face-to-face meeting." (Several individuals mentioned this)

Q13 - What was your opinion of the quality of the response?

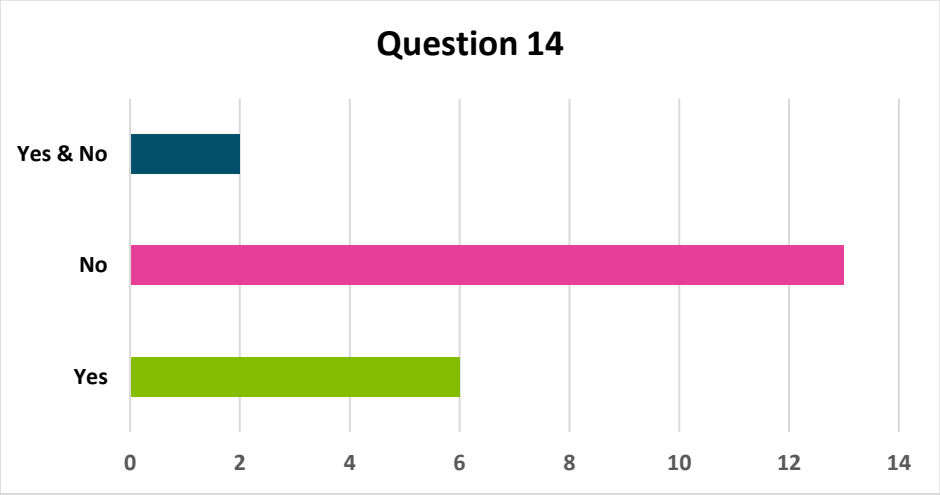
Individuals were asked to give an opinion on the quality of the response. Comments to this question include:

"Very disappointing due to lack of involvement and not appearing to understand the issues."
"The response was garbled. I introduced the Equalities Act into the mix which muddled the issue. The reply did not address the complaint at all."
"No accountability was taken or noted."
"Very poor they just seemed to find an excuse for everything."
"Wasn't happy with initial response but phone call helped with a long conversation on phone."
"Felt it was a tick box style and it was not really looked into."
"Well written and apologetic. Felt at bottom of a pile and noted waiting time."
"Felt it was more of I am doing this because I have to rather than I agree with the investigative process. The response was a bit blunt. It felt as if they were irritated that they had to go through the process."
"In some ways it was alright but did not go far enough."

"I would use the words they 'hedged their bets' and slid away from issues. They came out with an apology for how I felt rather than having dealt with the issues. There was an assumption made that I was wrong about some things which implied I was lying."
"Very apologetic. Talked about how things were going to be put in place. Something positive was being done on several of the different complaints I had."
"I thought the response they gave was dodging and they were making excuses. I do not believe what I was told as I have gone back since and seen no signage. I was also told the staff would have asked me If I had personal belongings. This did not happen."
"A very poor response. Despite the length of time, it was almost a copy and paste response instead of looking at rudeness and unkindness of particular staff at the time."

Q14 - Did it answer all your questions/points?

Thirteen individuals (62%) stated that the response did not answer all their questions/points.



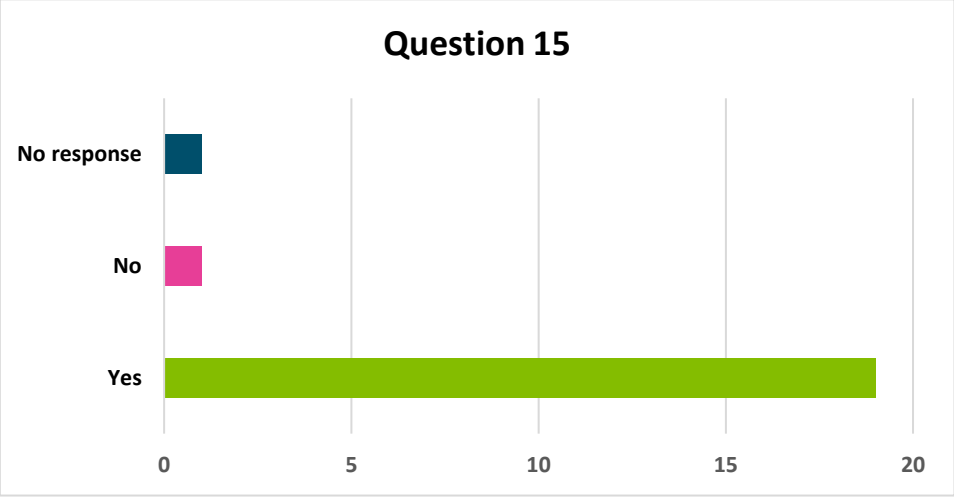
Q14a - If not, why not?

