THE HEALTH AND PERSONAL SOCIAL SERVICES (SPECIAL AGENCIES) (NORTHERN IRELAND) ORDER 1990

THE HEALTH AND PERSONAL SOCIAL SERVICES (NORTHERN IRELAND) ORDER 1991

THE HEALTH AND SOCIAL CARE (REFORM) ACT (NORTHERN IRELAND) 2009

The Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009

The Department of Health, Social Services and Public Safety, in exercise of the powers conferred by Section 8 (1) (b) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (**a**), Article 10 of, and paragraph 6 of Schedule 3 to, the Health and Personal Social Services (Northern Ireland) Order 1991 (**b**) and Article 4 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 (**c**), hereby direct as follows:

ARRANGEMENT OF DIRECTIONS

PART I

CITATION, COMMENCEMENT, INTERPRETATION AND APPLICATION

1. Citation and commencement
2. Interpretation
3. Application of Directions

PART II

HANDLING AND CONSIDERATION OF COMPLAINTS BY HSC BODIES

4. Requirements to make arrangements
5. General Duty to Co-operate
6. Responsibility for arrangements and complaints manager
7. No investigation of complaint

PART III

THE INITIAL COMPLAINT

8. Requirement to deal with the complaint
9. Person who may make a complaint

(**a**) 2009 c.1 (N.I.)
(**b**) S.I. 1991/194 (N.I.1)
(**c**) S.I. 1990/247 (N.I.3)

10. Making a complaint
11. Time limits
12. Acknowledgement and record of complaint
13. Investigation
14. Response

PART IV
MONITORING AND PUBLICITY

15. Monitoring
16. Learning
17. Annual Reports
18. Publicity
19. Training

PART V
TRANSITIONAL PROVISION AND REVOCATIONS

20. Transitional provision
21. Revocations

PART I

CITATION, COMMENCEMENT, INTERPRETATION AND APPLICATION

Citation and commencement

1.These Directions, which may be cited as the Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009, shall come into operation on 1st April 2009.

Interpretation

2. In these Directions —

"the 2009 Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"arrangements" means the arrangements which are required to be made under these Directions;

"care" (except in paragraph 9 (4)) means "health care" and "social care", other than care provided under the Children (Northern Ireland) Order 1995(**a**);

(a) provided by a HSC body, or which it is a duty of a HSC body to provide; or

(b) provided in a hospital, regulated establishment or agency or other facility which is managed by a person (whether an individual or a body) who is not a HSC body, and with whom any such body has made arrangements for the provision of care;

"complaint" means a complaint about any matter connected with the provision of care by a HSC body, and "complainant" shall be construed accordingly;

(**a**) S.I. 1995/755 (N.I.2)

"complaints manager" means the person appointed under paragraph 6 (1) (b);

"disciplinary proceedings" means —

(a) any procedure for disciplining employees adopted by a HSC body;

(b) any reference of any matter to a representative body having disciplinary powers over members of a profession;

(c) any reference of any matter to the police; and

(d) any inquiry under the Inquiries Act 2005(**a**);

"former Directions" means the Directions specified in paragraph 21;

"healthcare" has the meaning given to it in section 2 (5) of the 2009 Act;

"HSC Board" means the Regional Health and Social Care Board established under section 7 of the 2009 Act;

"HSC body" means a Health and Social Care body which for the purposes of these Directions (except in paragraph 5 (1)(a)) are the HSC Board, HSC trusts and special agency;

"HSC trust" means a Health and Social Care trust established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991;

"independent provider" means a body who is not themselves a HSC body but with whom a HSC body has made arrangements for the provision of care;

"NI Commissioner for Complaints" means the NI Commissioner for Complaints appointed in accordance with the Commissioner for Complaints (Northern Ireland) Order 1996(**b**) ;

"Patient and Client Council" means the Patient and Client Council established under section 16 of the 2009 Act;

"patient or client" means a person who is receiving, or has received, care provided by, or on behalf of, a HSC body;

"person subject to complaint" means any person or persons against whom a complaint is made or, where the complaint does not identify a named person against whom the complaint is brought, a person who, in the opinion of the complaints manager, is best able to deal with the matters which are the subject of the complaint;

"RQIA" means the Health and Social Care Regulation and Quality Improvement Authority established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (**c**);

"relevant person" means—

(a) a patient or a client;

(b) any person who has been refused any care;

(**a**) 2005 c.12
(**b**) S.I. 1996/1297 (N.I.7)
(**c**) S.I. 2003/431 (N.I.9)

(c) any person who is receiving, or has received, any care from, or is affected by any action, omission or decision of, a HSC body.

"relevant HSC body" means the HSC body which —

(a) provides the care;

(b) has the duty to provide the care;

(c) takes the action, omission or decision,

which is the subject of the complaint.

"social care" has the meaning given in section 2 (5) of the 2009 Act;

"special agency" means the following special health and social care agency established under Article 3 of the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 —

(a) The Northern Ireland Blood Transfusion Service.

Application of Directions

3.These Directions apply to any complaint made on or after 1st April 2009 in respect of the HSC bodies specified above.

PART II

HANDLING AND CONSIDERATION OF COMPLAINTS BY HSC BODIES

Requirements to make arrangements

4.—(1) Each HSC body shall make arrangements in accordance with the provisions of these Directions for the handling and consideration of complaints.

(2) The arrangements must be such as to ensure—

(a) that the complaints procedure is accessible;

(b) that complaints are dealt with efficiently;

(c) that complaints are properly investigated;

(d) that complainants are treated with respect and courtesy;

(e) that complainants receive, so far as reasonably practicable —

(i) assistance to enable them to understand the procedure in relation to complaints; or

(ii) advice on where they might obtain such assistance;

(f) that complainants are, as far as possible, involved in decisions about how their complaint is handled and considered;

(g) that complainants receive a timely and appropriate response;

(h) that complainants are told of the outcome of their complaint; and

(i) that action is taken in light of the outcome of a complaint.

(3) The arrangements shall be in writing and a copy of the arrangements shall be given, free of charge, to any person who makes a request for them.

(4) Where a HSC body makes arrangements for the provision of care with an independent provider, it must ensure that the independent provider has in place arrangements for the handling and consideration of complaints about any matter connected with its provision of care as if these Directions applied to it.

(5) Each HSC body shall make arrangements in accordance with Part IV (Monitoring and Publicity) of these Directions for monitoring the effectiveness of and for publicising the arrangements for dealing with complaints.

General duty to co-operate

5.—(1) The arrangements under these Directions must be such as to ensure that a full and comprehensive response is given to a complainant and to that end there is all necessary co-operation in the handling and consideration of complaints between —

(a) different HSC bodies as defined in section 1(5) of the 2009 Act;

(b) the RQIA; and

(c) the NI Commissioner for Complaints.

(2) The general duty to co-operate required by sub-paragraph (1) includes in particular, a duty to —

(a) answer questions reasonably put by the body carrying out the investigation;

(b) provide any information relating to the complaint which is reasonably requested by the body carrying out the investigation; and

(c) attend any meeting reasonably required to consider the complaint.

Responsibility for arrangements and complaints manager

6.—(1) Each HSC body must appoint—

(a) a senior person within the organisation to take responsibility for ensuring compliance with the arrangements made under these Directions and for ensuring that action is taken in light of the outcome of any investigation; and

(b) a person, in these Directions referred to as a complaints manager—

(i) to perform the functions of the complaints manager under the arrangements;

(ii) to perform such other functions relating to the investigation of complaints as the HSC body may direct; and

(iii) generally to co-ordinate and manage the operation of the procedures for dealing with complaints under the arrangements.

(2) The functions of the senior person appointed under sub-paragraph (1) (a) may be performed personally or by a person authorised by the HSC body to act on his behalf.

(3) The functions of the complaints manager appointed under sub-paragraph (1) (b) may be performed personally or by a person authorised by the HSC body to act on his behalf.

No investigation of complaint

7.—(1) The following complaints are excluded from the scope of the arrangements made under these Directions and shall not be investigated, or shall cease to be investigated—

(a) a complaint made by a HSC body which relates to the exercise of its functions by another HSC body;

(b) a complaint made by an employee of a HSC body about any matter relating to his contract of employment;

(c) a complaint made by an independent provider about any matter relating to arrangements made by a HSC body with that independent provider;

(d) a complaint arising out of a HSC body's alleged failure to comply with data subject requests made under the Data Protection Act 1998(**a**) or a request for information under the Freedom of Information Act 2000(**b**);

(e) a complaint about which the complainant has stated that he intends to take legal proceedings;

(f) a complaint about which a HSC body is taking or is proposing to take disciplinary proceedings in relation to the substance of the complaint against a person subject to complaint;

(g) a complaint which has lead to the protection of vulnerable adults policy or procedures having been activated;

(h) a complaint which is the subject matter of a Child Protection enquiry;

(i) a complaint which has raised an independent inquiry and/or a criminal investigation;

(j) a complaint which has resulted in a referral to a professional regulatory body;

(k) a complaint which activates the Children Order Representation and Complaints Procedure;

(l) a complaint the subject matter of which has previously been fully investigated under —

(i) these Directions; or

(ii) former Directions.

(m) a complaint which is being or has been investigated by the NI Commissioner for Complaints.

(2) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with sub-paragraph (1) (e), investigation shall be commenced, or resumed, where a complainant states in writing that he no longer intends to pursue a remedy by way of legal proceedings.

(3) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with sub-paragraph (1) (f), investigation shall be commenced, or resumed in relation to any matter which has not been dealt with by disciplinary proceedings.

(4) Where the investigation of a matter which is the subject of a complaint is not commenced, or has ceased, in accordance with heads (g), (i) or (j) of sub-paragraph (1), investigation shall be commenced, or resumed in relation to any matter which has not been dealt with under the proceedings referred to in those heads.

(5) The Chief Executive of the relevant HSC body shall notify the complainant and any person subject to complaint of any decision not to investigate the complaint or to discontinue an investigation of a complaint under sub-paragraph (1) and of any start, or resumption, of an investigation.

(6) The notification to be given under sub-paragraph (5) shall be in writing and shall state the reason for any decision referred to in that sub-paragraph.

(**a**) 1998 c.29
(**b**) 2000 c.36

PART III

THE INITIAL COMPLAINT

Requirement to deal with the complaint

8. Subject to paragraph 7, a complaint shall be dealt with in accordance with the arrangements if it is made —

(a) by a person specified in paragraph 9;

(b) in the manner specified in paragraph 10;

(c) about any matter connected with the provision of care; and

(d) within the period specified in paragraph 11.

Person who may make a complaint

9.—(1) A complaint may be made by —

(a) a relevant person; or

(b) a person (in these Directions referred to as a representative) acting on behalf of a relevant person in any case where the relevant person —

(i) has died;

(ii) is a child;

(iii) is unable by reason of physical or mental incapacity to make the complaint himself; or

(iv) has requested the person to act on his behalf.

(2) In the case of a relevant person who has died or who is incapable, the representative must be a relative or other person, who, in the opinion of the complaints manager, had or has a sufficient interest in his welfare and is a suitable person to act as representative.

(3) If in any case the complaints manager is of the opinion that a representative does or did not have a sufficient interest in the person's welfare or is unsuitable to act as representative, he must notify that person in writing, stating his reasons. The complaints manager may then either refuse to deal with the complaint or nominate another person to act with respect to the complaint.

(4) In the case of a child, the representative must be either a parent, or in the absence of both parents, guardian or other adult person who has care of the child, or where the child is in the care of an authority or a voluntary organisation, the representative must be a person authorised by the authority or the voluntary organisation.

(5) In these Directions any reference to a complainant includes a reference to his representative.

Making a complaint

10.—(1) Where a person wishes to make a complaint under these Directions, he may make the complaint to the complaints manager or any other member of the staff of the relevant HSC body.

(2) Any person other than the complaints manager to whom a complaint is made, whether orally, in writing or electronically, shall refer the complaint to the complaints manager.

(3) A complaint may be made orally or in writing, including electronically, and —

(a) where it is made orally, the complaints manager or other member of staff of the relevant HSC body shall make a written record of the complaint which includes the name of the complainant, the subject matter of the complaint and the date on which it was made, and provide a copy of the written record to the complainant; and

(b) where it is made in writing, the complaints manager shall make a written record of the date on which it was received.

(4) For the purposes of these Directions where the complaint is made in writing it is treated as being made on the date on which it is received by the complaints manager or as the case may be, other member of the staff of the relevant HSC body.

Time limits

11.—(1) Subject to sub-paragraph (2), the period for making a complaint is—

(a) six months from the date on which the matter which is the subject of the complaint occurred; or

(b) where the complainant was not aware that there was cause for complaint, within—

(i) six months from the date on which the matter which is the subject of the complaint comes to the complainant's notice; or

(ii) twelve months from the date on which the matter which is the subject of the complaint occurred,

whichever is the sooner.

(2) Where a complaint is received which was not made during the period specified in sub-paragraph (1) it shall be referred to the complaints manager and if he is of the opinion that —

(a) having regard to all the circumstances of the case, it would be unreasonable to have expected the complainant to have made the complaint within that period; and

(b) notwithstanding the time that has elapsed since the date on which the matter which is the subject of the complaint occurred, it is still possible to investigate the complaint properly,

the complaint shall be treated as though it had been received during the period specified in sub-paragraph (1).

Acknowledgement and record of complaint

12.—(1) The complaints manager shall send to the complainant a written acknowledgement of the complaint within 2 working days of the date on which the complaint was made.

(2) Where a complaint was made orally, the acknowledgment shall be accompanied by the written record mentioned in paragraph 10 (3) (a) with an invitation to the complainant to sign and return it.

(3) The complaints manager shall send a copy of the complaint and its acknowledgement to any person subject to complaint unless he has reasonable grounds to believe that to do so would be detrimental to that person's health or wellbeing.

(4) The acknowledgement sent to the complainant under sub-paragraph (1) must include information about the right to assistance from the Patient and Client Council.

Investigation

13.—(1) A complaint must be investigated to the extent necessary and in a manner which appears most appropriate to an efficient and effective resolution.

(2) The complaints manager may, in any case where he thinks it would be appropriate to do so and with the agreement of the complainant, make arrangements for independent expert advice, conciliation or other assistance for the purposes of resolving the complaint.

(3) The complaints manager must take such steps as are reasonably practicable to keep the complainant informed about the progress of the investigation.

Response

14.—(1) The complaints manager must ensure a written response is prepared to the complaint which summarises the nature and substance of the complaint, describes the investigation and summarises its conclusions.

(2) The response must be signed off by the Chief Executive of the relevant HSC body. A copy shall be provided to the complainant and any person subject to complaint.

(3) The Chief Executive of the relevant HSC body can delegate responsibility for responding to a complaint, where in the interests of a prompt reply a designated executive director of the relevant HSC body undertakes this task on the Chief Executive's behalf.

(4) The response must be sent to the complainant within 20 working days beginning on the date on which the complaint was made or, where that is not possible, the complainant must be notified of the delay and the full response issued as soon as reasonably practicable.

(5) The response must notify the complainant of his right to refer the complaint to the NI Commissioner for Complaints should he remain dissatisfied with the outcome of the HSC complaints procedure.

(6) Copies of the response mentioned in sub-paragraph (1) must be sent to any other person to whom the complaint was sent under paragraph 12(3).

(7) Responses should not be made electronically.

