Northern Ireland
Public Services
Ombudsman

Complaints handling in the public sector in Northern Ireland

Research undertaken by the Northern Ireland Public Services Ombudsman

June 2021

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1. Executive Summary

1.1 Introduction

NIPSO undertook this research to gain greater understanding of the complaints processes, procedures and practices of a range of public bodies within NIPSO's jurisdiction. The research was intended to address the complaints handling procedures of the public bodies, including:

- experience of complaining to a public body in Northern Ireland
- barriers to improved complaints handling
- improvements that might be made to complaints handling in the future

The findings are based on five sector-based focus groups with complaints handlers; three complainant and advocacy-based focus groups; a detailed review of 1218 NIPSO complaints files; interviews with four citizens with experience of making a complaint to a public body; research on the complaints procedures of 129 public bodies as displayed on their websites, and a survey of 600 members of the public.

1.2 Findings

The review of the complaints handling procedures of the public bodies found that:

- Complaints-related information on public body websites was not always easily accessible.
- Almost half of the public bodies reviewed did not have a definition of a complaint on their website.
- Access to a complaints policy or guidance to making a complaint was the most consistent element of the information researched.
- Multiple options (most commonly in writing, by phone or by email) are offered for making a complaint by most organisations.
- There are large disparities between public bodies in the number of stages of the complaints process.
- There is variance on whether organisations offer an informal complaints process.

Key experiences of complaining to a public body in Northern Ireland include:

- Evidence the general public can often be reluctant to make a complaint.
- Complaints handlers perceive making a complaint to be straightforward, but the entry point to complain is not always considered clear to those making a complaint.
- Evidence suggests that minority groups are subject to specific barriers. For example, homeless people may not be able to receive written correspondence if they have no fixed address.

- Responses to complaints can take long periods of time .
- Some people making a complaint can feel vulnerable and fear repercussions for their actions.
- The experience of the complaints process can be characterised by uncertainty, frustration and stress.
- People who had experience of making a complaint in the care home sector noted the inconsistent nature of record keeping.

Barriers to improved complaints handling include:

- Complaints handlers' reliance on responses from other staff to resolve issues.
- The availability of the staff members needed for complaint resolution, as well as the complexity of the complaint can prevent quick complaint resolution.
- Pressure on the complaints handlers affects complaint resolution, particularly the number of available complaints handling staff and the volume of complaints.
- A general perception that a public body can focus on blame rather than improvement.

Improvements that might be made to complaints handling in the future include:

- The role of complaints handling needing wider recognition and resourcing.
- Making complaints a priority at the senior levels of an organisation to support the development of a culture of improvement.
- Public bodies learning from good practice already happening.
- In general, complaints handling being improved by simpler, faster and more transparent complaints processes.
- Greater support for people making a complaint, possibly with external agencies.

1.3 Conclusions and Reflections

There is room for wider standardisation of complaints processes and handling in order to simplify complaints handling across public bodies.

Recognition of the complaints handlers' skill set is important for improving complaints handling because of their specific skill set and unique role that links the person making the complaint to the public body. Training and retention of complaints handlers, as well as the prioritising of their role in an organisation is important in any future development of complaints handling.

Any large-scale improvement to complaints handling is dependent on a positive culture towards learning from complaints with public bodies recognising that services are always changing and developing and therefore there will always be aspects of a service that could be improved.

Best practice can be shared within a sector but could also be shared across sectors which might also extend beyond complaints handling practice to include the promotion of good governance in relation to complaints handling.

2. Introduction

The Office of the Northern Ireland Public Services Ombudsman (NIPSO), under Part 3 of the Public Services Ombudsman Act (Northern Ireland) 2016, has the powers to set standards in the management of complaints. NIPSO provides a free, independent and impartial service to members of the public who believe they have suffered an injustice as a result of the actions of a public service provider. This research was undertaken in order to gain greater understanding of the complaints processes, procedures and practices of a range of public bodies within NIPSO's jurisdiction.

The research was intended to address the complaints handling procedures of the public bodies, including:

- experience of complaining to a public body in Northern Ireland.
- barriers to improved complaints handling.
- improvements that might be made to complaints handling in the future.

The research findings are based on a series of elements undertaken or delivered on behalf of NIPSO:

- Five sector-based focus groups with complaints handlers who work for public bodies in local councils, government departments, education, health and social care, and housing. These group discussions were facilitated by NIPSO staff during 2018. Approximately 100 people attended these discussions;
- Three complainant and advocacy-based focus groups which took place in 2018:
  - people with experience of complaining in one care home (15 participants);
  - representatives from organisations with experience in the field of equalities and human rights (15 participants);
  - representatives from advocacy bodies (14 participants);
- A detailed review of 1218 NIPSO complaints files selected randomly from the years 2012-18. This work was completed in October 2020;
- Interviews with four citizens with experience of making a complaint to a public body. These interviews took place in May and June 2020;
- Research on the ease of accessibility, and nature of complaints procedures of 129 public bodies' websites, considering the similarities and differences of approach within and between different sections of the public sector in Northern Ireland. This work was completed by NIPSO in May 2021; and
- A public awareness survey carried out by Opinion Research Services, was completed in May 2021. 600 participants each took part in a telephone interview to determine their experience of making a public service complaint.

3. Findings

3.1 The complaints handing procedures of the public bodies within the remit of the Ombudsman

Research was carried out by NIPSO which examined the websites of 129 public bodies across various sectors. The full table is included in Appendix 1 and shows all the data compiled. The table below focuses on the largest sectors for comparison and includes 75 of the 129 public bodies in total

Table 1 - Review of complaint information across public body websites: Key aspects for main sectors (75 public bodies out of 129)

Sector	Total number of bodies	3 clicks or less to access complaint info on their website	Had a definition of a complaint on their website	Had a complaint policy or guidance	Multiple options to complain (at least writing, phone or by email)	Had no more than two stages for complaint	Had an informal process within complaint handling procedure
NI Depts & NI Assembly	11	9 (82%)	9 (82%)	11 (100%)	8 (73%)	4 (36%)	7 (64%)
Health	17	15 (88%)	9 (53%)	12 (71%)	15 (88%)	13 (76%)	4 (24%)
Education & Training	18	6 (33%)	11 (61%)	16 (89%)	15 (83%)	4 (22%)	14 (78%)
Local govt	13	9 (69%)	8 (62%)	13 (100%)	12 (92%)	0	6 (46%)
Housing	16	12 (75%)	11 (69%)	15 (94%)	15 (94%)	4 (25%)	5 (31%)

Complaints-related information on public body websites was not always easily accessible

While 61% of all of the public bodies had complaints information three clicks or less from their websites' homepages, almost two fifths of websites required four or more clicks to find this information. Most accessible was the complaints information from the Health sector websites (88% within three clicks or less). While there was a high degree of consistency across each of the HSC Trusts, and the information was easily accessible, it is worth noting the variation in language. Out of six Trusts, four different names of web pages were used; 'Contact us', 'Get in Touch', 'Get involved' and 'About us'.