Of those that answered 'No' to Q14, follow up comments include:

"They were defensive about a clunky appointment system. Headache nurses could not understand why my treatment wasn't timely and another person's was."
"I sent a 2nd complaint letter. My complaint about the actual doctor was brushed off."
"Not really, they did not appreciate how distressful it was."
"They didn't address the issue because they did not seem to know what it was but put my daughter's surgeon in the firing line instead. It was neither his fault nor the issue."
"They gave me a load of garbage and it appears no change of procedure to avoid a reputation of the event for someone else in the future."
"They did answer but the report was incorrect."
"The answer was incomplete, and I thought that the answer didn't really acknowledge how bad the experience was."
"Because it doesn't go far enough. They said they would create a safe haven in 5 years."
"There were apologies but nothing about dealing with the staff members named who this patient refused to accept treatment from."
"There was no apology for my loss just excuses."

Q15 - Was it delivered in a way that you could easily understand?

The overwhelming majority of complainants (19 / 90%) stated that the findings were given in an easily understandable way.



Q15a - If not, why not?

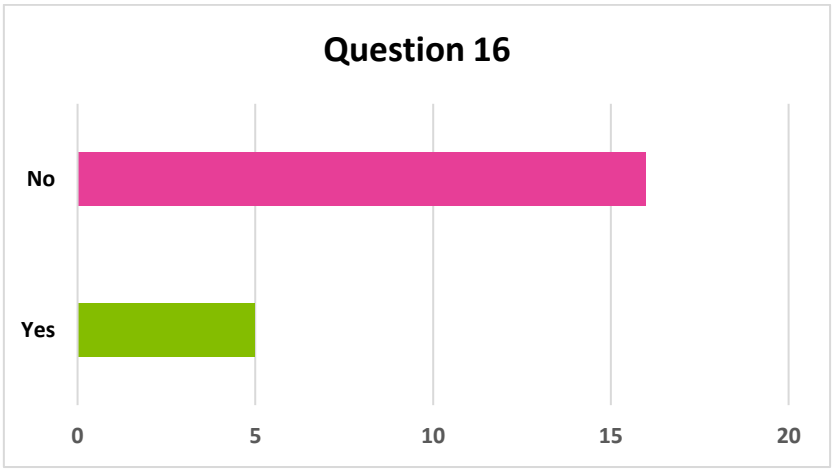
The one individual who said it was not delivered in an easily understandable way stated that it '*used too much jargon*' that they didn't understand.

Section 5 – Satisfaction with the outcome

Questions 16 through to 16c looks at complainants' satisfaction with the response initially received, the offer of an opportunity to meet to discuss the response and finally what made the complainant satisfied with the findings.

Q16 - Were you satisfied with the outcome/findings?

Sixteen individuals (76%) said they were not initially satisfied with the outcomes whilst 5 (24%) said they were satisfied.



Q16a - If not, why?

Comments include:

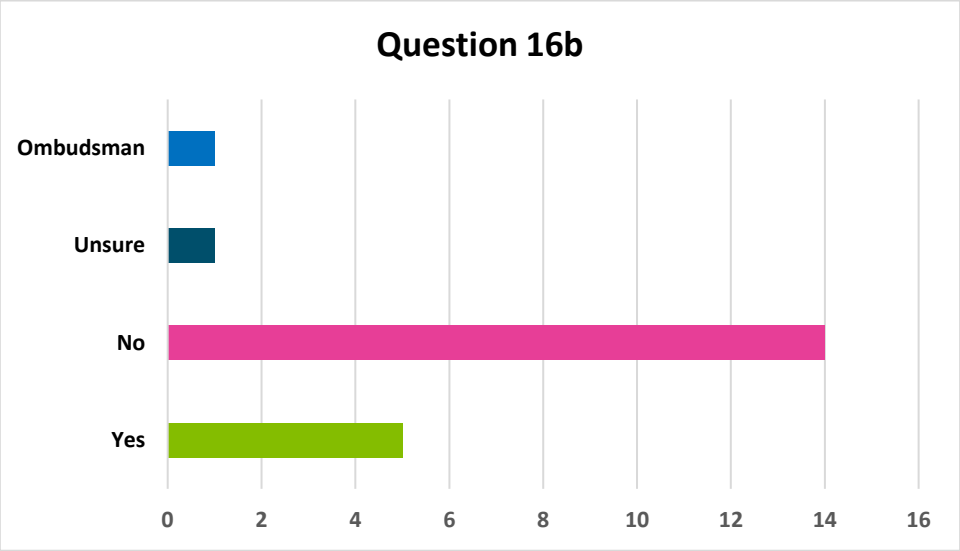
"[I] Am unsure how to resolve further issues."
"It caused me distress not only was I being let down by the medical team but refusing to admit the issue of appointments meant they would not be addressing the issue. I was so disgusted with the response I felt I was screwed."
"Because I couldn't see that they would take steps to change their behaviour and I feel that the medical professionals do not take responsibility for their actions."
"My daughter's situation remains as bad with no foreseeable solution."
"Just as before just excuses as no real feeling of solving the problems raised."
"No apology. No reassurance it will change."
"Just excuses no guarantee. Others had treatment of some sort. Said sorry but no resultant change."
"Nothing got done."
"I felt a third excuse would come up if I persisted and I could not be bothered to continue all I would get was excuses."
I feel I am regarded as a pain since raising the problem.
"No satisfactory response even though I have been to the ombudsman. The trust does not seem to be talking to the ombudsman."
"The staff member had been very rude to me, and I would have like some acknowledgment for her action. It appears they accepted her denial and therefore no consequences. I would have liked if she had been sent on some training course."
"The answer was incomplete and a bit superficial."
"It did not go far enough. They understood on paper the implications of what I went through but there was no real understanding."

One individual was partially satisfied with their outcome also commented.

"[Whilst] I was happy they had found where the issues were and were going to fix them. But the complaint about the doctor was not covered properly. The action covered the porters and nurses. Why was the doctor not covered properly?"

Q16b - Were you offered an opportunity to meet, or did further investigation take place?

In response to this question, 14 (66%) said they were either not offered an opportunity to meet to discuss the findings with 5 (24%) stating they were offered the opportunity to meet. In addition, one individual took their complaint to the Parliamentary Health & Social Care Ombudsman and the other individual did not know.



Individuals also commented:

"No. They dismissed, refused to address the second complaint, about the doctor. I felt from the tone of the letter I was being accused of being motivated by a desire for financial compensation. This was not the case and I felt insulted."
"Yes. I was offered the opportunity to meet."
"No Livewell did not answer me at all since last July."
"Yes. Further investigation took place."
"Yes, but a meeting is not viable for me."

Q16c - If yes – what made you satisfied with the findings as shared with you?

For those that answered 'Yes' to Q16 comments include:

"Things were well dealt with."
"I was satisfied with the way they addressed the first complaint."

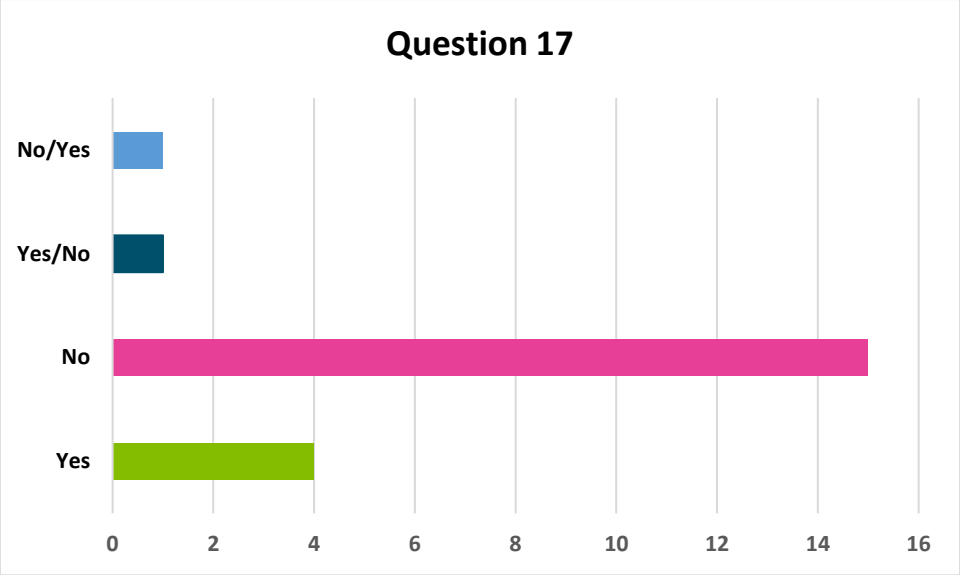
"Phone call [to discuss]."
"More [of] an investigation trying to find what had happened to patient. Wording could have been better."
"Yes, gave a much better report. [However] Final report did not cover their mistakes."
"At least they were trying to tackle the issue. However, Derriford did say it was 5 years before a haven could be created. So how many people with autism will have to suffer. Derriford said they were going to start autism training which is good training."