PART IV

MONITORING AND PUBLICITY

Monitoring

15.—(1) For the purposes of—

(a) monitoring the arrangements made for the handling and consideration of complaints;

(b) considering the nature, volume and outcome of complaints;

(c) taking remedial action following investigation of complaints; and

(d) organisational learning,

the relevant HSC body shall prepare reports at quarterly intervals for consideration by its board.

(2) The reports mentioned in sub-paragraph (1) must—

(a) specify the number of complaints received;

(b) identify the subject matter of those complaints;

(c) summarise how they were handled including the outcome of the investigations;

(d) specify the number of complaints that have been referred to the NI Commissioner for Complaints; and

(e) identify any complaints where the recommendations of the NI Commissioner for Complaints were not acted upon, giving the reason why.

(3) For the purposes of ensuring the efficient use of resources HSC bodies will monitor the effectiveness and usage of independent experts, conciliation and lay person assistance.

(4) HSC trusts must provide the HSC Board with such information relating to complaints as the HSC Board reasonably requests for the purposes of monitoring and performance management, and only to the extent that it is not in contravention of the Data Protection Act 1998.

Learning

16.—(1) All HSC bodies are responsible for ensuring that arrangements are in place for the purposes of organisational and regional learning.

(2) The HSC Board is responsible for collating and sharing the learning arising from HSC trust complaints.

Annual Reports

17.—(1) Each HSC body shall publish a report annually on its handling and consideration of complaints under these Directions which shall be sent to—

(a) the Department of Health, Social Services and Public Safety;

(b) the Patient and Client Council;

(c) the RQIA; and

(d) the NI Commissioner for Complaints.

(2) HSC trusts' annual reports should also be sent to the HSC Board.

Publicity

18.—(1) Each HSC body shall take such steps as are necessary to ensure that—

(a) any person connected with the provision of care by, or on behalf of that body;

(b) staff working for that body;

(c) the Patient and Client Council;

are fully informed of the arrangements for dealing with complaints and are informed of the name of the complaints manager and the address at which he can be contacted.

(2) The requirement to provide information specified in sub-paragraph (1) includes a requirement to provide information on the services which the Patient and Client Council offers to persons who wish to make complaints.

Training

19. Each HSC body must ensure that its staff are informed about and appropriately trained in the operation of the complaints arrangements.

PART V

TRANSITIONAL PROVISION AND REVOCATIONS

Transitional provision

20. Where, before 1st April 2009, a complaint has been made in accordance with any former Directions, it must be investigated, or in an appropriate case continue to be investigated, in accordance with the former Directions as if these Directions had not come into effect.

Revocations

21. The following Directions are revoked—

(a) The Health and Personal Social Services Complaints Procedures Directions (Northern Ireland) 1996;

(b) The Health and Personal Social Services (Special Agencies) Complaints Procedures Directions (Northern Ireland) 1996; and

(c) The Miscellaneous Complaints Procedures Directions (Northern Ireland) 1996.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 1st April 2009

A senior officer of the
Department of Health, Social Services and Public Safety

COMPLAINTS
IN
HEALTH AND SOCIAL CARE

Standards & Guidelines for Resolution & Learning

1 April 2009

SUMMARY

Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning replaces the existing HPSS Complaints Procedure 1996 and provides a streamlined process that applies equally to all health and social care (HSC) organisations. As such it provides a simple, consistent approach for staff who handle complaints and for people raising complaints across all health and social care services.

The standards and guidelines have been developed in conjunction with HSC organisations, following public consultation. They reflect the changing culture across health and social care with an increasing emphasis on the promotion of safety and quality and the need to be open, to learn and take action in order to reduce the risk of recurrence.

The changes to the new HSC complaints procedure include:

- the removal of Independent Review;
- the introduction of Standards for Complaints Handling;
- the introduction of an “Unacceptable Actions” policy for handling unreasonable, vexatious or abusive complainants; and
- clarity on the application of the Children Order Representations and Complaints Procedure.

This new single tier process also aims to provide:

- a strengthened, more robust, local resolution stage;
- an enhanced role for commissioners in monitoring, performance management and learning; and
- improved arrangements for driving forward quality improvements across the HSC.

The new process recognises that there will be times when local resolution will fail. Where this happens the complainant will be advised of their right to refer their complaint to the NI Commissioner of Complaints (the Ombudsman).

The guidelines for resolution and learning provide HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as the use of independent experts, lay persons and conciliation;
- resolve complaints more quickly;
- provide flexibility in relation to target response times;
- provide an appropriate and proportionate response;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning.

The standards for complaints handling are designed to assist HSC organisations in monitoring the effectiveness of their complaints handling arrangements locally and build public confidence in the process.

These new arrangements are effective from 1 April 2009.

SECTION 1 - INTRODUCTION 4
What the guidance covers 7
What the guidance does not cover 8
SECTION 2 - MAKING A COMPLAINT 14
What is a complaint? 14
Promoting access 14
Who can complain? 14
How can complaints be made? 18
Supporting complainants and staff 22
What are the timescales for making a complaint? 22
SECTION 3 - HANDLING COMPLAINTS 24
Accountability 24
Actions on receipt of a complaint 28
Investigation 31
Responding to a complaint 35
SECTION 4 - LEARNING FROM COMPLAINTS 42
Reporting & Monitoring 42
Learning 46
SECTION 5 - ROLES AND RESPONSIBILITIES 47
ANNEXE 1: STANDARDS FOR COMPLAINTS HANDLING 50
ANNEXE 2: LEGAL FRAMEWORK 62
ANNEXE 3: PROFESSIONAL REGULATORY BODIES 64
ANNEXE 4: HSC PRISON HEALTHCARE 65
ANNEXE 5: THE NI COMMISSIONER FOR COMPLAINTS 66
ANNEXE 6: THE PATIENT AND CLIENT COUNCIL 67
ANNEXE 7: ADVOCACY 68
ANNEXE 8: CONCILIATION 69

ANNEXE 9: INDEPENDENT EXPERTS 74

ANNEXE 10: LAY PERSONS 78

ANNEXE 12: HONEST BROKER 81

ANNEXE 13: VULNERABLE ADULTS 83

ANNEXE 14: UNREASONABLE, VEXATIOUS OR ABUSIVE COMPLAINANTS 85

ANNEXE 15: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE 92

Definitions of Key Terms

Throughout the standards and guidelines the following terms have the meanings set out below:

complaint	means "an expression of dissatisfaction that requires a response"
complainant	means an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	means the Chief Executive of the HSC organisation
Complaints Manager	means the person nominated by an HSC organisation to handle complaints
Family Practitioner Service (FPS)	means family doctors, dentists, pharmacists and opticians
honest broker	this is the term used to describe HSC Board's role in FPS complaints
HSC Board	means the Health and Social Care Board
HSC organisation	means a HSC organisation which commissions or provides health and social care services and for the purpose of this guidance includes the HSC Board, HSC Trusts, the Northern Ireland Ambulance Service (NIAS),the Business Services Organisation, the Public Health Agency, Family Practitioner Services, Out-of Hours Services, pilot scheme providers

the Ombudsman	The NI Commissioner for Complaints
out-of hours services	means immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
PCC	means the Patient and Client Council
pilot scheme	refers to personal dental services provided by an HSC Trust
pilot scheme complaints procedure	means a complaint s procedure established by the pilot scheme
practice-based complaints procedure	means a FPS complaints procedure established within the terms of the relevant regulations
registered provider	person carrying on or managing the establishment or agency
RQIA	means the Regulation, Quality & Improvement Authority: the regulatory body responsible for regulating, inspecting and monitoring the standard and quality of health and social care services provision provided by independent and statutory bodies in Northern Ireland
registered establishments and agencies	for example, residential care homes, nursing homes, children's homes, independent clinics/ hospitals, nursing agencies, etc. registered with and regulated by RQIA
regulated sector	means registered establishments and agencies

senior person (designated)	means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC Trust
service user	means a patient, client, resident, carer, visitor or any other person accessing HSC services
special agency	means the NI Blood Transfusion Agency

SECTION 1 - INTRODUCTION

Purpose of the Guidance

1.1 This guidance sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces existing guidance and provides a streamlined complaints process which applies equally to all HSC organisations, including the HSC Board, HSC Trusts, the Business Services Organisation, the Public Health Agency, the NI Blood Transfusion Service, Family Practitioner Services (FPS), Out of Hours services, pilot schemes and HSC prison healthcare. As such, it provides a simple, consistent approach for staff who handle complaints and for people raising complaints across all health and social care services.

1.2 This guidance aims to promote an organisational culture in health and social care that fosters openness and transparency for the benefit of all who use it or work in it. It is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The procedure provides the opportunity to put things right for service users as well as improving services. Dealing with those who have made complaints provides an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.

Local resolution

1.3 The purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve

complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10 working days within FPS settings).

1.5 Local procedures should be easily accessible, open, fair, flexible and conciliatory and should encourage communication on all sides. They should include a well-defined process for investigating and resolving complaints. Complainants must be advised of their right to refer their complaint to the NI Commissioner for Complaints (the Ombudsman) if they remain dissatisfied with the outcome of the complaints procedure.

Principles of an effective complaints procedure

1.6 *Complaints in HSC* has been developed around four key principles:

- openness and accessibility – flexible options for pursuing a complaint and effective support for those wishing to do so;
- responsiveness – providing an appropriate and proportionate response;
- fairness and independence – emphasising early resolution in order to minimise strain and distress for all; and
- learning and improvement – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements and, as such, will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of complaints handling by highlighting the added value of complaints within health and social care and making the process more acceptable/amenable to all.

1.8 Complaints are seen as a significant source of learning within health and social care and provide opportunities to improve:

- outcomes for services users;
- the quality of services; and
- service user experiences.

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and feed the lessons learnt into quality improvement.

What the guidance covers

1.10 *Complaints in HSC* deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by, for example:

- The Health and Social Care Board (HSC Board)
  - commissioning and purchasing decisions (for individuals)
- Family Practitioner Services
- Health and Social Care (HSC) Trusts
  - hospital and community services
  - registered establishments and agencies where the care is funded by the HSC
  - HSC funded staff or facilities in private pay beds
  - HSC prison healthcare
- The Northern Ireland Blood Transfusion Service (NIBTS)
- The Business Services Organisation[1] (services provided relevant to health and social care)
- The Public Health Agency[2]

1.11 *Complaints in HSC* may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased persons under the Access to Health Records (NI) Order 1993 as an alternative to making an application to the courts.

[1] Inserted by the Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints - effective from 26 July 2010

[2] Inserted by the Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints - effective from 26 July 2010

What the guidance does not cover

1.12 *Complaints in HSC* does **not** deal with complaints about:

- private care and treatment or services including private dental care[3] or privately supplied spectacles; or
- services not provided or funded by the HSC, for example, provision of private medical reports.

1.13 Complaints may be raised within an organisation which that organisation needs to address, but which do not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC organisation should ensure that there are other processes in place to deal with these concerns. For example:

- staff grievances;
- an investigation under the disciplinary procedure;
- an investigation by one of the professional regulatory bodies;
- services commissioned by the HSC Board ;
- a request for information under Freedom of Information;
- access to records under the Data Protection Act 1998;
- an independent inquiry;
- a criminal investigation;
- the Children Order Representations and Complaints Procedure;
- protection of vulnerable adults ;
- child protection procedures;
- coroner's cases;
- legal action.

1.14 Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately passed to the

[3] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/

Complaints Manager for onward transmission to the appropriate department. If any aspect of the complaint is not covered by the referral it will be investigated under the HSC Complaints Procedure. In these circumstances, investigation under the HSC Complaints Procedure will only be taken forward if it does not, or will not, compromise or prejudice the matter under investigation under any other process. The complainant must be informed of the need for referral.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances. Staff may, however, complain about the way they have been dealt with under the HSC Complaints Procedure and provided they have exhausted the local grievance procedure, may take the matter up with the Ombudsman. Family practitioners may also complain to the Ombudsman about the way they have been dealt with under the complaints procedure.

Disciplinary Procedure

1.16 The HSC Complaints Procedure is concerned only with resolving complaints and learning lessons for improving services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a professional regulatory body (see paragraph 1.20 below). The purpose of the complaints procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

1.17 Where a decision is made to embark upon a disciplinary investigation, action under the complaints procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the complaints procedure.

1.18 The Chief Executive (or designated senior person) must advise the complainant in writing that a disciplinary investigation is under way, that they may be asked to take part in that process and that any aspect of the complaint not covered by the referral will be investigated under the HSC Complaints Procedure.

1.19 In drafting these letters, the overall consideration must be to ensure that when the investigation has moved into the disciplinary procedure, the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body

1.20 A similar approach to that outlined above should be adopted in a case referred to a professional regulatory body (Annexe 3). The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation may need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the HSC Board

1.21 Complaints about the HSC Board's purchasing decisions may be made by, or on behalf of any individual personally affected by a purchasing decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities. Where general concerns about commissioning issues are raised with the HSC Board a full explanation of the

HSC Board's policy should be provided. These issues should not, however, be dealt with under the HSC Complaints Procedure.

Access to Information

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000 and requests for access to health or social care records under the Data Protection Act 1998.

Independent Inquiries and Criminal Investigation

1.23 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended can recommence if there are outstanding matters which remain to be dealt with.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annexe 15. The

HSC Board and HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995.

Protection of Vulnerable Adults

1.26 Where it is apparent that a complaint relates to abuse, exploitation or neglect of a vulnerable adult then the regional *Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance*[4] (*Sept 2006*) and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults* should be activated by contacting the Adult Protection Co-ordinator at the relevant HSC Trust[5]. The HSC Complaints Procedure should be suspended pending the outcome of the safeguarding vulnerable adults' investigation and the complainant advised accordingly. When the safeguarding vulnerable adults' investigation has concluded, consideration of that part of the original complaint on which action was suspended can recommence if there are outstanding matters which remain to be dealt with.

Child Protection Procedures

1.27 Dissatisfaction with the process or about decisions made in relation to a Child Protection enquiry should be dealt with through the Child Protection Registration Appeals Process. *The Area Child Protection Committees' (ACPC) Regional Policy and Procedure (April 2005)*[6] outlines the criteria for appeal under that procedure. These include:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- the threshold for registration/deregistration was not met;

[4] http://www.dhsspsni.gov.uk/ssi/safeguarding_vulnerable_adults.pdf
[5] Information about and contact details for HSC Trusts can be accessed at: http://www.hscni.net/index.php?link=services
[6] http://www.dhsspsni.gov.uk/acpcregionalstrategy.pdf

- the category for registration was not correct.

Coroner's Cases

1.28 With the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroner's investigation they will continue to be dealt with under the complaints procedure. Once the Coroner's investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner can then be dealt with under the complaints procedure.

Legal Action

1.29 Even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person named in the complaint of this decision in writing.

1.31 It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to pursue their complaint through the complaints process the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot then be investigated under the HSC complaints procedure.

SECTION 2 - MAKING A COMPLAINT

What is a complaint?

2.1 A complaint is "**an expression of dissatisfaction that requires a response**". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are really complaints and need to be handled as such.

Promoting access

2.2 Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursuing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised on the types of help available through front-line staff, the Complaints Manager and the Patient and Client Council (PCC). HSC organisations should promote and encourage more open and flexible access to the complaints procedure and other less formal avenues in an effort to address barriers to access. Standard 2: *Accessibility* provides the criteria by which organisations should operate (Annexe 1 refers).

Who can complain?

2.3 Any person can complain about any matter connected with the provision of HSC services. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and

- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

Consent

2.4 Complaints by a third party should be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the subject of the complaint is deceased.