Almost half of the public bodies reviewed did not have a definition of a complaint on their website

Public bodies defined what they could and could not consider to be a complaint somewhere in the information on their website. This was most common in NI Departments & NI Assembly websites (82%) and least common in the Health sector (53%). The definitions of complaints were not always prominent on NI Department websites, however, and while the similar themes were addressed (delays in receiving information, incorrect information, attitude of staff for example) they were often expressed differently, site-to- site.

Access to a complaints policy or guidance to making a complaint was the most consistent element of the information researched

85% of all of the public bodies had a policy or guidance available on their website. Four of the five sectors were at 89% or higher – with both Local Government and NI Departments & NI Assembly websites with 100% of websites making this information available. The lowest ranked sector was Health at 71%.

Multiple options are offered for making a complaint by most organisations

77% of public bodies offered multiple means (minimum in writing, by phone or by email) to make a complaint. From the compiled sectors, all sectors ranked at 83% or above, with Housing (94%) and Local Government (92%) ranking highest.

There are large disparities between public bodies in the number of stages of the complaints process

The final two areas (the number of stages for a complaint and the offer of an 'informal' complaint) demonstrate the high degree of difference in the complaints processes across the public bodies. 43% of the public bodies offered no more than two stages in their complaints process; therefore, two thirds of public bodies offer three or more stages. The Health sector offers fewest stages (76% two stages or less), however, in the other four sectors, a minimum of 64% deal with complaints in three stages or more.

At present all of the Local Government bodies (13 in total) deal with all complaints in three or more stages. Of the 11 local councils included in this group, there is consistency in a three stage approach, however stage one can be formal or informal depending on the council, and might last between 5 and 20 days. Acknowledging a complaint may or may not be part of this initial time scale. Stages two and three similarly vary in length between 10 and 20 days.

There is variance on whether organisations offer an informal complaints process

Overall, 40% of the public bodies offer an informal complaints process. This is highest in Education & Training (78%), and lowest in Health (24%) and Housing (31%). The regional colleges across Northern Ireland offer the same approach in terms of formal and informal stages and the timescales of each stage.

Comments from the focus group research shed light on this variance, as participants considered there to be advantages and disadvantages. In general, informal complaints might be considered as a stage before the more structured complaints handling process takes over (written records, interviews/investigation, time frames etc). However, the definition of an informal approach varies, for example some public bodies do not record informal complaints or offer any timeframe. Some do not offer an informal process at all. Complaints handlers generally considered an informal process to be an aspect of good practice and considered the main advantage of an informal complaints process to be the speedy resolution of issues that can be easily fixed. The focus group with experience of complaining in a care home setting also noted the benefits of an informal complaint as it gave staff the opportunity to resolve the matter quickly, before a formal complaint was made.

"Not having to record a formal written complaint … the benefit to the customer is [they] get an immediate and personal resolution … they get a quicker response".
(Complaints handlers' focus group participant)

"Process wise, formal and informal aren't really different in how they are handled … [the person making the complaint still receives] acknowledgement letters and have target response times of five days and 20 days. The difference is in the detail or depth of the investigation … informal is a review process rather than an investigation with interviews."
(Complaints handlers' focus group participant)

Complaints handlers, however, also acknowledged this approach can come with drawbacks. For example, if informal complaints are not recorded, then recurring issues cannot be monitored and fixed. In some instances, informal complaints are not subject to the usual time frames and do not always receive the same attention from members of staff. There was also evidence in the equality/advocacy focus groups that an informal process is advantageous because of its speed, but there was recognition that this is conditional to communicating with a member of staff with sufficient skills and confidence to deal with the issue.

"There could be serious issues … patterns emerging that we don't know about … [an informal process] lacks openness."
(Complaints handlers' focus group participant)

Case Study 1

The bullying started in my daughters first year at secondary school. I phoned the school to make them aware of it, but nothing was done. In the middle of her second year, another incident took place, and this escalated to social media. I made a complaint and went to the school to speak to the deputy head. The school throughout the whole ordeal didn't properly record any of the incidents. I was worried about my daughter's well-being and performance.

Further incidents happened, but when I complained, I didn't feel that my complaints were being taken seriously, as nothing changed for my daughter while she was at school. On one occasion I approached the school and was referred to a pastoral care teacher who was little to no support and didn't even know who my daughter was. I sent a letter to the Board of Governors, who invited me to a meeting, however the bullying still continued. In the end, I had to withdraw my child from school as it was unsafe for her physically and mentally being there.

I contacted the Children's Law Centre and met with them to seek advice as I was at my wits' end. They were very helpful. I didn't know where else to go as the Board of Governors were no help, they did not uphold my complaint. We discussed strategies to get my daughter back to school. Further meetings with the school were difficult, they refused to allow an advocate for my daughter to be present at the meetings. One in particular, the Board of Governors appeals meeting, was the most horrible experience. It was intimidating, one of the panel members was aggressive, argumentative and talked over my husband and I was in tears.

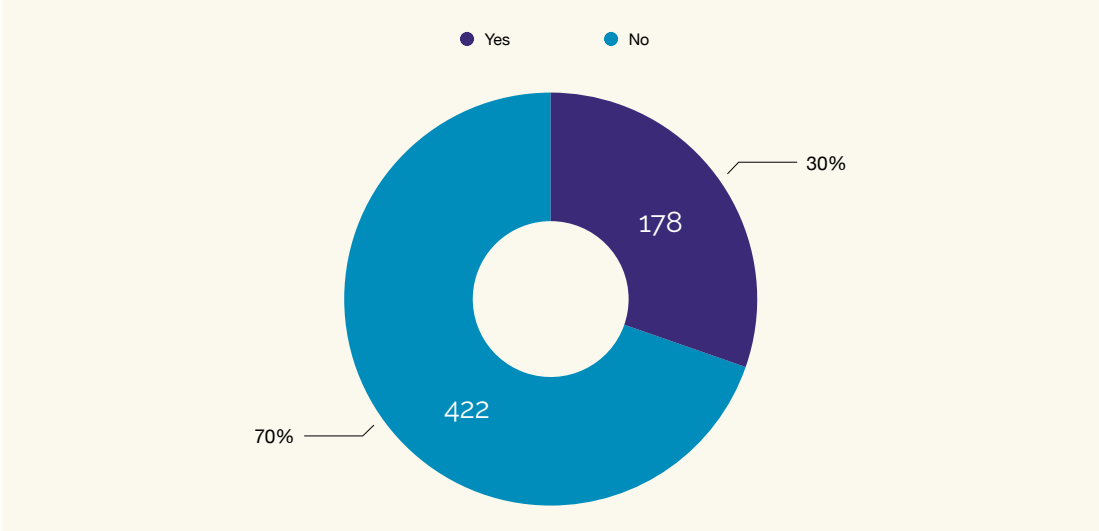
I received a letter from the Board of Governors to say I had exhausted the complaints process. I made a referral to the Ombudsman. Their investigation was thorough and looked at a lot of detail. A draft report was written, but the school's slow response delayed the process unnecessarily, they claimed they did not understand the process. Deadlines should have been set and adhered to.