Section 6 – UHPNT response to the complaint and what could be improved around complaints handling

Questions 17 through to 20 looks at whether complainants felt that their concerns were taken seriously, whether the complainant believes the Trust has learned from their experience, whether complainants were signposted to the Parliamentary Health & Social Care Ombudsman and what steps the complainant thinks the Trust can take to improve complaints handling.

Q17 - Did you believe that the Trust had taken your concerns seriously?

This questions ask individuals whether in their view, their complaint/concerns had been taking seriously. Fifteen individuals (71%) thought that their complaint had not been taken seriously with four (19%) saying yes, it had.



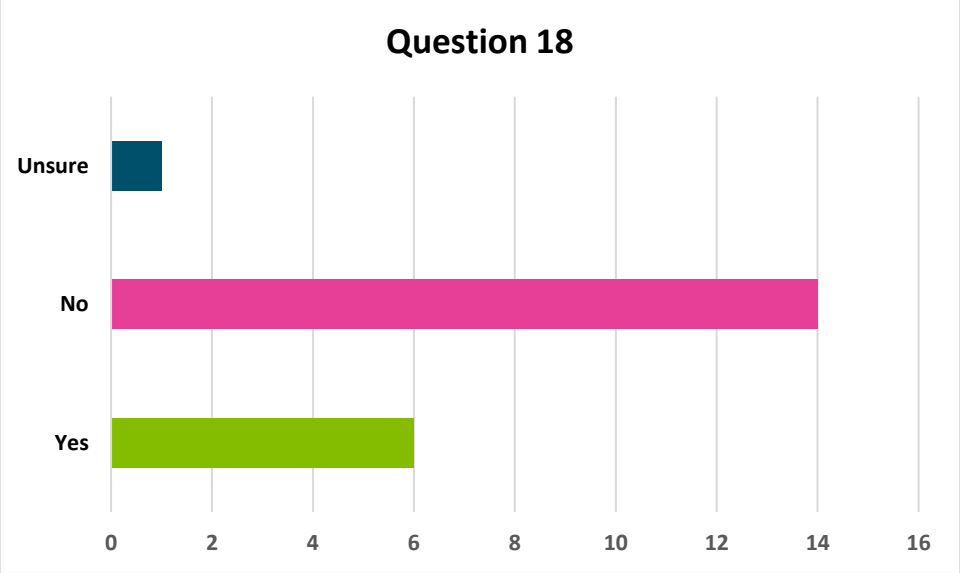
Individuals also commented:

***"Yes & No**. The person handling the complaint did and he resolved the issues. Nobody else that I spoke to, did."*
***"No**. Absolutely not they will just carry on doing what they have been doing. I was offered the opportunity to meet. [In my opinion] The only concern of the Trust was to protect its own reputation not to protection of the patients."*
***"No**. I was offended and exhausted by the process as it really didn't' solve the issue I had raised."*
***"Yes**. Felt that they had taken concerns very seriously."*
***"Yes**. I was pleased because they explained they were going to put procedures in place."*
***"No**. As they did not appreciate the problems and issues raised."*
***"No**. I felt it was brushed under the carpet. The surgeon took the fall for it; it was not his fault or issue. It was the stoma team that is the issue."*
***"No**. They only gave excuses."*
***"No**. No reassurance it would not occur in future."*
***"No**. No guarantee that changes might take place."*
***"No & Yes**. Didn't feel so at the start but yes after phone call."*
***"No**. No apology and nothing about incorrect report."*
***"No**. In the grand scheme of things for the NHS it was a misdemeanour, and I could sort out the issue myself."*

*"**No**. Impression that they did not take it seriously."*
*"**No**. There is no proof anything has been followed up. Have they spoken to the staff and have there been consequences for the staff."*
*"**No**. Not serious enough. To a point they hadn't appreciated quite how terrible the experience was."*
*"**Yes**. However, they did not understand the impact on me. This is not an understood issue."*

Q18 - Did you believe that the Trust had learnt from your experience?