2.5 Where a person is unable to act for him/herself, his/her consent shall not be required.

2.6 The Complaints Manager, in discussion with the Chief Executive (or senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or senior person) must provide information in writing to the person outlining the reasons the decision has been taken. More information on consent can be found in the DHSSPS' good practice in consent guidance[7].

[7] http://www.dhsspsni.gov.uk/public_health_consent

2.7 Third party complainants who wish to pursue their own concerns can bring these to the HSC organisation without compromising the identity of the patient/ client. The HSC organisation must consider the matter, investigate and address, as fully as possible, any identified concerns. A response will be provided to the third party on any issues which it is possible to address without breaching the patient's/ client's confidentiality.

Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the Data Protection Act 1998 and the Human Rights Act 1998. The common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed but more detailed information can be found in the HSC guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information*.[8]

2.9 It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health or social services records may need to be disclosed to the people investigating the complaint, but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that this could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

[8] http://www.dhsspsni.gov.uk/confidentiality-consultation-cop.pdf

Third Party Confidence

2.10 The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social services professional. Only that information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HSC who have a demonstrable need to know in connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

2.11 Disclosure of information provided by a third party outside the HSC also requires the express consent of the third party. If the third party objects, then it can only be disclosed where there is an overriding public interest in doing so.

Use of Anonymised Information

2.12 Where anonymised information about a patient/client and/or third parties would suffice, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use information, then it can only be used where there is an overriding public interest in doing so.

How can complaints be made?

2.13 Complaints may be made verbally or in writing and should also be accepted via any other method, for example, the telephone or electronically. The complainant should be asked to put the complaint in writing, or assisted to do so. It is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint. HSC organisations should be mindful of technological advances and consider local arrangements to ensure there is no breach of patient/client confidentiality.

2.14 Complaints may be made to any member of staff - for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint "on the spot" or pass it to the Complaints Manager. It is important that front-line staff are trained and supported to respond sensitively to the comments and concerns raised and are able to distinguish those issues which would be better referred elsewhere. Front line staff should familiarise themselves with the Equality Good Practice Reviews' principles for dealing with and managing complaints[9].

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, in writing to the Chief Executive. All HSC organisations have

[9] Guidance Note – Implementing the Equality Good Practice Reviews (January 2004) http://www.dhsspsni.gov.uk/eq-gprs-circ-hssps-29jan04.pdf

named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services; and
- Registered Establishments and Agencies.

Family Practitioner Services (family doctors, dentists, pharmacists, opticians)

2.16 All Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure for handling complaints. The practice-based complaints procedure forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaints Manager if he/she does not feel able to approach immediate staff.

2.18 Where requested, the HSC Board will act as "honest broker" in the resolution of a complaint. The objective for the HSC Board should be, wherever possible, to restore the trust between the patient and the practitioner/practice staff. This will involve an element of mediation on the part of the HSC Board or the offer of conciliation services where they are appropriate. The HSC Board's Complaints Manager should seek - with the complainant's agreement - to involve the FPS Complaints Manager as much as possible in resolving the issues. The HSC Board's Complaints Manager is also available to practice staff for support and advice.

2.19 The HSC Board has a responsibility to record and monitor the outcome of those complaints lodged with them.

2.20 The HSC Board will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint independent experts, lay persons or conciliation services, where appropriate.

2.21 Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes, publicising the arrangements for dealing with complaints, ensuring that any complaint made under the complaints procedure is investigated, making sure that time limits for investigation are adhered to and complainants are advised of outcomes of the investigation. Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure.

2.23 Complaints may be made by service users or by persons acting on their behalf providing they have obtained the service user's consent. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider. The registered provider is required by legislation to ensure the complaint is fully investigated.

2.24 Individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that has commissioned the care on their behalf. The HSC Trust that has commissioned the care has a

continuing duty of care to the service user and should participate in local resolution as necessary.

2.25 Where complaints are raised with the HSC Trust, the Trust must establish the nature of the complaint and consider how best to proceed. For example, the complaint may be about an aspect of the "care plan" and can, therefore, only be fully dealt with by the Trust. The complaint may also trigger the need for an investigation under child protection or protection of vulnerable adults procedures or indeed, might highlight non-compliance with statutory requirements. It is not the intention to operate parallel complaints procedures, however, if the RQIA is notified of a breach of regulations or associated standards it will review the matter and take whatever appropriate action is required. It is important, therefore, that Trusts work closely with the registered providers, other professionals and the RQIA to enable appropriate decisions to be made.

2.26 HSC Trusts must assure themselves that regulated establishments and agencies which deliver care on their behalf are effective and responsive in their handling of complaints. Service users may approach the Ombudsman if they remain dissatisfied. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the registered provider without HSC Trust participation in local resolution will be referred to the HSC Trust by the Ombudsman for action.

2.27 Copies of all correspondence relating to regulated sector complaints should be retained. RQIA will use this information to monitor all regulated services including those services commissioned by the HSC Trust.

2.28 In due course, these arrangements will also apply to other services which will be regulated by RQIA, including Fostering Agencies and Voluntary Adoption Agencies.

What information should be included in the complaint?

2.29 A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – e.g. an apology or an explanation or changes to services.

Supporting complainants and staff

2.30 Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (Annexe 6 refers). Independent advocacy and specialist advocacy services are also available (Annexe 7 refers). Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate (Annexe 1 refers).

What are the timescales for making a complaint?

2.31 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh.

2.32 If a complainant was not aware that there was cause for complaint, the complaint should normally be made within **six months** of their becoming

aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

2.33 There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

2.34 In any case where a Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to him/her to pursue this further.

2.35 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

SECTION 3 - HANDLING COMPLAINTS

Accountability

3.1 Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation to take responsibility for the local complaints procedure and to ensure compliance with the regulations and that action is taken in light of the outcome of any investigation. In the case of HSC Trusts, a Director should be designated (or a Clinical Governance Lead in FPS setting). All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements. Standard 1: *Accountability* provides the criteria by which organisations should operate (Annexe 1 refers).

3.2 Where care or treatment is provided by an independent provider, for example residential or nursing home care, the commissioning body must ensure that the contract includes entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Performance Management

3.3 Complaints provide a rich source of information and should be considered a vital part of the HSC organisation's performance management strategy. HSC organisations need to be able to demonstrate that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's governance and risk management arrangements.

3.4 Complaints should be used to inform and improve. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

3.5 Local arrangements must be such as to ensure that a full and comprehensive response is given to a complainant and to that end there is all necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DHSSPS Pharmaceutical Inspectorate;
- NI Commissioner for Complaints (the Ombudsman); and
- The Regulation and Quality Improvement Authority (RQIA).

3.6 This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

Complaints Manager

3.7 HSC organisations must have a designated Complaints Manager of appropriate authority and standing who is readily accessible to both the public and members of staff. While it is not essential that this title be used, it is nevertheless important that the person with the role is easily identifiable to service users. The Complaints Manager is responsible for co-ordinating the

local complaints arrangements and managing the process and is supported in his/her role by the designated senior person. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;
- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- advise and support vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints and be aware of the role of the Medical and Dental Defence organisations to assist staff;
- have access to all relevant records (including personal medical records);
- take account of any corroborative evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure these are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt and maintain records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.8 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options

for pursuing the complaint and the consequences of following these options. Throughout the process, the Complaints Manager should assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

3.9 HSC organisations must ensure that the complaints process is well publicised locally. This means that service users should be made aware of:

- their right to complain;
- all possible options for pursuing a complaint, and the types of help available; and
- the support mechanisms that are in place.

3.10 Ready access to information can make a critical difference to the service user's experience of HSC services. Information about services and what to expect, the various stages involved in the complaints process, response targets and independent support and advice should be available. Clear lines of communication are required to ensure complainants know who to communicate with during the lifetime of their complaint. The provision of information will improve attitudes and communication by staff as well as support and advice for complainants.

3.11 Local information should:

- be visible, accessible and easily understood;
- be available in other formats or languages as appropriate;
- be provided free of charge;
- outline the arrangements for handling complaints, how to contact complaints staff, the availability of support services, and what to do if the complainant remains dissatisfied with the outcome of the complaints process.

Training

3.12 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. Staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.13 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate (Annexe 1 refers).

3.14 All complaints received should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. However received, the first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to the complaint are addressed.

3.15 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation. Early provision of information

and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to appropriately. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.16 Where possible, all complaints should be recorded and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that will require a formal investigation or those that should be referred outside the HSC Complaints Procedure. Front-line staff will often find the information they gain from complaints useful in improving service quality. This is particularly so for complaints that have been resolved "on the spot" and have not progressed through the formal complaints process. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

3.17 A complaint should be acknowledged in writing within **2 working days** of receipt. FPS complaints should be acknowledged within 3 working days in line with legislative requirements. (See Legal Framework at Annexe 2) A copy of the complaint and its acknowledgement should be sent to any person subject to complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person's health or well-being. The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the organisation.

3.18 There should be a statement expressing sympathy or concern over the incident. This is a statement of common courtesy, not an admission of responsibility.

3.19 It is good practice for the acknowledgement to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within 10 working days. Where these response timescales are not possible an explanation must be provided to the complainant.

3.20 The acknowledgement should:

- seek to confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with a member of the complaints staff or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

3.21 Complaints Managers should provide the complainant with further information about the complaints process. This may include locally produced information leaflets or those provided by the Ombudsman's Office or the RQIA. It is also advisable to include information about the disclosure of patient information at this stage.

Joint Complaints

3.22 Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify the other organisation(s) involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

3.23 Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the HSC Board or HSC Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Investigation

3.24 HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only “resolution” but to ascertain what happened, to establish the facts, to learn, to detect misconduct or poor practice and to improve services. Standard 5: *Investigation* provides the criteria by which organisations must operate (Annexe 1 refers).

3.25 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must not be adversarial and must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/ senior person, wherever necessary, about the conduct or findings of the investigation. Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be

advised of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales. All those involved should be kept informed of progress throughout. Those staff involved in the investigation process should familiarise themselves with the Equality Good Practice Reviews' principles for staff undertaking complaints investigation[10].

Assessment of the complaint

3.26 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level within the organisation. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence. HSC organisations should refer to the DHSSPS' guidance *How to classify adverse incidents and risks*[11] to assist them in developing processes to assess complaints.

Investigation and resolution

3.27 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

[10] Guidance Note – Implementing the Equality Good Practice Reviews
[11] http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

3.28 The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others. There are a number of options available to assist HSC organisations in the resolution of complaints. These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of:

- senior managers/ professionals at an early stage;
- honest broker;
- independent experts;
- lay persons; or
- conciliators.

3.29 It is not intended that HSC organisations utilise all the options outlined above as not all these will be appropriate in the resolution of the complaint. Rather HSC organisations should consider which option would assist in providing the desired outcome. The HSC Board will provide the necessary support and advice to FPS in relation to access and appointment of these options, where appropriate.

Completion of Investigation

3.30 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[12] will assist HSC organisations in ensuring the completeness and readability of such reports.

[12] http://www.dhsspsni.gov.uk/hsc_sqsd__34-07_guidance.pdf

3.31 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual accuracy and to ensure clinicians/ professionals agree with and support the draft response.

3.32 All correspondence and evidence relating to the investigation should be retained. The Complaints Manager should ensure that a complete record is kept of the handling and consideration of each complaint. Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

3.33 HSC organisations should regularly review their investigative processes to ensure the effectiveness of these arrangements locally.

Circumstances that might cause delay

3.34 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.31).

Periods of acute mental illness

3.35 If a service user makes a complaint during an acute phase of mental illness, the Complaints Manager should register the complaint and

consideration should be given to delaying the complaint until his/her condition has improved. A delay such as this will need either the agreement of the complainant or someone who is able to act on his/her behalf including, where appropriate, consultation with any advocate. The decision about whether a complainant is well enough to proceed with the complaint should be made by a multi-disciplinary team, and the Complaints Manager should refer regularly to this team to establish when this point has been reached.

Physical Injury

3.36 Where a complainant is alleging physical injury, a physical examination should be arranged without delay and with the consent of the injured person. Medical staff undertaking the physical examination should clearly report their findings. If a person refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented.

3.37 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements.

Responding to a complaint

3.38 A full investigation of a complaint should normally be completed within 20 working days (10 working days within FPS). Standard 6: *Responding to complaints* provides the criteria by which organisations must operate (Annexe 1 refers).

3.39 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC must obtain a postal address for the purposes of the response to maintain appropriate levels of confidentiality. **Responses should not be made electronically**.

3.40 Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

3.41 The Chief Executive (or Clinical Governance Lead) may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task (or the governance lead within FPS settings). In such circumstances, the arrangements for clinical and social care governance must ensure that the Chief Executive (or Clinical Governance Lead) maintains an overview of the issues raised in complaints (including those FPS complaints lodged with the HSC Board), the responses given and be assured that appropriate organisational learning has taken place. HSC organisations should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

3.42 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any aspect of the letter; and
- advise of their right to take their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

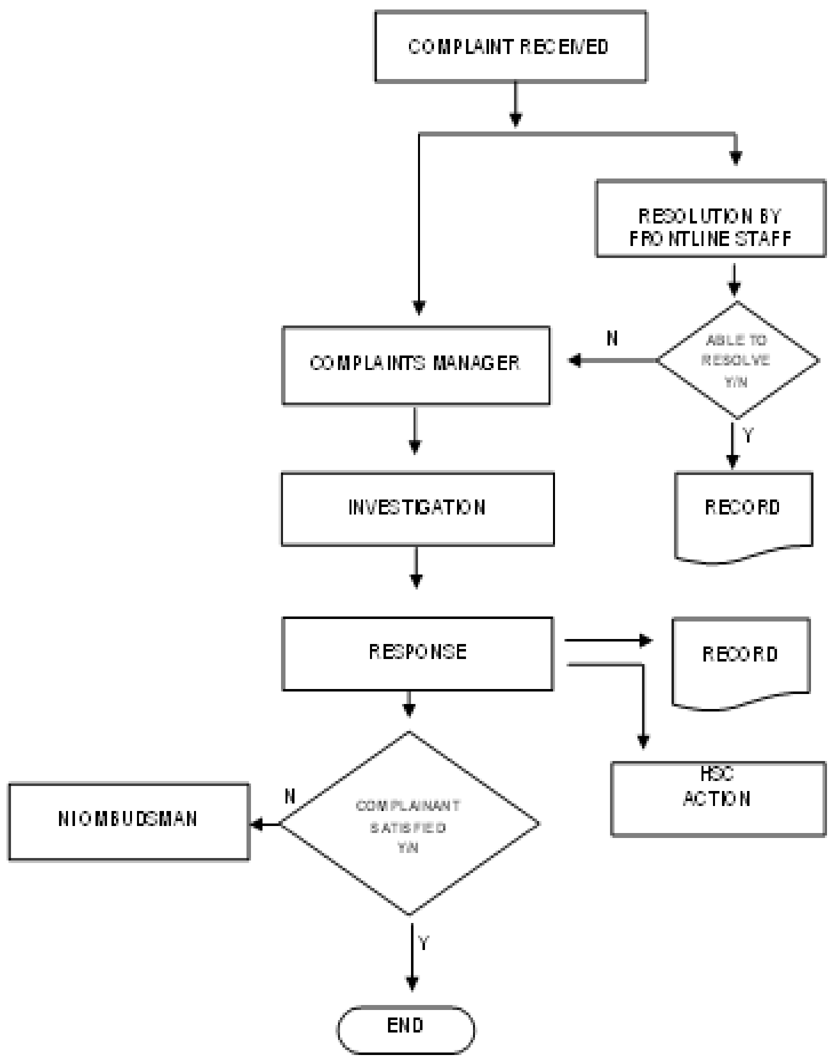
Concluding Local Resolution

3.43 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying “closure”.