3.2 The experience of complaining to a public body in Northern Ireland

There is evidence the general public can often be reluctant to make a complaint

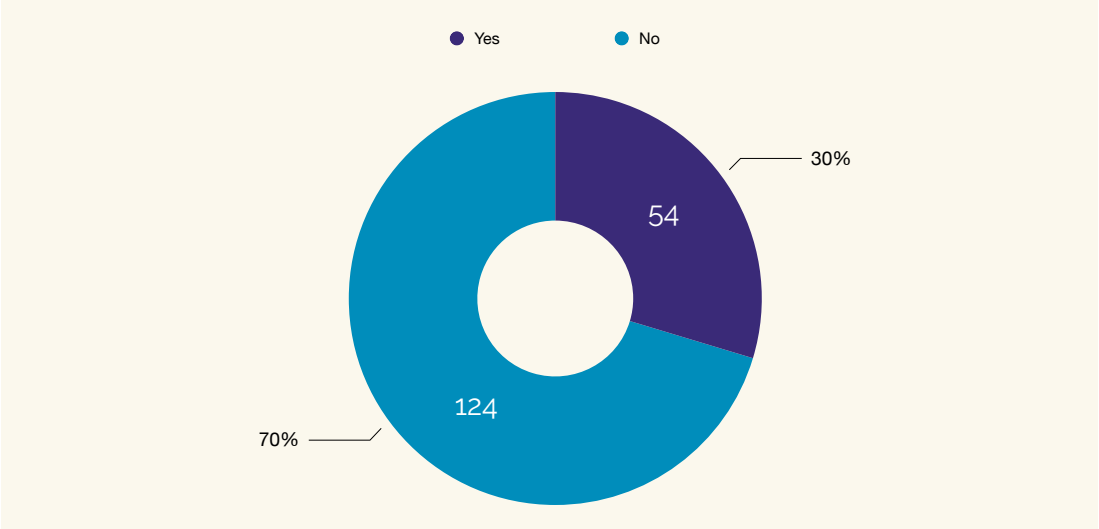
NIPSO recently commissioned a public awareness survey based on a sample size of 600 and representative of the Northern Ireland population. Their responses shed some light on the general public's attitudes to making a complaint. Overall, just under one-third (30%) of residents are dissatisfied with the level of service they had received from a public body in the last five years.

Chart 1 – Participants who were dissatisfied with level of service in a public body in the last 5 years



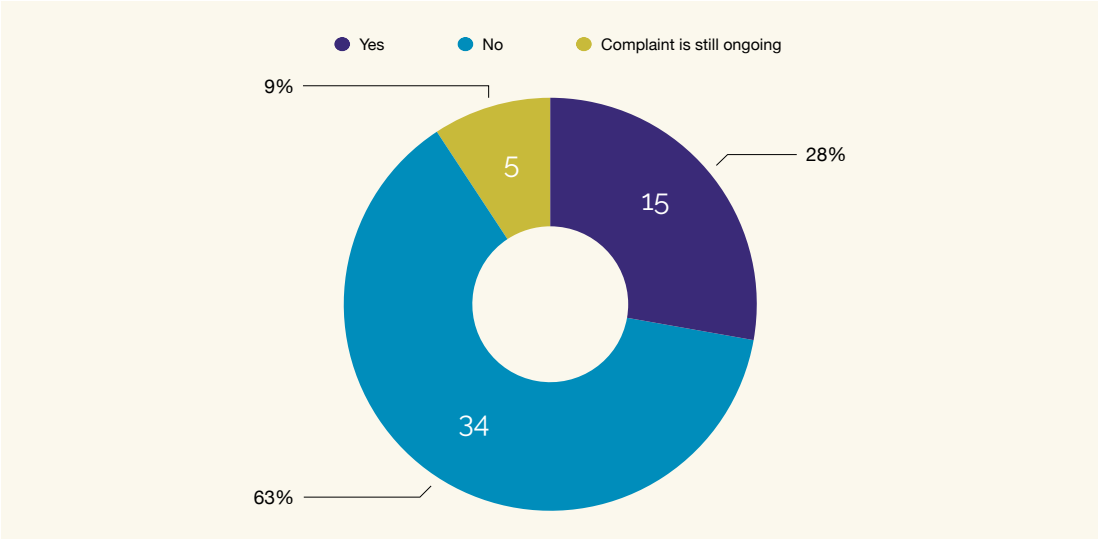
Of those 178 participants, only 54 (30%) had made a complaint and 124 (70%) had not.

Chart 2 – Participants who made a complaint if dissatisfied



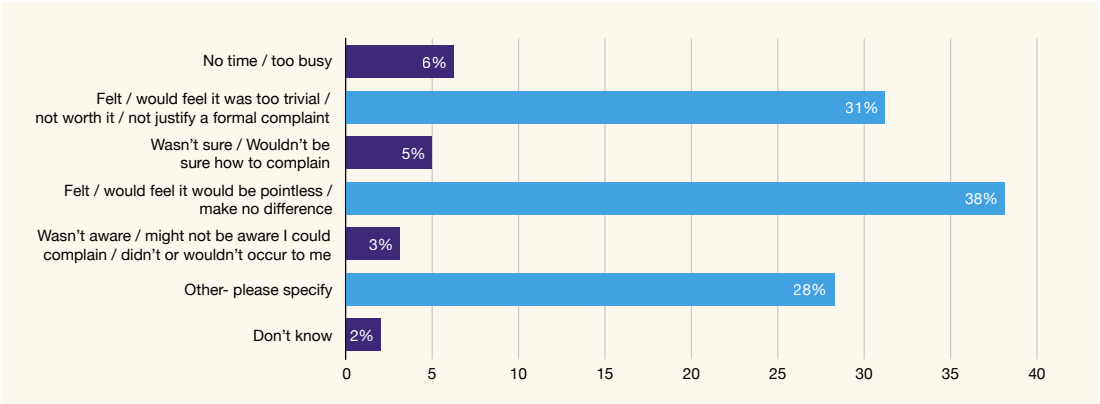
Of those who did make a complaint, just over a quarter (28%) considered the matter resolved, while nearly two-thirds (63%) considered the matter unresolved and nearly a tenth (9%) considered the matter ongoing.