Six individuals (29%) thought that the Trust had learnt from their experience, but 14 (66%) did not. One individual was unsure but did not provide any further comment.



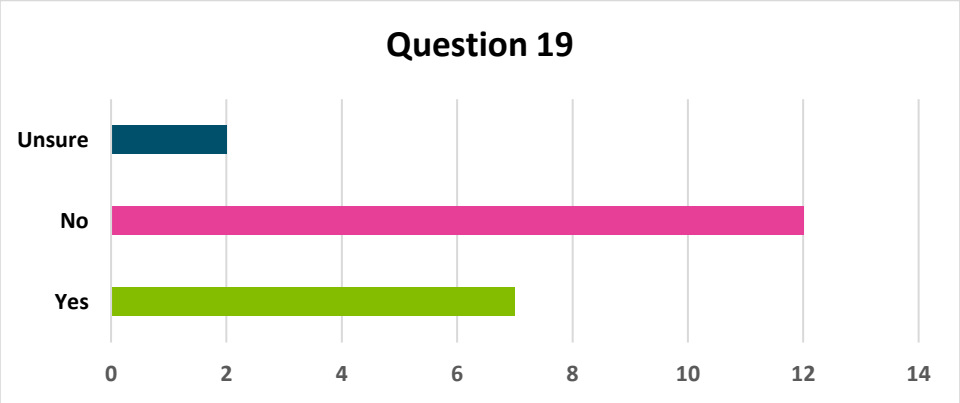
Individuals also commented:

*"**No**, I don't think so. It seems to be just crisis management and a shambles. Lots of people were saying how long they had waited. Staff seem to be just waiting outside consultant's doors doing nothing and gave the impression that patients are a nuisance."*
*"**No**, as it felt that some things had happened again and feel others will suffer."*
*"**Yes**, because of what they said they would put into place."*
*"**No**. They did not appear to have done anything about the issues."*

*"**No**, this also raises the issue for people with learning difficulties. The hospitals are not all inclusive. There should be a priority to care for people for disabilities. There is nothing about stoma on the Derriford website."*
*"**No**. Goes back to lack of reassurance or accountability."*
*"**No.** I Feel really disappointed about the whole procedure."*
*"**Yes**, They did give me answers and really knew what had happened to me."*
*"**No**, as said before there was no signage about valuables, dentures, and spectacles."*
*"**No.** Feel they do not care."*
*"**Yes**. Possibly but feel they are not in a position to do anything about it."*
*"**Yes**, but I am unsure if training is going on in A&E. Think they are being genuine."*

Q19 - Were you appropriately signposted to the Parliamentary Health & Social Care Ombudsman?

Twelve (57%) said they were not informed or signposted to the Parliamentary Health & Social Care Ombudsman whilst 7 (33%) said they were.



Q20 - How do you think the Trust could improve their complaints handling?

Comments from Individuals on how improvement could be made to the Trust's complaint handling process are given below. The main observations include:

- An independent complaints overseer.
- Better training for complaints handlers.

- Involve the individual more in the process and ensure the complaint is fully understood.
- Conduct more communication via phone or Face to Face during the process.
- More empathy with the complainant.
- Time taken for the complaints process needs to be speeded up.

*"**1.** It would be better if you could write direct to the department.* ***2.** There should be better training for staff handling complaints.* ***3.** There are too many links in the chain.* ***4.** It would be better if you had a complaints person dealing with complaints in each department.* ***5.** It would be better if the PALS Officer didn't have other job roles at the same time.* ***6.** Dealing with complaints is the only way to handle them and run a department efficiently."*
"The only way the Trust can improve complaints handling is to have a completely independent complaints over seer. That is the only way they can ever improve complaints because their first instinct is bury any compliant and to lose the paperwork common instinct is to defend themselves."
"They should not take the complaint personally."
"Felt the process was becoming a chore. To speak on the telephone that would have helped me. To make me feel I was doing a good job by alerting them rather than making me feel I was bothering them."
"Face to face meetings would have been nice. Emails are useful for progress reports."
"They need an informal process where they sit down and talk to you and discuss solutions with lots of people. They never really worked out what the issue was, but it is a big issue."
"Do a proper investigation. Try not to find excuse for everything."
"1. Need to phone people. *2. Keep them updated.* *3. Speed up time taken to respond.* *4. Service could be more informative."*