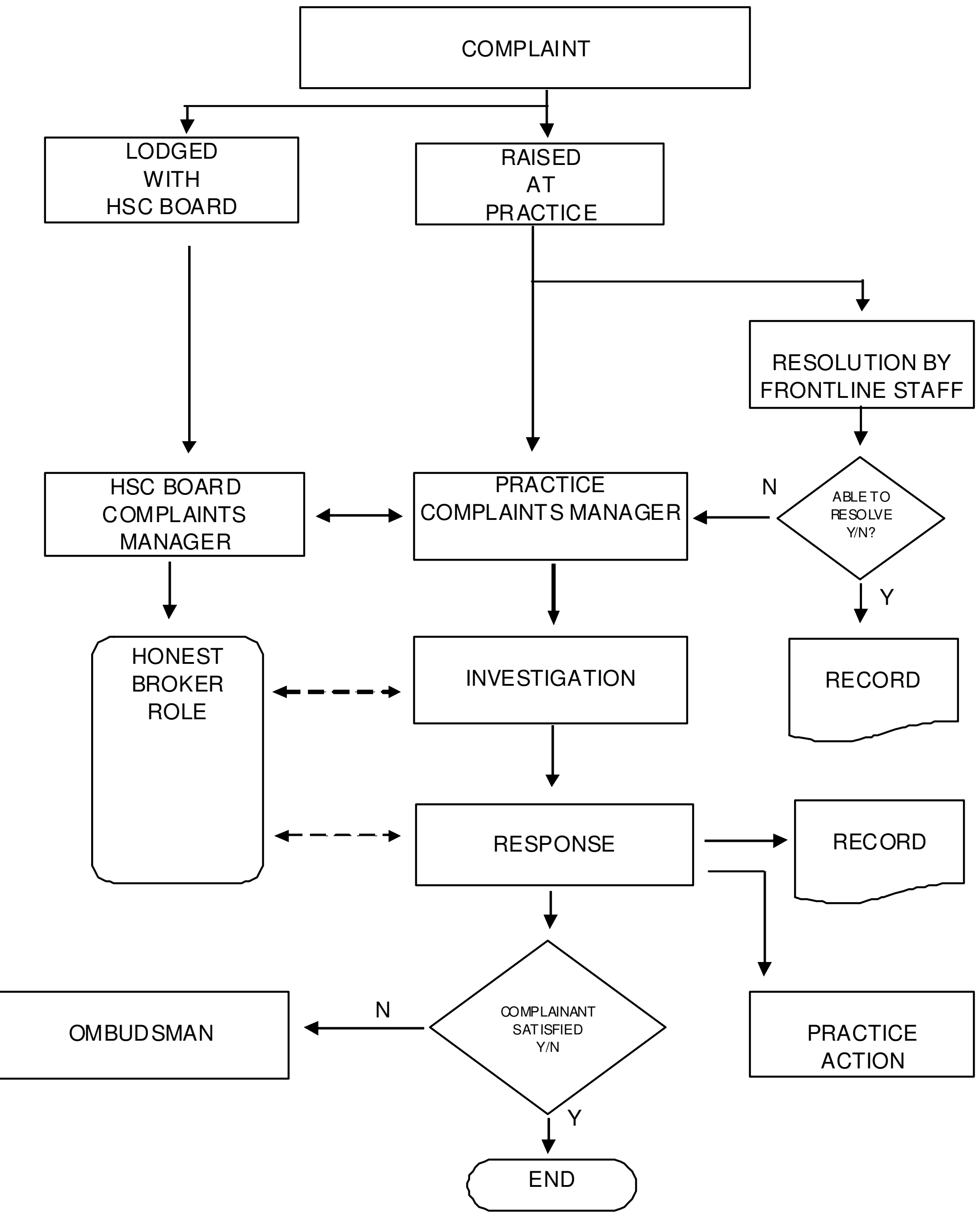
3.44 Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive/Clinical Governance Lead, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from their complaint.

3.45 This completes the HSC Complaints Procedure. Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

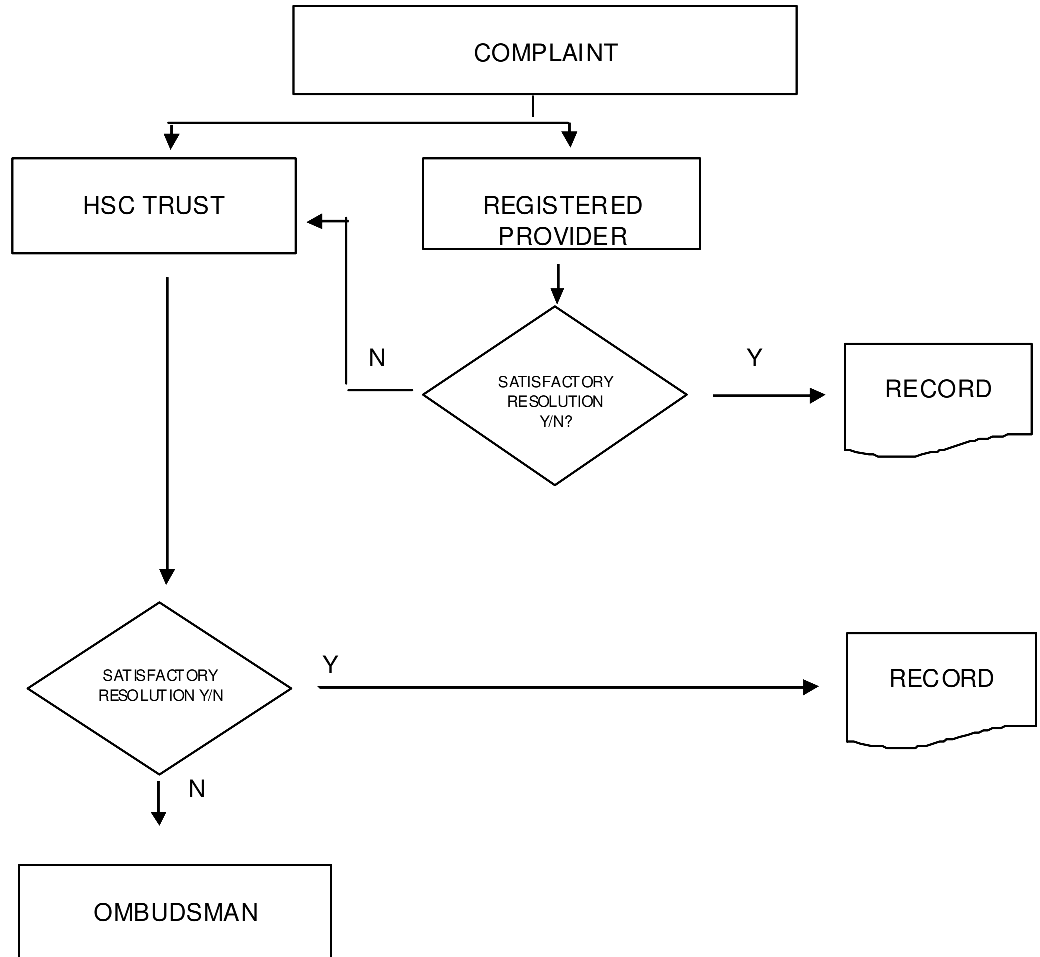
HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



REGISTERED ESTABLISHMENTS & AGENCIES FLOWCHART



SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement Family Practitioner Services	within 2 working days* of receipt within 3 working days
Response Family Practitioner Services	within 20 working days within 10 working days

* A working day is any weekday (Monday to Friday) which is not a local or public holiday.

SECTION 4 - LEARNING FROM COMPLAINTS

Reporting & Monitoring

4.1 Each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally. The HSC organisation must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements[13].

4.3 The *Standards for Complaints Handling* (Annexe 1 refers) provide the criteria by which organisations must operate and will assist organisations in monitoring the effectiveness of their complaints-handling arrangements locally. HSC organisations should also involve service users and staff to improve the

[13] Controls Assurance Standard, Risk Management, Criterion 5 http://www.dhsspsni.gov.uk/risk_07_pdf.pdf

quality of services and effectiveness of complaints-handling arrangements locally.[14]

4.4 The HSC must ensure they have the necessary technology/ information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems as described below.

The HSC Board

4.5 The HSC Board must maintain an oversight of all Family Practitioner Service and HSC Trust complaints received (including HSC prison healthcare) and be prepared to investigate any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

4.6 The HSC Board must provide the Department with quarterly complaints statistics in relation to all FPS and, where appropriate, out-of-hours services.

4.7 The HSC Board must produce an annual report on complaints outlining the number of FPS and, where appropriate, out-of-hours services complaints received, the categories to which the complaints relate and the response times. The annual report should also include the number of FPS complaints in which the HSC Board acted as "honest broker". Copies should be sent to the PCC, the RQIA, the Ombudsman and the DHSSPS. Reports must not breach patient/ client confidentiality.

HSC Trusts

[14] Circular HSC (SQSD) 29/07: Guidance on Strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

4.8 HSC Trusts (including the Northern Ireland Ambulance Service) must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide the HSC Board with quarterly complaints reports outlining the number and type of complaint received, the investigation undertaken and actions as a result including those relating to registered establishments and agencies, the Children Order and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare;

4.10 HSC Trusts must produce an annual complaints report to include the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints. Copies should also be made available to the HSC Board, PCC, RQIA, the Ombudsman and the DHSSPS. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Board and HSC Trusts should receive quarterly reports summarising the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.12 The HSC Board's quarterly reports to their management board should include a breakdown of complaints received in relation to **all** Family Practitioner Services and, where appropriate, out-of-hours services.

4.13 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on

behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.14 Family Practitioner Services must provide the HSC Board with:

- quarterly complaints statistics outlining the number of complaints received; and
- copies of all written complaints received - within 3 working days of receipt.

Arrangements should ensure that the complainant is aware and agrees to his/her complaint being forwarded to the HSC Board.

4.15 The HSC Board must record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.16 All other HSC organisations must publish annually a report on complaints handling. Copies should be sent to the PCC, HSC Board and the DHSSPS. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.17 All regulated establishments and agencies are required to provide RQIA, on request, with a statement containing a summary of complaints made during the preceding 12 months and the action that was taken in response. RQIA will record and monitor all outcomes and will report on complaints activity within the regulated sector.

DHSSPS

4.18 The DHSSPS will continue to collect statistics on the number, type and response times of complaints made to HSC organisations. A regional breakdown of complaints statistics will be provided via the Departmental website on an annual basis.

Learning

4.17 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[15].

4.18 Learning is a critical aspect of the HSC Complaints Procedure and provides an opportunity to improve services and contribute to and learn from regional, national and international quality improvement and patient safety initiatives. The HSC, RQIA and Ombudsman must share the intelligence gained through complaints.

4.19 The HSC Board must have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints ensuring they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

[15] The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

SECTION 5 - ROLES AND RESPONSIBILITIES

HSC Board

5.1 The HSC Board is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The S*tandards for Complaints Handling* provides a level against which HSC service performance can be measured (Annexe 1 refers).

5.2 The HSC Board must maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The HSC Board must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The HSC Board must have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The HSC Board will provide a vital role in supporting FPS complaints that includes:

- providing support and advice;
- the role of “honest broker” between the complainant and the service provider;
- providing independent experts, lay persons, conciliation services, where appropriate;
- recording and monitoring the outcome of all complaints;
- addressing breaches of contractual arrangements; and
- sharing complaints intelligence with appropriate authorities e.g. the DHSSPS Pharmaceutical Inspectorate.

HSC Organisations

5.5 HSC organisations must:

- make arrangements for the handling and consideration of complaints and publicise these arrangements locally;
- appoint a Complaints Manager with responsibility for co-ordinating the local complaints arrangements and managing the process;
- appoint a senior person to take responsibility for delivering the organisation's complaints process and ensuring that all necessary organisational learning takes place;
- ensure that all staff who provide services on their behalf are aware of, and trained in, the procedures to be followed when dealing with complaints;
- ensure that complainants and staff are supported and made aware of the availability of support services;
- ensure that there is full co-operation between organisations/bodies in the handling and consideration of complaints;
- integrate complaints management into the organisation's clinical and social care governance and risk management arrangements;
- monitor the effectiveness of local complaints handling arrangements;
- have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints; and
- where appropriate, publish annually a report on complaints handling.

The Regulation and Quality Improvement Authority (RQIA)

5.6 The Regulation and Quality Improvement Authority (RQIA) is an independent non-departmental public body. RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.

5.7 RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DHSSPS. RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

5.8 RQIA has a duty to encourage improvement in the delivery of services and to keep the DHSSPS informed on matters concerning the provision, availability and quality of services.

5.9 RQIA may be contacted at:

9th Floor, Riverside Tower
Lanyon Place
Belfast
BT1 3BT
Tel: 028 90 517500
Fax: 028 90 571501
http://www.rqia.org.uk/home/index.cfm

ANNEXE 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

1. The following standards have been developed to address the variations in the standard of complaints handling across HSC organisations. These will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally and will build public confidence in the process by which their complaint will be handled.

2. These are the standards to which HSC organisations are expected to operate. These standards complement existing Controls Assurance Standards, the Quality Standards for Health and Social Care, the Minimum Standards in relation to registered establishments and agencies and the Standards for Patient and Client Experience[16]. The standards for complaints handling are:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

[16] http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);
2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;
3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;
4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;
5. Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;
6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;
7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure;

8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;
2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable;
4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;
2. Complaints from a third party must, where possible, have the written consent of the individual concerned;
3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;
4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;
5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered;
6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements;

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;
2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;
3. HSC organisations will promote the use of independent advice and advocacy services;
4. HSC organisations will facilitate, where appropriate, the use of conciliation;
5. HSC organisations will adopt a consistent approach in the application of DHSSPS guidance on responding to unreasonable, vexatious or abusive complainants;
6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs;
7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;
4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;
6. All HSC providers/ commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;
7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised;

8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements;

STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;
2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;
3. HSC organisations will consider a variety of methods of responding to complaints;
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;
5. The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);
6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint;
7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;
2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;
3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;
4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;
5. HSC organisations must review the arrangements for complaints handling and responsiveness.

STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;
2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;
3. Learning will take place at different levels within the HSC (individual, team and organisational);
4. HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;
5. HSC organisations will incorporate learning arising from any review of findings of an investigation;
6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives;

7. HSC organisations will include learning from complaints within its Annual Report on Complaints, where Annual Reports are required.

ANNEXE 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- The Health and Personal Social Services General Dental Services Regulations (NI) 1993;
- The General Ophthalmic Services Regulations (NI) 2007;
- The Pharmaceutical Services Regulations (NI) 1997.

Pilot Scheme Directions

- Directions to Health and Social Services Boards concerning the implementation of pilot schemes (personal dental services) (NI) 2008

The Children (NI) Order 1995:

- The Representations Procedure (Children) Regulations (NI) 1996.

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) 2009;
- Amendment Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010).