Chart 3 – Participants who considered their complaint to be resolved, unresolved or did not know



There was a wide range of reasons why participants did not or would not complain. Out of the 38% of residents who did not or would not complain, around three in ten (31%) considered the matter too trivial or not worth the effort to justify a complaint and more than one-third (38%) considered that making a complaint was pointless, or that it would make no difference.

Chart 4 – Why participants chose not to complain



There was also evidence from the various focus groups which suggests there are many factors that act as barriers to making a complaint, dissuading people from doing so. It can be perceived to be a complicated process; formal and sometimes technical language is used. It takes time and sometimes the discussions demonstrated there is a belief that the public body will not take the complaint seriously and that it is too large and powerful to properly address the complaint of a single person.

"[The process is] going toe-to-toe with a powerful organisation that is too big to take on."
(Complainant and advocacy focus group participant)

"For every two complaints you could have 25 dissatisfied customers that don't complain."
(Complaints handlers' focus group participant)

Complaints handlers perceive making a complaint to be straightforward, but the entry point to complain is not always considered clear to those making a complaint

When complaints handlers were asked to assess aspects of good practice, most focus group participants considered the process of making a complaint to be 'simple', 'open' and 'accessible' to the general public. The website research in section 3.1 also found high levels of complaints policies and procedures on public bodies' websites. However, while there is evidence of some mitigations in place (such as textphone services, or the offer of an interpreter) barriers to making a complaint remain, as not everyone has digital access, or the required level of IT skills to access and respond to this information. Complaints handlers also recognised that the people wanting to make a complaint may experience certain barriers, such as literacy difficulties.

Research participants, with experience of complaining in a care home setting, stated they had received no information about how to complain at the point of entry into the care system and did not know they could complain to anyone outside the care setting.

Evidence suggests that minority groups are subject to specific barriers

The focus groups with advocacy/equality organisations highlighted how there are specific barriers for certain groups. Homeless people, for example, may not be able to receive written correspondence if they have no fixed address. People who are blind or with sight difficulties may find it difficult or impossible to read correspondence. People from certain ethnic minorities may experience a cultural resistance to making a complaint. Also large sections of the population struggle with literacy and language difficulties, thus limiting their engagement with and understanding of the complaints process.

"The Trust wouldn't let me to complain on my father's behalf. The Trust asked for my father to sign a letter of consent which I asked him to do, my father was upset as he was blind at the stage."
(Individual interview with someone who made a complaint)

Responses to complaints can take long periods of time

Despite public bodies intentions noted in their policies and procedures to respond to complaints quickly, there is evidence that some response times were lengthy. The review of NIPSO's own case files demonstrates a high volume of responses taking longer than 2 weeks, with just over 60% of complaints taking longer than 15 days to achieve an initial response.

Table 2 – Overview of public bodies' response times to complaints (of cases analysed)

Complaints finished with public body at...	No. finished with public body at this stage	Response in 15 days or less	Response in 16 - 60 days	Response in 61 days or more
First stage	267	102 (38%)	119 (45%)	46 (17%)
Second stage	170	64 (37%)	78 (46%)	28 (16%)
Third stage	79	42 (53%)	30 (38%)	7 (9%)

Chart 5 - Public bodies' response rates to complaints at stage one (No. of days taken to respond at that stage)

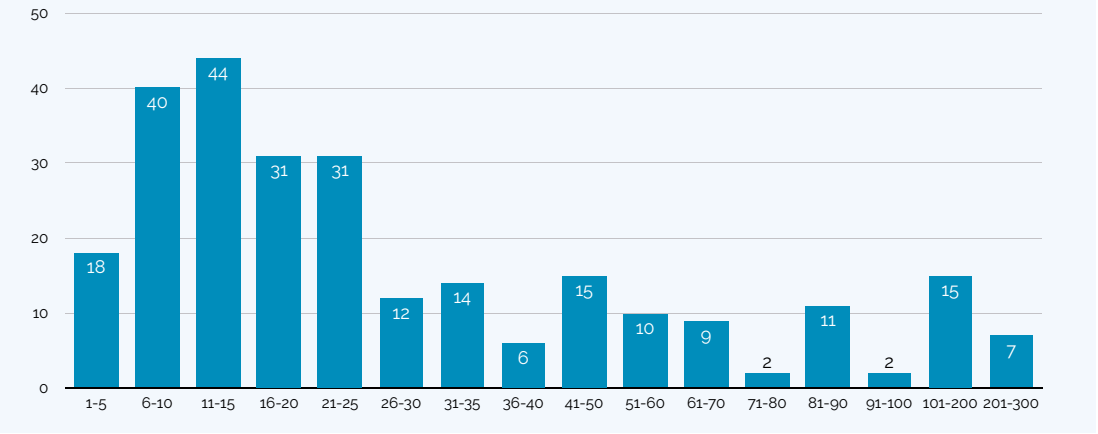


Chart 6 - Public bodies' response rates to complaints at stage two (No. of days taken to respond at that stage)