"More care and empathy. Keeping updated on procedure. What learning has resulted in staff training"
"More empathy needed from the start."
"[The process needs to be] *More personal not a standard tick box. No talking, all information through emails."*
"Be a bit more human."
"[The process needs to be] *a conversational experience rather than a generic email."*
"Speed the time up for the complaints process"
"Get a reply to correspondence. (8 weeks no reply)"
"Involve the person in the process, do not just look at it from the Trust point of view. I feel I was allowed no right of response."
"Just to be more companionate. The initial sentence of the letter/ email is nice, but do not to be blunt in replies and word letters better."
"I think they somehow have to get a second review to check the answers were not superficial. There should be some sort of quality control on the final response."
"I think the response is fine but slightly wordy. For my specific complaint it actually worked for me. The complaints people were nice to me and dealt with it quite well."

Healthwatch Plymouth Observations

Healthwatch Plymouth has the following Observations.

Patients, relatives, and carers want to have confidence in the services they receive from any health or social care provider. When things go wrong, they want to feel assured that their concerns or complaint will be taken seriously and that there will be an appropriate investigation into the issues they raise and that they are involved in the initial stages of the investigation and kept informed of the progress of the investigation through to its conclusion. They also want assurance that where lessons have been identified that the learning from these is taken forward to reduce the risk of others having a similar experience as them.

Equally, information on how to raise concerns or make a complaint needs to be easily accessible. From the responses from those we interviewed it is clear that information was accessible via different routes including internet searches, hospital staff and external organisations.

In addition, it is equally clear from the individuals we interviewed, that some had a good experience of the complaints process whilst other's experience was not so good.

Where a generally 'good' experience was received, it was mainly because:

- the individual felt engaged with the process from the very start;
- there was a meeting/conversation to discuss the issues in detail;
- they were kept informed as the process progressed;
- they felt the investigation was thorough and
- that the Trust understood the issues and were learning from the events that took place.

Where a 'not so good' experience was reported it was generally down to:

- Limited or intermittent communication often with the individual having to 'chase' for information;
- No initial meeting to fully understand the concerns/complaint;
- The feeling that the investigation was not fully considering the concerns raised and that the Trust were looking for excuses as to why something had happened;
- No opportunity to meet to discuss the findings;
- No assurance that the Trust had learnt from the issues raised;
- That the time taken to investigate and reply to the concerns/complaint was too long.

Other observations around specific areas include:

- All concerns/complaints should be taken seriously and from the responses it is uncertain whether this is the case. Someone losing their hearing aid or false teeth may not seem relevant, but it is to the patient.
- Keeping patients informed during the process will help the overall outcome. Patients are aware that there are operational pressures, but this should not delay investigation and responding to complaints.
- Providing information about the Parliamentary & Health Ombudsman in the response to the concerns/complaint maybe be perceived that there is no option to discuss the response. It maybe better to offer an opportunity to discuss the response before providing information on escalation.
- Irrespective of the complexity of the concerns/complaint, the process should be timely and easily understood by the individual raising concerns. Whilst it is right that service lines should be the respondent, it feels that different degrees of importance in dealing with the complaint are being set by individual service lines leading to different experiences for patients/relatives.

Our Recommendations

In our opinion, all experiences should be of the same standard that fully involves the individual within the complaints process throughout. It would appear from these interviews that the experience is varied within UHP and therefore we have the following recommendations:

1. From the information provided by individuals to Healthwatch based on the Complaints Reference Number, that an audit against service lines is made to identify where the process may not be as robust.
2. Carry out a review of the complaints process including timelines to ensure it remains 'fit for purpose' or to identify where improvement can be made to the process.
3. From the review, identify any additional or refresher training for staff involved in the process to improve patient experience, particularly around involvement, communication, and assurance around Trust learning.

4. Consider adding a 'quick link' to the UHPNT Website Homepage for concerns/complaints. Healthwatch accepts that there is a link to PALS in the 'About Us' section but adding a quick link makes it more prominent and subconsciously says that the hospital takes concerns/complaints seriously.