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;
- The Adult Placement Agencies Regulations (NI) 2005;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007;

ANNEXE 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: 020 7713 5155 www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: 020 7333 6622 www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: 020 7887 3800 www.gdc-uk.org	**Royal Pharmaceutical Society of Great Britain (RPSGB)** Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 020 7735 9141 www.rpsgb.org
General Medical Council (GMC) Doctors Phone: 0845 357 8001 www.gmc-uk.org	**Pharmaceutical Society of Northern Ireland** Pharmacists and pharmacy premises in Northern Ireland Phone: 02890 326927 www.psni.org.uk
General Optical Council (GOC) Opticians Phone: 020 7580 3898 www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: 020 7357 6655 www.osteopathy.org.uk	**Council for Healthcare Regulatory Excellence (CHRE)** aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. www.chre.org.uk
Health Professions Council (HPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 020 7582 0866 www.hpc-uk.org	**Northern Ireland Social Care Council (NISCC)** Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: 02890 417600 www.niscc.info

ANNEXE 4: HSC PRISON HEALTHCARE

1. From 1 April 2008 responsibility for HSC prison healthcare was transferred to the DHSSPS. From that date the DHSSPS has delegated responsibility for commissioning those health and social services to the Eastern Health and Social Services Board (EHSSB). From 1 April 2009 this responsibility has transferred to the HSC Board. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

2. Complaints raised about care or treatment or about issues relating to the provision of prison healthcare will be dealt with under the HSC Complaints Procedure.

ANNEXE 5: THE NI COMMISSIONER FOR COMPLAINTS

1. The NI Commissioner for Complaints (the Ombudsman) can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly – and the organisation or practitioner has not put things right where they could have – the Ombudsman may be able to help.

2. The Ombudsman's contact details are:

Mr Tom Frawley
Northern Ireland Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Tel: (028) 9023 3821

3. Further information can be accessed at:
www.ni-ombudsman.org.uk

ANNEXE 6: THE PATIENT AND CLIENT COUNCIL

1. The Patient and Client Council (PCC) is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance to individuals making or intending to make a complaint; and
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services.

2. If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman.
- referral to other agencies, for example, specialist advocacy services;
- help in accessing medical/social services records;

3. All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from:

www.patientclientcouncil@hscni.net; or
Freephone 0800 917 0222

ANNEXE 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

ANNEXE 8: CONCILIATION

1. Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the practice/ pharmacy/ HSC organisation and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the practice/ pharmacy/ HSC organisation; or
- when there are misunderstandings with relatives during the treatment of the patient.

2. All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each others' point of view and ask questions.

3. Where a complainant is considered unreasonable, vexatious or abusive under the *Unacceptable Action Policy* (Annexe 14 refers) then conciliation would NOT be an appropriate option.

4. Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, for example, if there is a breakdown in the relationship between a doctor or practitioner and their patient.

5. Conciliation may be requested by the complainant, the practice/pharmacy or the HSC organisation. In FPS complaints it may be suggested by the HSC Board.

FPS arrangements

6. The Practitioner/ Practice/ Pharmacy Manager should approach the HSC Board Complaints Manager for advice.

7. Where a request for a conciliator is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the HSC Board Complaints Manager will advise the FPS practice/ pharmacy. In some cases the HSC Board may consider an alternative to conciliation, such as, an honest broker.

Agreement by parties involved

8. The FPS Practice/ Pharmacy Manager/ HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach

and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

9. Where it has been agreed that the intervention of a conciliator is appropriate, the HSC organisation or HSC Board (on behalf of FPS) should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand what conciliation involves;
- agreeing the timescales;
- agreeing when conciliation has ended; and
- explaining what happens when conciliation ends.

10. The conciliator must advise the practice/pharmacy/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The practice/pharmacy must then notify the HSC Board of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or HSC Board (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

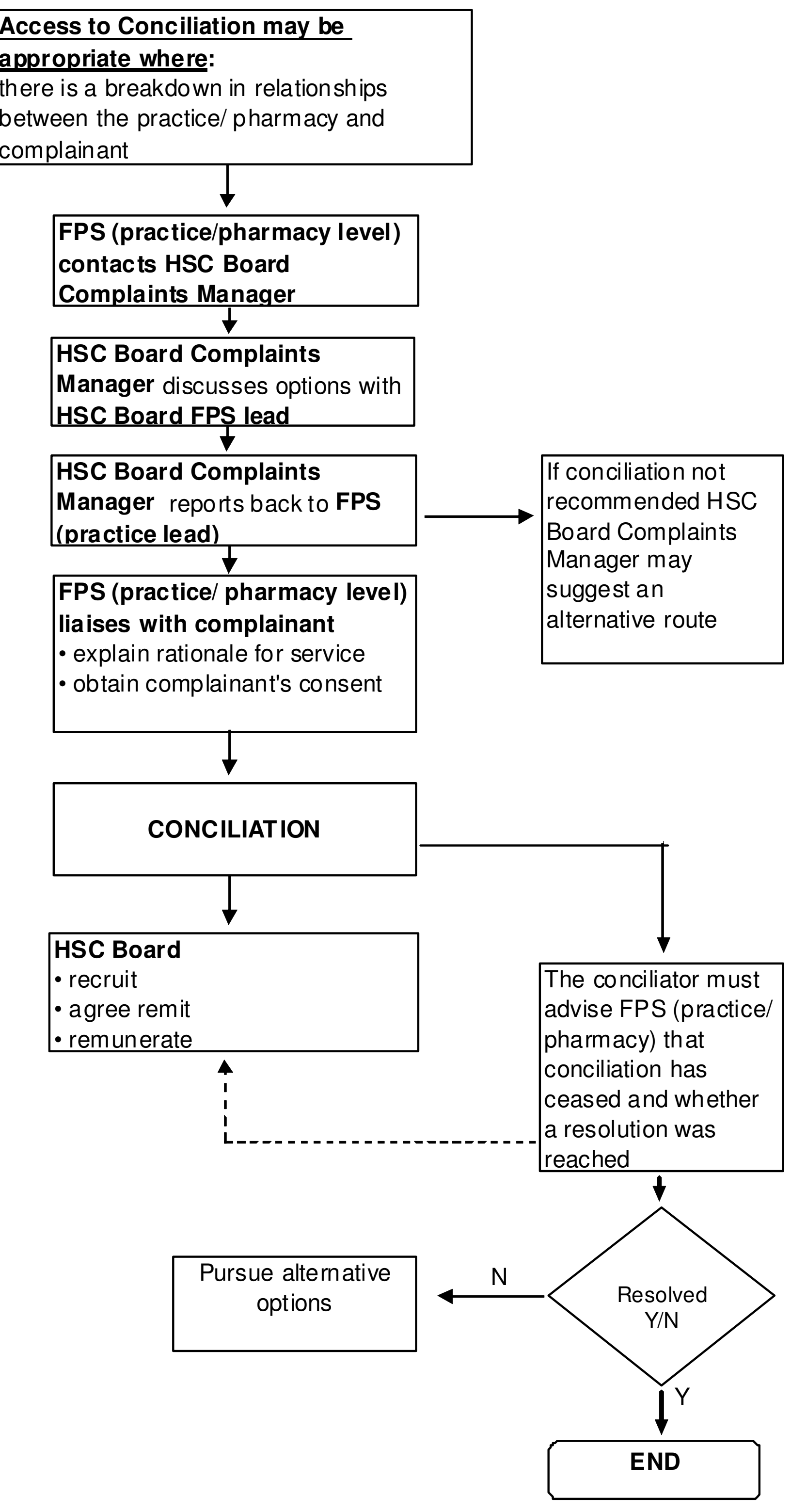
Appointment of conciliators

12. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate conciliation service. In addition it is responsible for all other arrangements, including remuneration.

Monitoring

13. The HSC Board will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

Conciliation – FPS Access



ANNEXE 9: INDEPENDENT EXPERTS

1. The use of an Independent Expert in the resolution of a complaint may be requested by the complainant, the practice/pharmacy or the HSC organisation. In FPS complaints it can also be suggested by the HSC Board. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation;
- to give an independent perspective on clinical issues.

FPS arrangements

2. The Practitioner/ Practice/ Pharmacy Manager should approach the HSC Board Complaints Manager for advice.

3. Where a request for an independent expert is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that independent expert advice would aid resolution then the HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice / Pharmacy Manager/ HSC organisation must contact the complainant and discuss the rationale for involving an Independent Expert

and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation or the HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

5. The HSC organisation may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding health and social care practice.

6. Where it has been agreed that an Independent Expert will be involved the practice/ pharmacy/ HSC organisation should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

7. The Independent Expert's findings/ report will be forwarded to the practice/pharmacy/ HSC organisation. A summary of the findings should be made available by the practice/ pharmacy/ HSC organisation to:

- the complainant; and
- the HSC Board (for FPS only).

8. The letter of response to the complainant is the responsibility of the practice/ pharmacy/ HSC organisation.

Appointment of Independent Experts

9. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

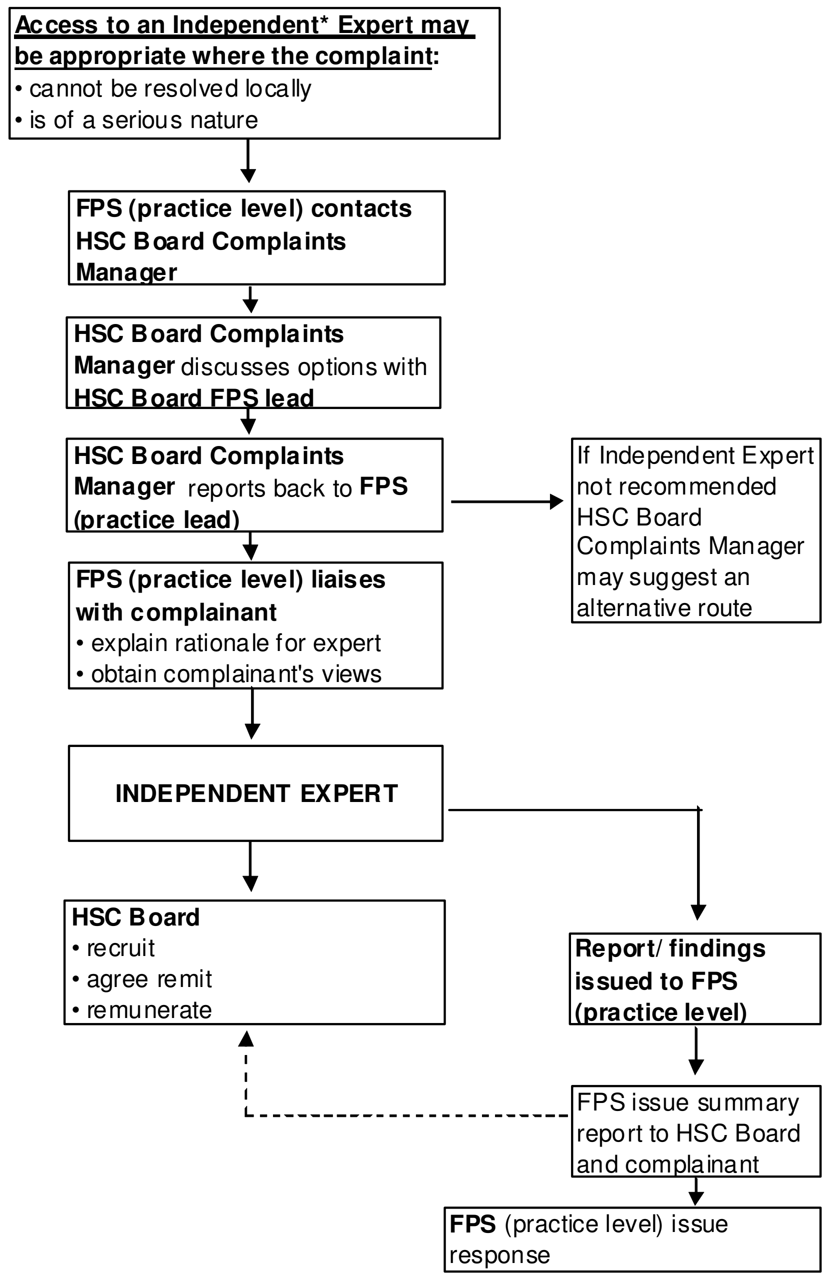
10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

12. The HSC Board will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

13. A flowchart outlining the process for FPS is shown overleaf.

Independent Experts - FPS Access



* definition of "Independent" = an Independent Expert must be recruited from another LCG area (and in certain circumstances outside Northern Ireland) and must have no connection with any of the parties to the complaint to avoid calling into question their objectivity and independence.

ANNEXE 10: LAY PERSONS

1. Lay persons may be beneficial in providing an independent perspective of non-clinical/ technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay person's involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the investigator during the investigation process where the complainant is considered unreasonable (Annexe 14 refers).

2. Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

- communication issues;
- quality of written documents;
- attitudes and relationships;
- access arrangements (appointment systems).

3. It is essential that both the provider and the complainant have agreed to the involvement of a lay person.

4. Lay persons should have appropriate training in relation to the HSC complaints procedure and have the necessary independence and communication skills.

FPS arrangements

5. The Practitioner/ Practice Manager should approach the HSC Board Complaints Manager for advice.

6. Where a request for a lay person is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that a lay person's involvement would aid resolution then the HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board may consider an alternative to a lay person.

Agreement and consent

7. The FPS Practice/ Pharmacy Manager/ HSC organisation must contact the complainant and discuss the rationale for involving a lay person and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation/ HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

8. Where it has been agreed that a lay person will be involved the practice/ pharmacy, HSC organisation should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand the focus of the issue(s);
- ensuring all parties understand what lay person involvement means;
- agreeing the timescales;
- agreeing to the provision of a final report, and
- explaining what happens when this process is complete.

9. The lay person's findings/ report will be forwarded to the practice/ pharmacy/ HSC organisation. A summary should be made available by the practice/ pharmacy/ HSC organisation to:

- the complainant; and
- the HSC Board (for FPS only).

10. The letter of response to the complainant is the responsibility of the practice/ pharmacy/ HSC organisation.

Appointment of lay persons

11. The HSC organisation or HSC Board (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person. In addition it is responsible for all other arrangements, including training, performance management and remuneration.

Monitoring

12. The HSC Board will monitor the effectiveness and usage of lay person arrangements within HSC Trusts and FPS.

ANNEXE 12: HONEST BROKER ROLE

1. “Honest broker” is the term used to describe the role of the HSC Board Complaints Manager in supporting and advising FPS on the handling of complaints. The complainant or the practice/ pharmacy can ask the HSC Board to act in this role at any point in the complaints process.

2. It is not an alternative to local resolution. Neither is it an opportunity for the HSC Board to take over an investigation. Rather it is about facilitating communications and building relationships between the practice/ pharmacy and the complainant. The honest broker will act as an intermediary and is available to both the complainant or practice/ pharmacy staff throughout the complaints process. For example, the honest broker may:

- provide advice to both the complainant and the practice/pharmacy;
- act as a link between both parties and/ or negotiate with them; and
- facilitate and attend meetings between both parties.

3. Paragraphs 2.16 to 2.20 outline the options available to complainants when pursuing FPS complaints. This includes an option to lodge their complaint directly with the HSC Board. Where the complainant contacts the HSC Board the Complaints Manager will explain the options available to resolve the complaint:

- that the complaint can be copied to the relevant practice/ pharmacy for investigation, resolution and response; or
- that the HSC Board can act as honest broker between the complainant and the practice/ pharmacy.

4. FPS co-operation in complaints of this type is essential for the role of honest broker to effectively assist in the successful local resolution of

complaints. FPS will be asked for their agreement should the complainant prefer the HSC Board's involvement.

5. Where the HSC Board Complaints Manager has been asked to act as honest broker he/she will:

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate; and
- ensure the complainant is informed about the progress of the practice/ pharmacy complaint.