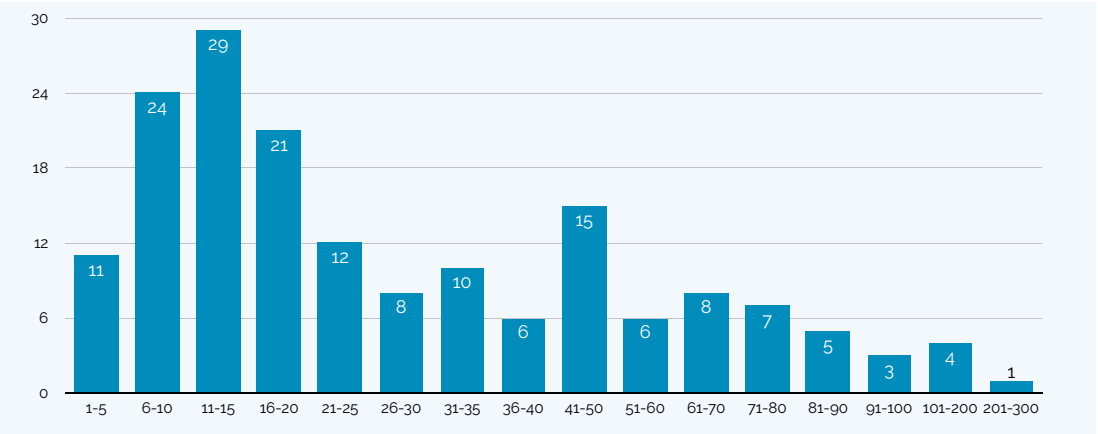
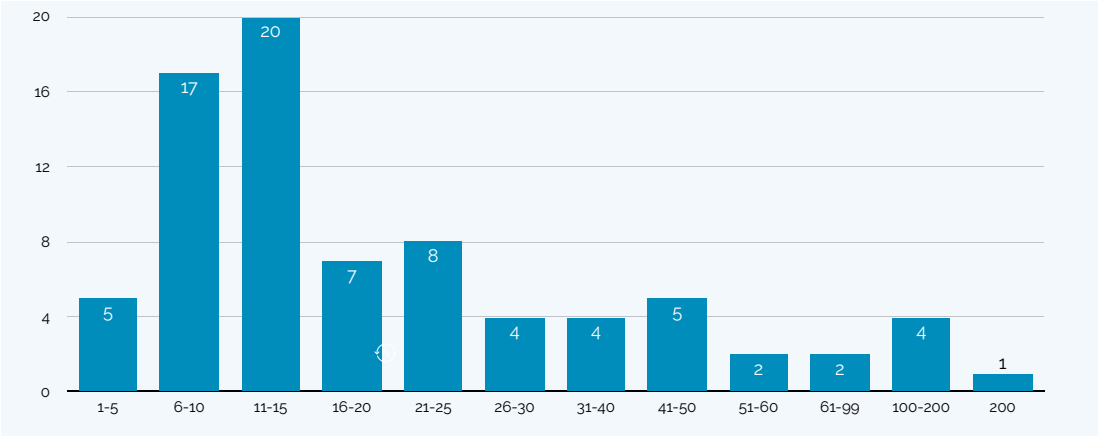


Chart 7 - Public bodies' response rates to complaints at stage three (No. of days taken to respond at that stage)



"It took over four months to get a formal response from the doctor ... [about] what happened to my father ... I submitted a freedom of information request for details of the illness of my father which took 90 days for the Trust to reply." **(Individual interview with someone who made a complaint)**

Some people making a complaint can feel vulnerable and fear repercussions for their actions

A recurring theme across all focus groups was the fear sometimes felt by someone making a complaint that their actions would lead to repercussions such as a lack of response from the public body about a service or the removal of a service. People making a complaint can feel exposed or vulnerable during the complaints process, often feeling that they are insignificant in the face of a much larger entity.

"You are not protected if you complain about care in nursing homes, from your GP or about domiciliary care ... In a nursing home you could be asked to leave, you could be told to find another doctor, your domiciliary carer doesn't turn up, you'll receive less medication, feeding or care, you're moved down the waiting list for a service." **(Complainant and advocacy focus group participant)**

"[Making a complaint people can be] vulnerable for whatever reason … for example literacy, language, confidence, emotional state."
(Complainant and advocacy focus group participant)

"Fear, as a factor in deterring complaints, is more relevant to complaining about health or housing services."
(Complaints handlers' focus group participant)

The experience of the complaints process can be characterised by uncertainty, frustration and stress

While complaints handlers generally considered complaints processes to be clearly set out, there were varying degrees of evidence across all focus groups that a lengthy complaints process could still be confusing for the person complaining. There was recognition that uncertainty was common for the complainant about what stage the process was at and particular concern about what was causing a delay. If no reason for delay was offered, complainants sometimes felt information was deliberately being kept from them and that the process was less than open and honest. Complainants could also feel suspicion about the process of a public body investigating itself.

"[People] see it as like … you are complaining to the organisation about the organisation … it is a David and Goliath thing … the decks are stacked from the outset … we'll whitewash them … [as a result] our role is to stress and ensure transparency [for complainants]."
(Complaints handlers' focus group participant)

"People feel like they are being fobbed off … [the organisation is] not taking them seriously [and only] responds or does something when we contact them."
(Complainant and advocacy focus group participant)

"The staff came to me and said if you have any concerns then come to us. But I said, 'I have been to you and I don't think my concerns are being taken seriously.'" **(Individual interview with someone who made a complaint)**

"I was very frustrated at the response I was getting from the Trust, and I wanted the facts to be looked at fairly, impartially by professionals who could assess the notes and really find out what happened to see if my complaint was justified and to see if there were these serious issues." **(Individual interview with someone who made a complaint)**

"Most people don't have the time to persevere I think the Trust use frustration to put people off making a complaint." **(Individual interview with someone who made a complaint)**

"Not keeping in touch with complainants and providing updates or not explaining long delays causes suspicions … people see collusion and cover up …[when] sometimes the [listed authority] is doing something" [to further the complaint.]" **(Complainant and advocacy focus group participant)**

A further level of uncertainty was in the complainants' lack of understanding of the roles and remits of external bodies (such as NIPSO, the Patient Client Council or the Regulation and Quality Improvement Authority). In NIPSO's review of 1218 of its own case files (between 2012 and 2018), only 670 of these cases were actually within the Ombudsman's jurisdiction. .

One focus group participant (from an advocacy organisation) summed up the main difficulties of the complaints process as "fear, futility and fatigue". Some complainant and advocacy focus group participants noted how the process of complaining can also be emotionally draining, varying according to the nature of the complaint, and if the citizen complaining has a mental health condition to begin with. NIPSO's review of case files also demonstrated that personal impacts included stress and distress, anxiety, frustration and demoralisation.

Dealing with what may have been a traumatic episode for someone and/or their loved one can often result in the complainant reliving their experience. Participants in the complainant and advocacy focus groups commented on how levels of support for someone making a complaint varied. This was of particular importance if dealing with the complaint took an extended period of time.

"Sometimes it is just the grief process and people don't want to see [the complaint] or deal with it anymore. It is not fair to expect people to keep going over a long time reliving the issue … We need to resolve complaints in a short period of time."
(Complainant and advocacy focus group participant)

"Your complaint has come about because of something that wasn't your fault, but the impact it has on you is huge … [it is the] first thing you think about in morning and last thing at night … [you are] constantly trying to think of how your complaint could be reworded so it could be accepted."
(Complainant and advocacy focus group participant)

People who had experience of making a complaint in the care home sector noted the inconsistent nature of record keeping

Participants in this focus group were often frustrated because written records were not made of complaints and meetings were not minuted. In the absence of written records, participants felt that making or continuing a complaint becomes one person's word against another. There were additional concerns that when complaints were made or forwarded to the HSC Trust, responses were made without any attempt to meet with the person or people who had made the complaint. Participants therefore questioned how this could be appropriate, given the absence of records or documentation of their complaints.