University Hospital Plymouth NHS Trust Response

"We would like to thank Healthwatch Devon, Plymouth & Torbay for their comprehensive report highlighting the importance of an effective complaint system in health and social care.

The report, based on interviews with previous complainants provides valuable insights that will help us to improve our complaint services with both immediate and long-term impacts.

We acknowledge the key findings of the report, which resonate with the concerns raised in the 2020 Healthwatch England report. Specifically, the issues of timeliness, lack of involvement in the process, comprehension of complaints, and confidence in the Trust's learning from experiences as areas that require our immediate attention.

Based on the feedback received, we have co-designed a new complaints process with patient representatives including the Patient Council, Patient Safety Partner, staff and Healthwatch Devon, Plymouth and Torbay that will soon be implemented following a pilot. Please see a response and related actions to each of the key findings and recommendations below:

Key finding: complainants felt that the process was not timely.

Action we are taking:

We understand that delays in the complaints process can be frustrating and undermine trust. Following the new co-designed complaints process, an agreed timeframe will be collaboratively decided between the investigator and complainant based on the complaint complexity. Other time pressure constraints have also been identified and refined to ensure a more efficient and timely

response to complaints. For example, all complaints will be acknowledged within three working days.

Key finding: Complainants did not feel involved in the process.

Action we are taking:

Feeling involved and heard is crucial for complainants. The co-designed complaints process includes early contact with complainants and agreed contact frequency during the complaint investigation to ensure individuals are more actively involved throughout the process and have regular opportunities to contribute their perspectives.

Key finding: Individuals felt that their complaint was not always fully understood and subsequently the response was incomplete.

Action we are taking:

Clear communication is essential. Under the new complaints process, opportunities for learning and understanding will be streamlined to help ensure complaints are fully understood and that our responses address all concerns accordingly. Ways we will do this include: early contact with complainants to understand the questions posed and collaboratively agree the scope and desired outcomes of the investigation; random quality appraisal of complaint response letters by our Patient Council and Patient Safety Partner to ensure relevance and ease of understanding; introduction of a 1 month period after the complaint response has been provided where complainants can clarify any responses and ask further questions; and the implementation of a complaints process satisfaction survey which will include questions around the quality of complaint responses.

Key finding: Complainants were unsure if or were not confident that the Trust had learnt from their experience.

Action we are taking:

Building confidence that we are learning from complaints is vital. We are looking at ways to improve our public reporting and communication of complaints including lessons learnt and complaint themes to demonstrate how we are implementing changes based on feedback. Follow up processes will also be

implemented on a three- and six-monthly bases to review how changes made are progressing.

Report recommendation 1: an audit against service lines is made to identify where the process may not be as robust.

Action we are taking:

We will continue to review data at an individual service line and care group level to identify areas of good practice and opportunities for further support and development.

Report recommendation 2: Carry out a review of the complaints process including timelines to ensure it remains 'fit for purpose' or to identify where improvement can be made to the process.

Action we are taking:

To date we have conducted three co-design workshops with staff, patients' representatives and Healthwatch with a focus on the results of this report. Based on the outcomes of these workshops and report, a new complaints process has been co-designed to ensure it remains fit for purpose from both a patient and staff perspective.

Report recommendation 3: From the review, identify any additional or refresher training for staff involved in the process to improve patient experience, particularly around involvement, communication, and assurance around Trust learning.

Action we are taking:

The design and content of our complaints training will be reviewed with opportunities for implementing mandatory patient experience training also currently being explored.

Report recommendation 4. Consider adding a 'quick link' to the UHPNT Website Homepage for concerns/complaints. Healthwatch accepts that there is a link to PALS in the 'About Us' section.

Action we are taking:

The patient experience website content and layout is currently being reviewed and will be updated soon.

We are committed to improving our complaints process and ensuring that all patients and their families feel heard, involved, and confident in our ability to learn from experiences. Your report has been instrumental in identifying areas for improvement, and we look forward to working collaboratively with Healthwatch Devon, Plymouth & Torbay to enhance our services including co-designing our complaints process satisfaction survey.

Thank you for your continued advocacy and support in improving healthcare services across Devon."

Darryn Allcorn

Chief Nurse & Director of Integrated Professions

University Hospitals Plymouth Trust (UHPNT)

Healthwatch Plymouth would like to thank all those who agreed to be contacted in relation to this conversation.

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