6. Whichever process is used it is important to note that the practice/ pharmacy are responsible for the investigation and the response. The HSC Board Complaints Manager, however, must ensure that:

- a written response is provided by the practice/ pharmacy to the complainant and any other person subject to the complaint;
- the written response is provided within 10 working days of receipt of complaint and where this is not possible that the complainant is informed; and
- the response notifies the complainant of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure.

7. The complainant may contact the HSC Board Complaints Manager for further advice and support.

ANNEXE 13: VULNERABLE ADULTS

Definition of vulnerable adult

1. For the purposes of “Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance” the term “vulnerable adult” is defined as: *a person aged 18 years or over who is, or may be, in need of community care services* ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation.*[17]

2. Adults who “may be eligible for community care services” are those whose independence and well being would be at risk if they did not receive appropriate health and social care support. They include adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen; e.g. whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

3. Making a complaint about health and social care can be intimidating, especially for people with mental health problems, learning disabilities or for those who are old or frail. HSC organisations should have consistent, explicit arrangements in place for advising and supporting vulnerable adults including signposting to independent advice and specialist advocacy services.

[17] Law Commission for England and Wales (1995) Mental Incapacity, Report No.231 London: HMSO – definition of “vulnerable adult” adopted by the HSC Regional Adult Protection Forum

Reportable offences and allegations of abuse

4. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect then the regional *Safeguarding Vulnerable Adults Policy and Procedural Guidance (Sept 2006)* and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults* should be activated (see paragraph 1.26).

ANNEXE 14: UNREASONABLE, VEXATIOUS OR ABUSIVE COMPLAINANTS

1. HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

2. In determining arrangements for handling such complainants, staff need to:

- ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- appreciate that even habitual complainants may have grievances which contain some substance;
- ensure a fair approach; and
- be able to identify the stage at which a complainant has become habitual.

3. The following *Unacceptable Actions Policy*[18] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

[18] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman

Unacceptable Actions Policy

4. This policy sets out the approach to those complainants whose actions or behaviour HSC organisations consider unacceptable. The aims of the policy are:

- to make it clear to all complainants, both at initial contact and throughout their dealings with the organisation, what the HSC organisation can or cannot do in relation to their complaint. In doing so, the HSC organisation aims to be open and not raise hopes or expectations that cannot be met;
- to deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered unacceptable. All complainants have the right to be heard, understood and respected. HSC staff have the same rights.
- to provide a service that is accessible to all complainants. However, HSC organisations retain the right, where it considers complainants' actions to be unacceptable, to restrict or change access to the service;
- to ensure that other complainants and HSC staff do not suffer any disadvantage from complainants who act in an unacceptable manner.

Defining Unacceptable Actions

5. People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is assertive or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, the actions of complainants who are angry, demanding or persistent may result in unreasonable demands on the HSC organisation or unacceptable behaviour towards HSC staff. It is these actions that HSC organisations consider

unacceptable and aim to manage under this policy. These unacceptable actions are grouped under the following headings:

Aggressive or abusive behaviour

6. Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

7. HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance[19] approach must be adopted. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

8. Complainants may make what the HSC consider unreasonable demands through the amount of information they seek, the nature and scale of service they expect or the number of approaches they make. What amounts to unreasonable demands will always depend on the circumstances surrounding the behaviour and the seriousness of the issues raised by the complainant. Examples of actions grouped under this heading include demanding responses within an unreasonable timescale, insisting on seeing or speaking

[19] www.dhsspsni.gov.uk/zerotolerance.pdf

to a particular member of staff, continual phone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

9. HSC organisations consider these demands as unacceptable and unreasonable if they start to impact substantially on the work of the organisation, such as taking up an excessive amount of staff time to the disadvantage of other complainants or functions.

Unreasonable persistence

10. It is recognised that some complainants will not or cannot accept that the HSC organisation is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the organisation persistently about the same issue. Examples of actions grouped under this heading include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the HSC organisation can or cannot do and continuing to pursue a complaint without presenting any new information. The way in which these complainants approach the HSC organisation may be entirely reasonable, but it is their persistent behaviour in continuing to do so that is not.

11. HSC organisations consider the actions of persistent complainants to be unacceptable when they take up what the HSC organisation regards as being a disproportionate amount of time and resources.

Managing Unacceptable Actions

12. There are relatively few complainants whose actions a HSC organisation consider unacceptable. How the organisation manages these depends on their

nature and extent. If it adversely affects the organisation's ability to do its work and provide a service to others, it may need to restrict complainant contact with the organisation in order to manage the unacceptable action. The HSC organisation will do this in a way, wherever possible, that allows a complaint to progress to completion through the complaints process. The organisation may restrict contact in person, by telephone, fax, letter or electronically or by any combination of these. The organisation will try to maintain at least one form of contact. In extreme situations, the organisation will tell the complainant in writing that their name is on a "no contact" list. This means that they may restrict contact with the organisation to either written communication or through a third party.

13. The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in the ending of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

14. HSC organisations do not deal with correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. When this happens the HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful. The HSC organisation will ask them to stop using such language and state that it will not respond to their correspondence if they do not stop. The HSC organisation may require future contact to be through a third party.

15. HSC staff will end telephone calls if the caller is considered aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that the behaviour is unacceptable and end the call if the behaviour does not stop.

16. Where a complainant repeatedly phones, visits the organisation, sends irrelevant documents or raises the same issues, the HSC organisation may decide to:

- only take telephone calls from the complainant at set times on set days or put an arrangement in place for only one member of staff to deal with calls or correspondence from the complainant in the future;
- require the complainant to make an appointment to see a named member of staff before visiting the organisation or that the complainant contacts the organisation in writing only;
- return the documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed;
- take other action that the HSC organisation considers appropriate. The HSC organisation will, however, tell the complainant what action it is taking and why.

17. Where a complainant continues to correspond on a wide range of issues and the action is considered excessive, then the complainant is told that only a certain number of issues will be considered in a given period and asked to limit or focus their requests accordingly.

18. Complainant action may be considered unreasonably persistent if all internal review mechanisms have been exhausted and the complainant continues to dispute the HSC organisation’s decision relating to their complaint. The complainant is told that no future phone calls will be accepted or interviews granted concerning this complaint. Any future contact by the complainant on this issue must be in writing. Future correspondence is read and filed, but only acknowledged or responded to if the complainant provides significant new information relating to the complaint.

Deciding to restrict complainant contact

19. HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to modify their behaviour or action before a decision is taken. Complainants are told in writing why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place.

Appealing a decision to restrict contact

20. A complainant can appeal a decision to restrict contact. A senior member of staff who was not involved in the original decision considers the appeal. They advise the complainant in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

Recording and reviewing a decision to restrict contact

21. The HSC organisation will record all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact may be reconsidered if the complainant demonstrates a more acceptable approach. A senior member of staff will review the status of all complainants with restricted contact arrangements on a regular basis.

ANNEXE 15: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995 (the Order) HSC Trusts are statutorily required to establish a procedure for considering:
   - any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
   - matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
   - those personal social services to children provided under the Adoption Order (NI) 1987.

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996.

3. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 (a flowchart to aid decision making is attached).

4. The HSC Board and HSC Trusts should familiarise themselves with these requirements.

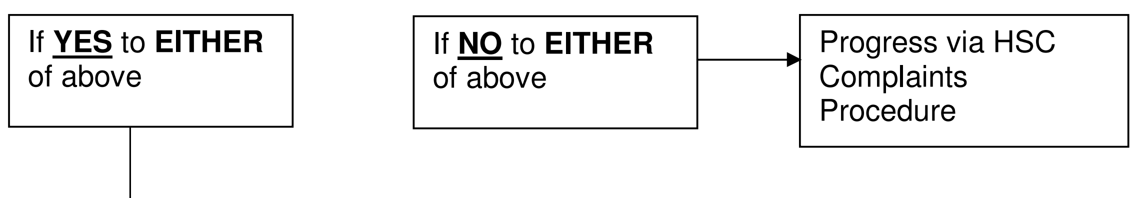
CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Complaint: Does it fit the definition of a Children Order complaint as below?

"…Any representation (including any complaint) made to the Trust … about the discharge of any of its functions under Part IV of the Order in relation to the child."
(Children (NI) Order 1995, Article 45(3))

OR

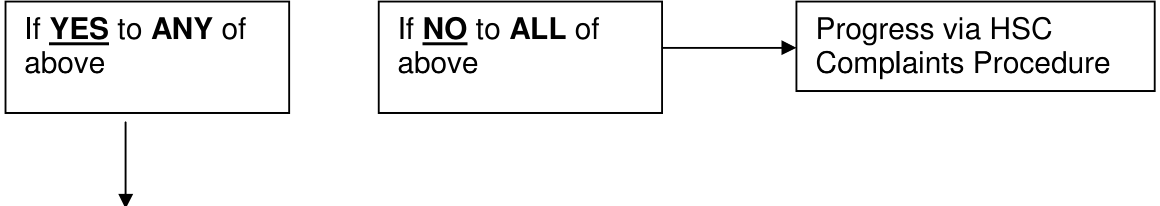
"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and para 6 of Schedule 5 to, the Children Order."
(Guidance & Regulations – Vol. 4, Para 12.5 – DHSS)



2. Does it meet the criteria of what may be complained about under Children Order?

"… about Trust support for families and their children under Part IV of the Order."
(Vol. 4, Para 12.8)

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.



3. <u>Complainant</u>: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need;

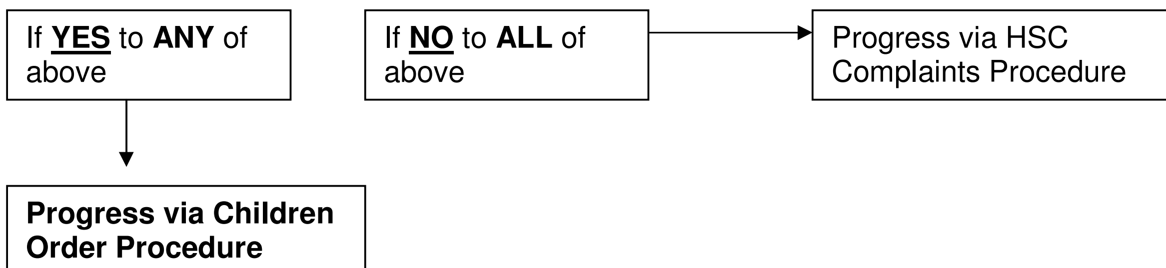
c. A parent **of his**;

d. Any person who is not a parent of his but who has **parental responsibility for him**;

e. Any Trust foster parent;

f. Such other person as the Trust considers has a sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- the person who had the day to day care of the child within the past two years;
- the child's Guardian ad Litem;
- the person is a relative of the child (as defined by Children Order, Article 2(2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- a friend;
- a teacher;
- a general practitioner.
  (Children (NI) Order 1995 Article 45(3))



<u>NB</u>: In order for a complaint to be eligible to be considered under the Children Order Procedure, the answer to 1 <u>and</u> 2 <u>and</u> 3 MUST all be YES.

Consent: *The (Trust) should always check with the child (subject to his understanding) that a complaint submitted reflects his views and that he wishes the person submitting the complaint to act on his behalf.* (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Trust Policy for approval by **Trust Policy Committee**

TYPE OF DOCUMENT

REFERENCE NUMBER	TP045/10
TITLE	Policy and Procedure for the Management of Complaints & Compliments.
Summary	The purpose of this policy is to provide guidance on how complaints are managed within the Belfast HSC Trust. Appendix 1 It is the Trust's wish to promote an open, honest and just culture, where all staff can learn from complaints.
Supercedes	Individual Legacy Trust's Policies
Operational date	April 2010
Review date	April 2013
Version Number	V1
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Department / Service Group	Medical Directors Group
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Date	Version	Author	Comments
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Approval Process – Trust Policies

Policy Committee	Approval	17/05/10	V1
Executive Team	Authorise	19.05.10	V1
Chief Executive	Sign Off	19.05.10	V1

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval		
Policy Committee	Ratify		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Local Approval Process

	Approval		

Dissemination

Areas :	

Title:
Policy and Procedure for the Management of Complaints & Compliments.

Purpose:

To provide staff with a greater understanding and guidance on complaint management within the Belfast Trust and to ensure learning from complaints can take place and they are managed in a positive and open manner.

Objectives:

- To provide information for all staff and service users on complaints management
- To ensure complaints are managed in a timely manner
- To ensure the Trust promotes a culture of openness and honesty when investigating all complaints
- To provide learning from complaints across the Trust
- To provide guidance on how to manage a complaint

Policy Statement(s):
This policy has been developed and set within the Legal Framework for Complaints Management within Health and Social Services.

The Belfast Health and Social Care (HSC) Trust are committed to providing the best possible services for patients, clients, visitors and staff. Complaints should be used to inform and improve. The Belfast Health and Social Care Trust aims for continuous modernisation and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Learning from complaints can only take place when they are managed in a positive and open manner. It is the Trust's wish to promote an open, honest and just culture, where all staff can learn from complaints.
It is essential that all staff are aware of their roles and responsibilities when dealing with complaints. This will enable them to respond positively, and where possible, resolve the complaint at local level.
Complaints will be dealt with promptly and effectively in order to eliminate the need for a complicated and time-consuming investigation process.

This policy provides the opportunity to put things right for service users as well as improving services.
All complaints will be treated in confidence, with due care and respect being paramount at all times.

Medical Director	**Chief Executive**
Date: 19 May 2010	**Date: 19 May 2010**

Source/Committee – Policy & Procedure for Complaints & Compliments – V1 – Date: 04/05/10

Index Page

Full Description

- 1.0 Title Page 5
- 2.0 Introduction Page 5
- 3.0 Purpose Page 5
- 4.0 The Scope Page 5
- 5.0 Objectives Page 5
- 6.0 Roles & Responsibilities Page 5
- 7.0 Policy /Guideline Descriptions Page 5
- 8.0 Policy statements Pages 5/6
- 9.0 Implementation / Resource requirements Page 6
- 10.0 Source(s) / Evidence Base Page 7
- 11.0 References, including relevant external guidelines Page 7
- 12.0 Consultation Process Page 7
- 13.0 Equality and Human Rights screening carried out Page 7
- 14.0 Procedures Page 7

Appendix Section

Appendix 1	Definitions	Page 8
Appendix 2	Roles and Responsibilities	Page 9
Appendix 3	Who Can Complain? How can complaints be made? Options for pursuing a complaint	Page 12
Appendix 4	What information should be recorded when taking a complaint?	Page 13
Appendix 5	Consent Confidentiality	Page 14
Appendix 6	Grading of the complaint	Page 15
Appendix 7	Investigation and Resolution	Page 16
Appendix 8	Responding to a complaint	Page 17
Appendix 9	What the policy does not cover	Page 18
Appendix 10	Flowchart summarising the process for staff to follow when dealing with Complaints	Page 19/20
Appendix 11	Service Group Complaint/ Enquiry Record Form	Page 21
Appendix 12	Internal/ External Support Contacts	Page 22/24
Appendix 13	Vexatious, unreasonably demanding, or persistent Complaints	Page 25
Appendix 14	Unacceptable Actions Policy	Page 26

Appendix 15 Vulnerable Adults Policy Page 30

Appendix 16 Complaints Leaflet Page 31

Appendix 17 & 18 Children Order Representations And Complaints Procedure Page 32

Full Description

Reference No: TP045/10

1. Title:

Policy & Procedure for the Management of Complaints and Compliments.