Case Study 2

My husband died from cancer. There were failures in his treatment, a lack of communication both with him and between Trusts, and there were also delays in dealing with my complaint.

There was no communication, no one wanted to speak to me. I became very anxious and my children became very distressed. My husband was in the wrong hospital.

This period was horrendous, I will never forget it. Some of the nurses were excellent but there were staff that couldn't care less and there were days he didn't get washed. One of the last times we spoke he told me how bad the treatment was. There was negligence and poor care. We were let down by the NHS. There was no coordination between the three hospitals, two Trusts, consultants, and doctors. What happened shouldn't have happened.

We complained, but when I received the report from the Trust there was an awful lot in the report that I didn't agree with and was not true. If the Trust had been honest and admitted mistakes had been made it would have been better.

Case Study 3

When my mum died the whole family was devastated. I felt she hadn't received the best care and I was determined to make sure this was not going to happen to anyone else. I was very frustrated at the response I was getting from the Trust, and I wanted the facts to be looked at fairly, impartially by professionals who could assess the notes and really find out what happened to see if my complaint was justified and to see if there were these serious issues.

After I received the Ombudsman's report I felt relieved, I felt that I had got part of my life back that had been consuming me for four years trying to get to the bottom of what had happened in my mother's case. It did find failings and there was maladministration. I felt the Ombudsman addressed the injustices. I was most impressed with the various codes of practice which were drawn upon to highlight these issues. I felt it brought me some peace.

3.3 The barriers to improved complaints handling

Complaints handlers roles can be difficult as they rely on responses from other staff to resolve issues

The role of complaints handlers is firstly to gather details of the complaint. What response is then made to the person complaining, as well as who makes that response, will vary according to the complaint, the sector and the individual organisation. Complaints handlers rely on the information provided by other members of staff. In the perception of some complaints handlers, this is not always seen as a priority, and getting staff to supply information within a given time frame can be difficult.

> *"Complaints handlers have responsibility for complaints, but little to no powers [to ensure compliance]."*
> **(Complaints handlers' focus group participant)**

> *"If it gets too bureaucratic … it's not what people want, they just want their query or issue resolved … a pragmatic approach is important".*
> **(Complaints handlers' focus group participant)**

Many complaints cannot be resolved quickly due to the availability of the staff members needed for resolution, as well as the complexity of the complaint

Complaints handlers recognised there were legitimate reasons for the slow response of staff. There are often operational pressures as staff continued to do their own jobs as well as investigating complaints. Absences and vacancies can result in staff taking on additional responsibilities, if there is increased demand on frontline services, this can have an accumulative effect on complaint resolution. Also, information required from third parties outside of the public service can further slow the process.

In this context, complaints handlers commented on the complex nature of some complaints, for example if the complaint is about more than one aspect of a service or involving several key personnel. In more complex cases the initial response received by the person complaining may not answer their question or fully address the issue and so the complaints process is elongated.

> *"[Clinicians] want to clear their names … sometimes want to seek legal advice or advice from the General Medical Council … [this] can lead to delays … There is generally no problem with ownership of a complaint or leadership on complaints".*
> **(Complaints handlers' focus group participant)**

"Sometimes you can't give people what they want … if disciplinary processes are ongoing … you cannot disclose … so the response might have to be circumspect, or if there are multiple complaints or heads of complaints. Sometimes it is an oversight, or the question is missed, or sometimes it is jargon in the response but we [complaints handlers] try to cover this with footnotes used to explain technical language."
(Complaints handlers' focus group participant)

Pressure on the complaints handlers affects complaint resolution

Handling of complaints is also affected by pressure on the complaints handling teams, particularly the number of available complaints handling staff and the volume of complaints (which can rise seasonally, depending on the sector). Some complaints handlers perceived a reduction of complaints handling staff, as well as a reduction of public service staff in general. This broader reduction can contribute to a less effective complaints handling service, and therefore more complaints. There were also some perceptions that service users' expectations are increasing.

Complaints handlers made some comment on how best practice complaints handling can, when called for, be face-to-face, which allows for dialogue, checking that the information has been understood and therefore a greater possibility that the issue has been resolved. Websites can give information, but not necessarily reassurance. There was some expression that the space and time to deliver information clearly, sensitively and personally (if not always in person) was a critical aspect of complaints handling that time constraints did not always allow for.

"At a local level people have other roles … At regional level there are dedicated complaints handlers … these are not big teams [who are] also dealing with subject access requests and freedom of information. Statutory deadlines trump deadlines for complaints". **(Complaints handlers' focus group participant)**

"[When people phone us] nobody asks how many complaints we've received … people are upset, and they want information … meeting the needs of the public isn't simply responding by formally creating a complaint."
(Complaints handlers' focus group participant)

"There is lots of work done on managing expectations … and to try to explain in accessible language why a decision has been made and why a different decision cannot be made. Staff going out to explain face to face very often is the best way to explain complicated issues … [because] complainants can ask follow up questions." **(Complaints handlers' focus group participant)**

"People phone to get information or find out … they want to talk to somebody rather than [read] information on a website … often they are seeking advice rather than making a complaint." **(Complaints handlers' focus group participant)**

There was a general perception a public body can focus on blame rather than improvement

Some participants from an advocacy perspective commented that the current approach to complaints processes focused too much on identifying failures and apportioning blame, rather than focussing on learning and sharing lessons. In their perception, this encouraged personal and organisational defensiveness. They also expressed the view that the current approach did not deter the rejection of complaints as a default first response by a public body, who would later accept the complaint only if the complainant challenged the decision. The process was characterised as reactive rather than proactive, and there was a perception that public bodies are going through the motions of the process and not really trying to resolve the problem.

Complaints handlers made frequent comment, but not blanket comment, on the existence of a culture of blame, avoidance of ownership, and complaints not being seen as an opportunity to improve a service. Complaints handlers also commented on good practice in sectors where this has changed and continues to change, but recognised the limits to their role where a negative approach remains.