2. Introduction:

This policy covers complaints received about any aspect of Health and Social Care services provided or commissioned by the Belfast Trust in hospital or community settings.
Any complaint relating to an application to obtain access to Health and Social Care records for deceased persons (under the Access to Health Records (NI) Order 1993) can be investigated through the Complaints Procedure. This would be an alternative to making an application to the Courts.

3. Purpose:

This Policy is designed to provide staff with a greater understanding and guidance on Complaint Management within the Belfast Health & Social Care Trust

4. The Scope:

This Policy is applicable to all staff that provide services within the Belfast Health & Social Care Trust. This also includes services that our commissioned or provided by the Independent Sector.

5. Objectives:

- To provide information for all staff and service users on complaints management
- To ensure complaints are managed in a timely manner
- To ensure the Trust promotes a culture of openness and honesty when investigating all complaints
- To provide learning from complaints across the Trust
- To provide guidance on how to manage a complaint

6. Roles and Responsibilities:

Appendix 2

7. Policy / Guideline description:

This Policy describes how Complaints/ Enquiries/ Compliments will be managed effectively within the Belfast Health & Social Care Trust. For

Definitions – *Appendix 1*

8. Policy statements:

8.1 All complaints must be formally acknowledged with two working days by a member of the Complaints Team.

8.2 Complaints must be responded to within a 20 working day timeframe and where this is not possible due to unforeseen circumstances a holding letter can be issued with the approval of the Complaints Manager.

8.3 The designated link person within each service area will be notified by the Complaints Team on receipt of the complaint. A copy of the complaint correspondence will be forwarded to the link person in the service group attaching a complaints memo outlining the process to be followed to ensure a timely response.

8.4 Support and advice available from Complaints Team upon request. Details on what information is required when recording a complaint – *Appendix 4*

8.5 The Complaints Team will provide a reminder to the link person via email or telephone to prompt the internal response.

8.6 Upon completion of the complaints investigation, the responsible link person must forward a draft response to the Complaints Team who will ensure all aspects of the complaint have been addressed. *Appendix 8*

8.7 Once the content of the draft is deemed to have answered all aspects of the Complaint, the response will be sent to the designated service manager/ director for approval and signature.

8.8 Where a third party wishes to make a complaint on behalf of someone else, consent must be sought. The Complaints Team will forward a consent form to the relevant person(s) requesting authorisation. *Appendix 3 & 5*

8.9 At all stages within the complaints process assistance from the Complaints Manager, Independent advice and support for complainants is also available from the Patient Client Council, Independent advocacy and specialist advocacy services. *Appendix 12*

8.10 It is essential that all staff are aware of their roles and responsibilities when dealing with complaints. *Appendix 2* This will enable them to respond positively, and where possible, resolve the complaint at local level.

8.11 This policy provides the opportunity to put things right for service users as well as improving services.

8.12 All complaints will be treated in confidence, with due care and respect being paramount at all times.

8.13 Complaints in relation to Children Services issues – *Appendices* 17 & 18

8.14 Where a complaint is made locally all attempts should be made to achieve local resolution. *Appendix 10*. Local Resolution forms can be found on the Trust intranet *Appendix 11* which should be completed and forwarded to the complaints@belfasttrust.hscni.net link for recording. However, where this is not possible and during office hours the complainant should be transferred to the Complaints Department *Appendix* 12. Outside of these hours, guidance as per *Appendix 8*

8.15 Normally, a complaint must be made within 6 months of the occurrence of the matter giving rise for concern, or from when the complainant became aware of the matter as detailed in the complaints leaflet. *Appendix 16*. Full and proper investigation is hindered where timescales extend beyond a six-month period, however, this should not be stringently applied and advice should be sought from the relevant Complaints Manager.

8.16 Where a complaint relates to the actions of more than one service area the Complaints Manager along with the Service Group Manager will identify and agree who will take the lead in investigating the complaint and co-coordinating the response for the complaint.

8.17 All complaints will be investigated accordingly to the degree of the grading. Not all complaints need to be investigated to the same degree. The grading of the complaint will identify the level of investigation required. *Appendix 6*

8.18 Some matters are excluded from investigation through the Trusts Complaints Procedure. *Appendix 9*

9.0 Implementation / Resource requirements:

A programme of complaints awareness and management training will be ongoing throughout the Trust to ensure that this procedure is followed and that staff encourages service users to make their views known.

Complaints' Training is now contained as part of the mandatory induction programme for new Belfast Health & Social Care Trust employees.

Further information on dealing with Vexatious, unreasonably demanding, or persistent Complaints can be found in *Appendix 13* and the Policy Acceptable Actions in *Appendix 14.*

10. Source(s) / Evidence Base:

Legacy Complaint Policies

DHSSPSNI Complaints Standards and Guidelines for Local Resolution and Learning – April 2009

11. References, including relevant external guidelines:

HPSS Complaints Procedure Regulations: April 2009

The Children (NI) Order 1995:

12. Consultation Process:

Senior Managers within Risk & Governance
Governance Leads within the Service Groups
Staff side
Human Resources and Equality Department
Independent Service User Group.

13. Equality and Human Rights screening carried out:

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.

✓ Screening completed No action required.

☐ Full impact assessment to be carried out.

14. Procedures:

Appendix 10

Medical Director

Date: 19 May 2010

Chief Executive

Date: 19 May 2010

Appendix 1 Definitions

Complaint

A complaint is "**an expression of dissatisfaction about care or services provided by The Trust, which requires a response".** Complainants may not always use the word complaint. They may offer a comment or suggestion that can be extremely helpful.

Enquiry

An enquiry is "**a request for information, explanation or clarification".**

Compliment

A compliment is **"an expression of praise, commendation, or admiration"**.

Promoting access

Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised of the types of help available through front line staff, the Complaints Managers and the Patient Client Councils. The Trust promotes and encourages an open and flexible access to the complaints procedure.

Co-operation

Local arrangements must be such as to ensure that a full and comprehensive response is given to a complainant. Therefore co-operation in the handling and consideration of complaints is essential between:

Internal Services or Corporate Groups, other HSC organisations and Regulatory authorities.

This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

The Trust has assigned Complaints Managers to Service and Corporate Groups who are readily accessible to both the public and members of staff. Names of these managers can be found on the Trusts internet

Appendix 2 Roles and Responsibilities

A. Chief Executive

As Accountable Officer, the Chief Executive is responsible for ensuring the Trust meets it's statutory and legal requirements and adheres to relevant complaint guidance.

The Chief Executive will:

1. ensure that the Trust takes the necessary action to ensure that lessons are learned and where appropriate, improvements are made to the service

2. ensure a Committee structure is in place to monitor and review the organisation's performance in complaints management

B. Trust Board

The Trust Board is responsible for the implementation of the Policy and Procedure for the Management of Complaints, Enquiries and Compliments and to ensure compliance with the Trust's statutory obligations as described in the relevant complaints legislation.

The Board will:

1. ensure that the organisation arrangements contained within the policy and procedures are implemented

2. monitor and review the overall reporting performance and receive regular reports

3. ensure complaints management is integrated within the Trust's Performance and Assurance Framework

C. Medical Director

The Medical Director or his deputy has the responsibility for the management of complaints throughout the Belfast Health and Social Care Trust.

The Medical Director has a shared responsibility with the Director of Nursing and Patient Experience for clinical quality.

The Medical Director will

- report to the Trust Board on the management of complaints at regular intervals

- develop suitable organisational arrangements for the management of complaints

- development and maintain systems to monitor and disseminate learning from complaints across the organisation

- put systems in place to ensure reporting of complaints to external agencies as required e.g. DHSSPSNI, Regional Health and Social Care Board and Regulation and Quality Improvement Authority

D. Co-Director Risk and Governance

The Co-Director will support the Medical Director in meeting his responsibility for complaints management of patients, clients, staff, public and patient safety.

The Co-Director has Trust-wide lead for the co-ordination, implementation, and evaluation of risk management systems and the Trust Risk Management Strategy.

The Co-Director will:

- promote an open, honest and just culture for complaints management
- maintain systems for the reporting, recording and analysing of complaints
- ensure that subsequent learning from complaints is shared across the Trust, through appropriate management structures
- take account of relevant complaints when reviewing service group risk registers and ensure appropriate linkage to the corporate risk register

E. Directors

It is the responsibility of the directors to:

- disseminate and promote this policy and procedure within their responsibility and ensure its implementation by providing support and advice to managers and staff
- ensure complaints are investigated thoroughly in accordance with existing policy and procedure
- ensure that complaints are monitored and reviewed within their Service Group and ensure any recommendations made as a result of investigations are implemented and monitored
- ensure that subsequent learning from complaints is shared across Service Groups, through appropriate management structures
- take account of relevant complaints when reviewing their Risk register and ensure that this is linked appropriately to the Corporate Risk Register
- ensure staff have access to advice and training on complaint management and, where appropriate, investigation and review
- sign off complaint responses on behalf of the Chief Executive

F. Co- Directors

It is the responsibility of the Co Directors to ensure that all complaints are managed efficiently and effectively within his/her span of responsibility.

The Co-Director will:

- deal with any queries Investigating Officers might have, including the need to contact or meet with the service user who made the complaint or enquiry
- agree the draft response with the Service Manager and forward this to the relevant Complaints Manager within identified timescales along with the supporting documentation

G. Service Group Managers

- Service Group Managers are responsible and accountable to their Director to ensure complaints are thoroughly investigated with their clinical and managerial teams and responded to within given time scales. Service Managers should also ensure that their teams approve draft responses and receive copies of final responses

H. Complaints Managers

Complaints Managers are responsible for:

- obtaining consent where required in the case of third party complaints or enquiries
- quality assuring all responses received pertaining to complaints or enquiries
- providing service user feedback, related analyses and reports to services and Committees within the Governance Accountability Framework
- providing information as requested by RQIA, Dept of Health and HSC Board
- contributing to training in relation to complaints investigation and management
- ensuring final Complaint Responses are sent to Service Managers and Co-Directors via team administrators.

I. All staff

Staff are responsible for:

- discussing and attempting to resolve complaints as they arise within the service and to put things right where possible within identified timescales
- giving each service user a copy of the Trust's Complaints Leaflet at first contact with the service to encourage all types of user feedback. Staff should advise that any concerns can be raised directly with them or, if preferred the leaflet can be used. Where this is not appropriate, consideration must be given as to when service users should be informed about the Trust's service user feedback process
- referring the matter as soon as possible to their line manager if unable to deal with complaints raised directly with them or seeking advice from complaints staff on how to proceed
- keeping their line manager updated on complaints and enquiries they are currently dealing with and outcomes including improvements made
- contributing to the investigation of complaints and enquiries within the service/team and returning statements, reports and other information to Investigating Officers within requested timescales
- informing their line manager and other team members (if appropriate) when they receive a written compliment from service users
- making sure that information relating to service user feedback is displayed in facilities accessed by service users and made available in inspections/audit

Appendix 3

Who Can Complain?
Any person can complain about any matter relating to the provision of services provided or commissioned by the Trust. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, (providing they have obtained the patient's or client's consent);
- parents (or persons with parental responsibility) on behalf of a child; and any appropriate person in respect of a patient or client who is deceased e.g. the next of kin.

How can complaints be made?

Complaints may be made verbally or in writing and should also be accepted via any other method, for example, the telephone or electronically. The Trust should be mindful of technological advances and ensure local arrangements are in place to ensure there is no breach of patient/client confidentiality.

Complaints may be made to any member of staff - for example receptionists, medical or care staff. In many cases complaints are made orally and front-line staff may resolve the complaint "on the spot". If this is the case it should be recorded on the Service Group, Complaints Record Form (Local Resolution), along with the action taken and outcome and forwarded to the Complaints Department for entry onto the Datix system. (This form can be found on the Trust's intranet site). Appendix 1

Complaints that cannot be resolved "on the spot" must be passed on to the Complaints Manager.

All front-line staff must be trained and supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere. Front line staff should familiarise themselves with the Equality Good Practice Reviews' principles for dealing with and managing complaints and the Standards for complaints handling.
dhsspsni.gov.uk/goodpractice reviews
dhsspsni.gov.uk/ Complaints in Health and Social care Standards & Guidelines for Resolution and Learning

Options for pursuing a complaint
Some complainants may prefer to make their complaint to someone within the Trust who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer to the Chief Executive. The Trust has named Complaints Managers. Names of these managers can be found on the Trusts internet s

Appendix 4

What information should be recorded when taking a complaint?

- A complaint need not be long or detailed, but it must include:
- Contact details name, address, telephone number, DOB, where appropriate hospital number, Dept/ Ward/ Facility and GP.
- Who or what is being complained about, including the names of staff if known
- Where and when the events of the complaint happened: and where possible, what remedy is being sought- e.g. an apology or an explanation or changes to services.
- Advice on consent when appropriate
- Once template is completed, forward to Complaints Department immediately for acknowledgement and action.

Appendix 5

Consent

Third party complaints may be made by a service user's relative, friend, carer, or other representatives such as their solicitor. Such complaints are acceptable provided the service user has given his/her written consent. In such circumstances the Complaints Department reserve the right to seek written consent from the service user prior to releasing information.

However, there will be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the individual is deceased.

The Complaints Manager, in discussion with the Service Group Director, Data Protection Officer, or other senior person, will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative the Trust will provide information in writing to the person outlining the reasons the decision has been taken. Where Consent has not been received, the complaints response will not be released. A second request letter to the complainant will be sent advising that consent is required. If consent has not been received, a third and final letter will be sent advising that the complaint will be closed within a stated timeframe.

More information on consent can be found in the DHSSPS good practice in consent guidance. (www.dhsspsni.gov.uk/publichealthconsent)

Confidentiality

Staff are required to promote and maintain service user and staff confidentiality and to comply with the requirements of legislation, for example, the Data Protection Act 1998 and the Human Rights Act 1998. The need for sensitivity and confidentiality is paramount. All staff must be particularly aware of requirements in this regard, given the nature of their work and the access they require in order to affect this procedure.

Staff are directed to the Code of Practice on Protecting the Confidentiality of Service Users DHSSPS (www.dhsspsni.gov.uk/confidentiality-consultation)

Appendix 6

Grading of the complaint

It is the responsibility of the Complaints Manager to ensure that all complaints are graded using the risk grading process as outlined in the Adverse Incident Reporting Policy and Procedure including Adverse Incident Investigation Procedure. The grading will also be agreed with the Service Group Manger.

All complaints graded as "red" will immediately be highlighted to the Senior Complaints Manager who will inform the Co-Director of Risk and Governance and the Co-Director of the Service Group who will be responsible in informing the relevant Director. It is the responsibility of the Director to inform the Chief Executive.

In cases where the complaint is as graded high risk (red) the Co-Director / Director will agree the level of investigation to be carried out. E.g. Root Cause Analysis (RCA).

All other complaints will be investigated accordingly to the degree of the grading.

Appendix 7

Investigation and Resolution

The purpose of the investigation is not only to ascertain what happened, to establish the facts, to learn, to detect misconduct or poor practice and to improve services but also gain 'resolution' for the complainant.

The investigation should be undertaken by a suitable person and conducted in a manner that is supportive to all those involved. Advice should be sought from the Complaints Manager / Senior Complaints Manger where necessary.

It may be more appropriate depending on the complexity of the complaint that a meeting would be offered to the family to discuss the outcome of the investigation. This decision would be agreed by the Complaints Manger and Service Group Manager.