"When I received the report from the Trust there was an awful lot in the report that I didn't agree with and was not true. If the Trust had been honest and admitted mistakes had been made, it would have been better." **(Individual interview with someone who made a complaint)**

"All [of the listed authorities in the local area] make a genuine effort to adhere to good practice … and there is evidence of learning and improvement … but organisational culture is defensive and remains so." **(Complainant and advocacy focus group participant)**

"There may be cultural issues in organisational maturity, defensiveness, not [seeing an] opportunity to improve. [There] is an opportunity to record all issues raised … not just formal complaints."
(Complaints handlers' focus group participant)

"[Handling complaints is] very challenging for complaints handlers … very stressful … [dealing with] defensive internal colleagues and aggrieved complainants … getting full and frank access to information internally can be difficult."
(Complaints handlers' focus group participant)

"[Our organisation] could definitely do with being better at identifying and sharing lessons learned." **(Complaints handlers' focus group participant)**

3.4 Improvements that might be made to complaints handling in the future

The role of complaints handling needs wider recognition and resourcing

As previously discussed in section 3.3, complaints handlers were clear that they rely on other professionals to respond to their requests for information or to carry out an investigation into an incident or practice. There were concerns that difficulties arise when professionals, proficient in their field, are asked to undertake an investigation with insufficient skills and experience to do so properly. One complaint handler commented that, while staff are trained in investigating an incident or issue, it is not always something they do regularly enough to do well. They noted the specific skill sets; "I couldn't teach geography but I'm asking a head of school to conduct an investigation to a high standard." Greater assistance from the complaints handlers might improve this process.

Complaints handling therefore requires training and expertise, and resourcing to do the job properly. There was some expression in the focus groups of resources being cut or stretched more thinly than before. There was also a perception from some participants that the volume of complaints is increasing and, in some cases, (housing, particularly) that the needs of sections of the client base are becoming more acute. Not only resourcing complaints handlers, but retaining complaints handlers, are vital aspects to improving complaints handling in the future.

"Having experienced teams, dedicated to complaints handling in local offices is a real strength ... Some areas ... staff are very good at going out to meet people... Regional offices do this, and it is valued by complainants as they feel listened to." **(Complaints handlers' focus group participant)**

"[It] can also be difficult if a second stage investigation finds that the first stage, although it was done by the book and everything done right, didn't see the big picture or was communicated badly to the complainant". **(Complaints handlers' focus group participant)**

Making complaints a priority at the senior levels of an organisation would support the development of a culture of improvement

As previously discussed, dealing with complaints can often be seen negatively as opposed to an opportunity for improvement to a service. Within all the focus groups, there was evidence of a perception that lessons are not always being learnt fully. Complaints handlers noted that more attention was paid to addressing a complaint when senior staff and/or management were more proactive. Greater levels of organisational change occurred when the complaints processes were made a priority from the top of the organisation down. Complainant and advocacy focus groups also suggested moving away from using the word 'complaints' with its adversarial implications, preferring instead 'feedback' which might be considered positive or negative.

Public bodies can learn from good practice already happening

There was plenty of evidence of good practice from the participants in the complaints handlers focus groups, particularly relating to how complaints can inform a wider process of improvement. Organisations not currently in the habit of comparing and contrasting their approach to complaints might consider developing a practice of shared learning both in their sector and across sectors.

- One HSC Trust has a review group which considers any adverse event and complaints in a Trust-wide context and decides whether learning from the incident is applicable outside the relevant area. In addition, it was reported that this Trust has a service user experience feedback group which meets six times per year.
- One third level organisation in the education sector reported that lessons learned from complaints are shared with heads of schools. The Chief Executive had been explicit in support for the implementation of any recommendations as a means of improvement. These recommendations are later 'spot checked' and there is a link created between lessons learned from complaints and the internal audit schedule.
- In housing, one organisation provided examples of how it is building links between complaints handling, its business improvement unit and its customer excellence framework. A 'lessons log' is populated from second stage investigations and lessons learned are brought to monthly housing and senior managers' forums.
- Within government departments it was reported that the general practice is for directors to promote lessons learned within their directorate. Practices vary, however, across different organisations, but there is a practice of sharing lessons with business / service managers, the information and risk-owners forum or other sub-board groups. Focus group participants from local councils reported that complaints officer roles are assigned at a sufficiently senior level within departments to promote compliance and implement learning which is routinely shared across business areas. It was also reported that local councils seek post-complaint feedback from 10% of complainants.

In general, complaints handling could be improved by a simpler, faster and more transparent complaints process

Discussions in the complainant and advocacy focus groups suggested that a more standardised approach to complaints processes would be more helpful for the general public. They note that a degree of uniformity in the complaints procedures might enable people, over time, to become familiar with the process.

One complaints handlers' focus group made specific comment about ensuring informal complaints are recorded as it is important to monitor areas where improvement is needed and not just the immediate resolution of one specific issue.

Complainant and advocacy groups also noted a need for any system not to be solely 'process-focused' built around a correspondence-based approach. Addressing the needs of people raising an issue or incident needed to be the priority. There was further comment on how it would be desirable for greater speed in the complaints handling as well as a more open process with clear lines of communication so that people making the complaint know exactly what stage they are at.

There could be greater support for people making a complaint, possibly with external agencies

Complainant and advocacy groups noted the physical and mental toll of making a complaint (usually over a serious issue, with a prolonged response time). This theme also came through in NIPSO's review of cases. The complainant and advocacy focus groups supported allowing advocates and advocacy organisations to make a complaint on behalf of a service user, as well as tailored support to be made available in a variety of formats throughout the process to reflect the needs of the person making the complaint.

> *"There is a real need for support … when you're complaining you're on one side and there are lots of people on the other side, there is no one sitting on your side … I needed someone to sit beside me."*
> **(Complainant and advocacy focus group participant)**

Case Study 4

There were failings in the care and treatment of my elderly father, as well as a very poor complaint handling and investigation process.

When I look back at my notes now, it has brought back mine and my father's pain from the time he was ill. There were long delays to begin with. It took a few days for a doctor to see my father when he first experienced blindness. It happened during visiting time and I rushed to the nurses' station for assistance for my father. It was quiet that evening and I approached two senior nurses and explained what had happened and asked for them to come and help my father. They said they were not responsible for my father and when I asked for a doctor, I was told there were none available.

I pleaded with them to call a doctor for my father. It took 15.5 hours for a doctor to see my father and the senior nurses did not come and see him or talk to him to try and reassure him as he was very anxious – over the course of 2 days. I could not believe what the two Staff Sister's said to me regarding coming to see my father or their lack of empathy and, after telling me no doctor was available, why they did not walk the 20 feet to my father's bed to examine or talk to him about his sudden onset bilateral blindness. My father was awake all night worried, hoping that a doctor would come. It was awful for him and the family felt helpless.

When he was in hospital, there were blood stains on the ceiling tiles above my father's bed and there were cases when bedpans spilled onto the floor and were not cleaned up properly. My father's drip fell out one day and it took hours for it to be replaced. The ward, which was full of old people, had no TV or radio – no distraction for the patients or to help lift their mood. I felt the staff did not do enough for my father.

I began to write letters of complaint to the Trust. I copied in the Chief Executive in the hope the letters were going to be taken seriously. I was frustrated because the Trust would only send me letters by post. I involved the Patient Client Council as I was frustrated with the process. The Trust wouldn't let me complain on my father's behalf. They asked for my father to sign a letter of consent which I asked him to do, but my father was very upset as he was blind at the stage and was frustrated the Trust would not accept his complaint without him signing the form and he said do they not know I am blind. He could not read what he was signing. It was heart-breaking to watch him try and sign his name in the little box on the form as his signature was all over the place. It was totally insensitive, and my father nearly did not sign the form as he was very distressed. It was so sad, but it was the only way for the complaint to be accepted by the Trust.

I was not offered the opportunity to meet any of the doctors or nursing team to discuss my father's care. I was only offered a meeting after my father had passed away. It took over four months to get a formal response from the medical team about what happened to my father. There was no attempt to resolve my complaint earlier on. The Trust didn't have my father's welfare in mind and the complaints process frustrated me and my father.

I rang the Ombudsman's office for advice and was told I had to exhaust the Trust's complaints process. It took over two and a half years to do this. I submitted a freedom of information request for details of my father's illness. It took ninety days for the Trust to reply. The whole experience was mentally and physically draining. Most people don't have the time to persevere. I think the Trust use frustration to put people off making a complaint. At one point the Trust told the Patient Client Council they left a message on my home phone offering to set up a meeting with my father and me. I asked the Patient Client Council if they could confirm the meeting details with the Trust as my home phone does not have a facility to leave a message. The Trust replied to the Patient Client Council, 'Apologies, it was a different Patient'. There was no attempt at all to set up a meeting or any offer of a meeting made.

The Ombudsman report into my father's complaint found a failure by the Trust to appropriately assess and make timely decisions to seek expert advice regarding my father's eye condition. This failure continued after the initial inadequate assessment as several other Doctors and Consultants examined or reviewed my father. The ongoing significance of his developing "red eye" condition should have been further and sooner investigated and escalated. My father's case did bring about some changes in patient care, proper hand-over and follow-up process between shifts and Trusts involved in patient care and the complaints process.

4. Conclusions & Reflections

A number of themes emerge from the research.

There is room for wider standardisation of complaints processes and handling

The process of making a complaint could be improved by standardising stages, time frames and (for some public bodies) improving the accessibility of information about making a complaint. These steps would help to simplify complaints handling across public bodies and, while there would be some variation sector to sector, there would at least be greater consistency in the process.

Recognition of the complaints handlers' skill set is important for improving complaints handling

The research has made clear that complaints handlers have a specific skill set and unique role that links the person making the complaint to the public body. While the role of complaints handlers will differ slightly, sector to sector, and between organisations, in general, a complaints handler needs to:

- record key details from the outset
- fully understand the concerns of the complainant so as to address these properly
- have a high level of people skills, including the ability to empathise
- investigate issues thoroughly and fairly
- know policy and procedure
- report back to people who have made a complaint with the right level of accessible information in context
- ensure the complaint has been fully addressed to the satisfaction of the person making the complaint

Training and retention of complaints handlers, as well as the prioritising of their role in an organisation is important in any future development of complaints handling. They need to be valued as key members of staff that help organisations to improve and develop. Prioritising the role of complaints handlers is a critical aspect of any attempt to increase public bodies' focus on the early resolution of complaints.

Any large-scale improvement to complaints handling is dependent on a positive culture towards learning from complaints

The culture of a public body was a recurring theme throughout the research from all participating focus groups. A negative approach to complaints was a key feature in people's experience of making a complaint and is a key barrier to improvement in services. A simpler, more efficient process and well trained and resourced complaints handlers will always be undermined by negative or defensive responses from a public body.

The process would be helped by organisations across the sectors recognising that services are always changing and developing, albeit at different rates, and therefore there will always be aspects of a service that could be improved. The complaints process is one way to do that. This change in perception can only come from the top of the organisation.

Best practice can be shared within a sector, but could also be shared across sectors

While complaints handlers made widespread comment about the sharing of practice between themselves particularly, and, to varying degrees across their sectors, it was unclear of the extent of sharing of best practice between sectors. While there are obvious sectoral differences between the nature of complaints and the types of responses needed, there may well be shared points of learning and fresh perspectives on complaints handling.

The sharing of best practice might extend beyond complaints handling practice to include the promotion of good governance in relation to complaints handling.

5. How the research has been used

The findings from this research project, together with our own extensive experience of dealing with complaints, have helped inform the creation of a draft Statement of Principles (SOP) and a draft Model Complaints Handling Procedure (MCHP). Both documents form part of our current public consultation on creating complaints handling standards for the public sector in Northern Ireland.

The research findings support the need for a streamlined and simple complaints handling procedure for all public bodies in Northern Ireland. We believe that a common set of standards will make the process of complaining easier and will also help staff who handle complaints within public bodies.

We have identified six key principles that make up the SOP for good complaint handling. To ensure good complaints handling by public bodies, we believe they should:

- Start off right
- Fix it early
- Focus on what matters
- Be fair
- Be honest
- Learn and improve

The MCHP sets out clear expectations for how public bodies should manage complaints and how members of the public can make a complaint and follow the complaints process. The MCHP promotes:

- A clear definition of what is and what is not a complaint
- A record of all complaints received
- Early resolution of complaints
- Resolution of complaints within an acceptable timeframe
- Clear stages within a complaints process
- Clear standards of investigation
- Signposting complainants to NIPSO if they remain unhappy with the outcome
- Reporting and publicising of complaints information
- Demonstration of active learning from complaints

6. Appendices

Appendix 1: Review of complaint information across public body websites in all sectors

Sector	Total number of bodies	3 clicks or less to access complaint info on their website	Had a definition of a complaint on their website	Had a complaint policy or guidance	Multiple options to complain (at least writing, phone or by email)	Had no more than two stages for complaint	Had an informal process within complaint handling proce-dure
Govt agencies	5	3	2	4	5	3	1
Arts	6	3	0	5	4	5	1
Health	17	15	9	12	15	13	4
Housing	16	12	11	15	15	4	5
Local govt	13	9	8	13	12	0	6
NI Depts	9	8	8	9	6	3	6
Education & Training	18	6	11	16	15	4	14
NI Assembly	2	1	1	2	2	1	1
Children & YP	2	1	1	1	1	0	1
Policing, Justice and Law	8	2	5	6	5	4	3
Charity & Voluntary	4	4	2	3	2	3	1
Harbours	5	0	0	1	1	5	0
Miscellaneous	19	12	8	18	12	7	8
Industrial Relations	2	0	1	1	1	2	0
Investment & Economy	3	3	3	3	3	2	1
Total	129	79	70	109	100	56	52
%	100%	61%	54%	85%	77%	43%	40%

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