The investigator should establish the facts relating to the complaint and assess the quality of the evidence and call upon the services of others if required.

Once the investigation is complete the investigator should prepare a draft response. The response should include and explain how the investigation was carried out and how the conclusions were reached. This draft response must be shared with the relevant staff to ensure factual accuracy and agreement. It should then be ratified by the Co Director / nominated person before being forwarded to the Complaints Department for formatting and forwarding to the Director for final signature.

Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required.

Others may be delayed due to the unavailability of a member of staff or a complainant as a result of personal or domestic arrangements, bereavement, a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure. It is important that the Complaint Manager is informed of any delays so that the Complainant can be kept updated.

Appendix 8

Responding to a complaint

It is the responsibility of the relevant Service Manager/Investigating Officer to prepare the draft response from the information obtained during the investigation. The response should be clear, accurate, balanced, simple, and easy to understand.

It should aim to answer all the issues raised by the complainant, in an open and honest way, explaining the situation, why it occurred and the action taken or proposed. Where possible this should be provided to the relevant Complaints Manager within 10 working days from receipt of the complaint.

The draft response should:

- address all of the concerns expressed and show that each element has been fully and fairly investigated
- explain what happened and why it happened
- detail any actions taken or proposed to prevent recurrence
- offer to meet the complainant
- where appropriate include an apology where things have gone wrong
- indicate that a named person is available to clarify any aspect of the letter
- their right to take their complaint to the Commissioner for Complaints if they remain dissatisfied with the outcome of the complaints procedure.

When the Service Group manager and Co-Director / nominated person is satisfied that the complaint has been fully addressed and agree the draft response, this should be forwarded to the Complaints Manager along with all relevant documentation and copies of all investigative reports. Upon receipt of the ratified letter the Complaints Manager will then forward response for signature by the relevant Director.

In line with the DHSSPS guidance, complaints must be investigated and the person making the complaint, issued with a written response, signed by the relevant Director, on behalf of the Chief Executive, within 20 working days where possible. If for any reason this is not possible the complainant will be advised of the delay, the reason for it and when they are likely to receive a full reply.

When the final response is signed off by the Director the Director's secretary will then send the letter to the complainant and a copy of the signed letter to the Complaints Manager for the file. The complaint is then closed. If the complainant remains dissatisfied they can contact the Complaints Department. Consideration will then be given to reopen the complaint for further local resolution. This may include advocacy or conciliation.

The Complainant can also contact the Commissioner for Complaints at this stage.

Appendix 9

What the policy does not cover

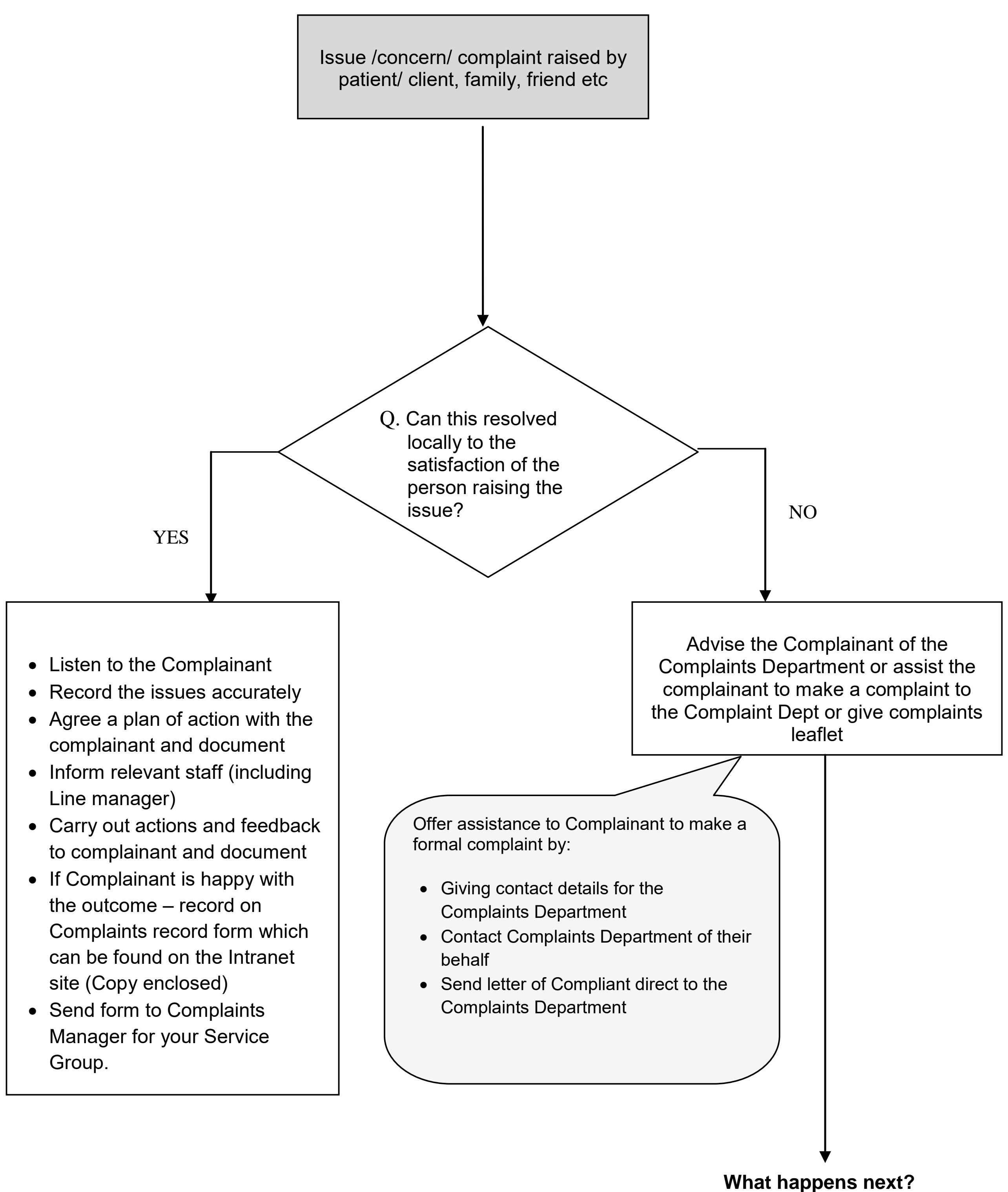
In such circumstances the Chief Executive should inform the person outlining why the exclusion applies.

Exclusions are as follows:

- private care and treatment or services including private dental care or privately supplied spectacles; except for those patients having private care in one of the Trust's facilities and the complaint is about care and treatment.
- services not provided or funded by the HSC, for example, provision of private medical reports; or
- the independent regulated sector (except for those that are commissioned by the Trust)
- staff grievances / complaints
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by Health & Social Care Board (HSCB)
- a request for information under Freedom of Information
- access to records under the Data Protection Act 1998
- an independent inquiry
- a criminal investigation
- protection of vulnerable adults *Appendix 15*
- child protection procedures
- coroners cases
- legal action

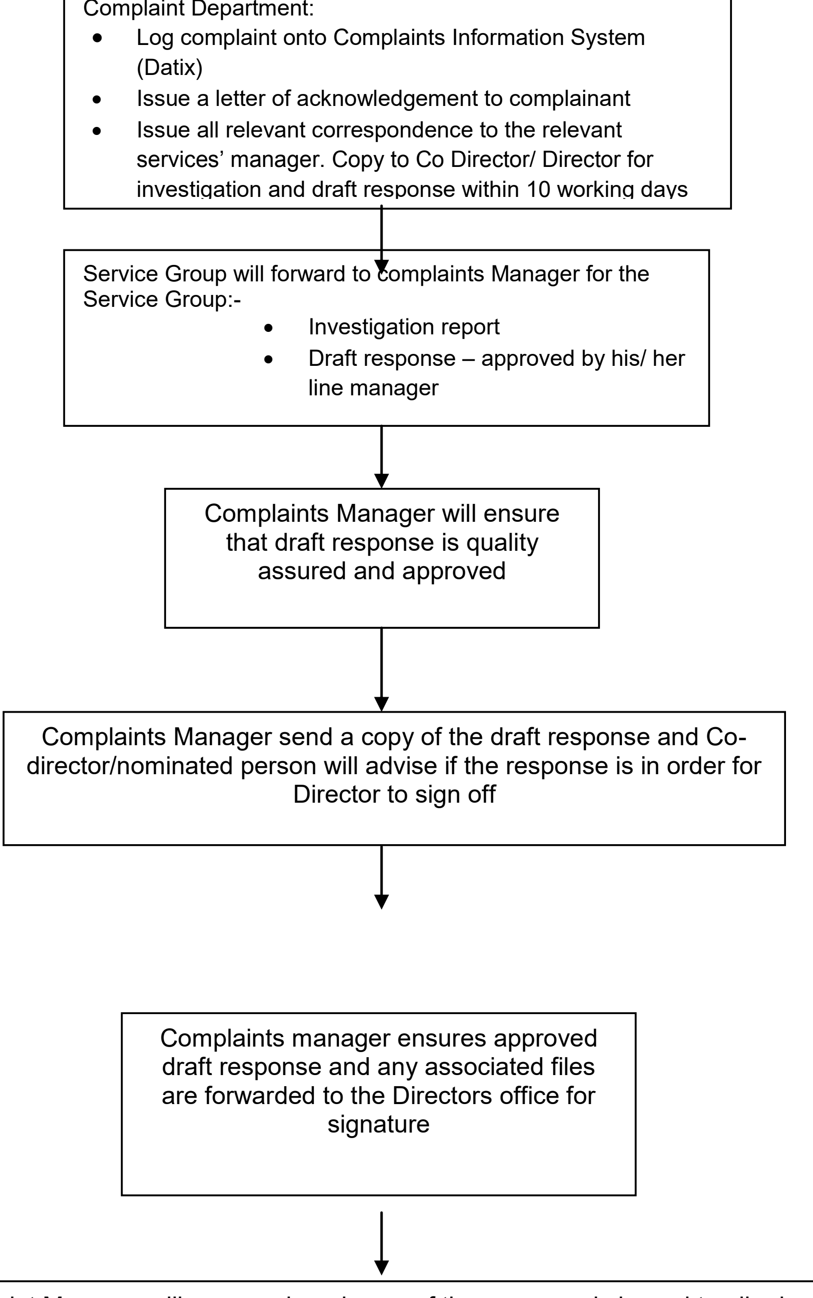
Appendix 10

Flowchart summarising the process for staff to follow when dealing with Complaints



Appendix 10 continued...

Flowchart summarising the process for Service Groups and Complaints Managers to follow when dealing with Complaints



Complaint Manager will ensure singed copy of the response is issued to all relevant managers. Where necessary, and in consultation with the Co-Director, Complaints Manager will formally follow-up any actions to be taken as a result of a complaint and ensure lessons learned are shared within the Service Area or across the Trust (NB: In all such cases the Governance Manager will be advised)

Complaints Manager will record above onto the Complaints Information System (Datix)

Appendix 11

Service Group Complaint/Enquiry Record Form

Date:
Time:
Details Taken By:
Location & Service Group:

Patient/Client Affected Details

Name:			
Address:			
Contact telephone number (if same person as complainant)			
Date of Birth: (if patient/client)		Hospital Number (if patient/client)	

Complainant Details (if different from above)

Name:	
Address:	
Contact number:	

NB: Consent – Advise complainant, if not patient, that consent may be required

Note of Complaint/Enquiry

Action Taken

Passed to Complaints Department: **NB: This information will be shared with the complaints department for statistical purposes only.**

Please return to:Complaints Department
6th Floor
McKinney House
Musgrave Park Hospital
Belfast
BT9 7JB
Or alternatively email us at: complaints@belfasttrust.hscni.net

Source/Committee – Policy & Procedure for Complaints & Compliments – V1 – Date: 04/05/10

Appendix 12 – Internal/ External Support/ Contacts

COMPLAINTS DEPARTMENT

The BHSCT Complaints Department are located at:

Musgrave Park Hospital
McKinney House
Stockman's Lane
Belfast
BT9 7JB

Tel: 028(90) 630023
Fax: 028(90) 903018

THE NI COMMISSIONER FOR COMPLAINTS

The NI Commissioner for Complaints (the Ombudsman) can carry out independent investigations into complaints about poor treatment or services or the administrative actions of the Trust. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly- and the Trust or practitioner has not put things right where they could have- the Ombudsman may be able to help.

The Ombudsman's contact details are:

Mr Tom Frawley
Northern Ireland Ombudsman
Freepost BEL 1478
Belfast
BT1 6BR

Tel: 028 90 233821
Free phone: 0800 34 34 24

Further information can be accessed at:

www.ni-ombudsman.org.uk
email: **ombudsman@ni-ombudsman.org.uk**

THE PATIENT AND CLIENT COUNCIL

The Patient and Client Council (PCC) is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. It's functions include:

- representing the interests of the public
- promoting involvement of the public
- providing assistance to individuals making or intending to make a complaint
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care

services

If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the Complaints Procedure and advice on how to take a complaint forward
- discussing the complaint and drafting letters
- making telephone calls
- helping prepare for a meeting and accompanying the complainant
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services;
- help on accessing medical/social services records.

All advice, information and assistance with complaints are provided free of charge and are confidential. Further information can be obtained from; **www.patientclientcouncil@hscni.net**; or

Free phone 0800 917 0222

ADVOCACY AND CONCILIATION

Some people who might wish to complain do not do so because they do not know how to, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their wishes and views known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

Within the Health and Social Care sector, advocacy has been available mainly for vulnerable groups, such as people with learning problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and can be intimidated by professional attitudes that may seem paternalistic and authoritarian.

The Trust should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to gain a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations such as;

- where staff or practitioners feel the relationship with the complainant is difficult

- when trust has broken down between the Trust and both parties feel it would assist in the resolution of the complaint

- where it is important, e.g. because of on-going care issues, to maintain the relationship between the complainant and the Trust

- when there are misunderstandings with the relatives during the treatment of the patient

All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each others' point of view and ask questions.

Complaints raised by unreasonable, vexatious or abusive complainants are NOT suitable for conciliation.

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, e.g. if there is a breakdown in the relationship between a doctor or practitioner and their patient.

Conciliation may be requested by the complainant or the Trust.

THE REGULATION QUALITY IMPROVEMENT AGENCY - RQIA

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. The Regulation and Quality Improvement Authority will monitor how complaints about the regulated services are handled.

Contact Details:

The Regulation and Quality Improvement Authority Headquarters
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Email: info@rqia.org.uk

Telephone number: 028 9051 7500
Fax: 028 9051 7501

Appendix 13

Vexatious, unreasonably demanding, or persistent Complaints

All Trust staff should respond to complainants in an appropriate and professional manner. However, there may be times when nothing can reasonably be done to assist or where further contacts place inappropriate demands on resources.

In such cases and in consultation with Senior Manager/ Co-Director will establish if the “Unacceptable Actions Policy”. Or Guidance for the handling of Habitual or Vexatious complains should be considered.

Introduction

Habitual or vexatious complainants are becoming an increasing problem for Healthcare Staff. The difficulty in handling such complainants places a strain on time and resources and can cause undue stress for staff that may need support in these difficult situations. Staff should respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further which can be reasonably done to assist them or to rectify a real or perceived problem.

In determining arrangements for handling such complainants, the Trust is presented with two key considerations:

a) To ensure that the complaints procedure has been correctly implemented so far as is possible and that no material element of a complaint is overlooked or inadequately addressed, and to appreciate that even habitual or vexatious complaints may have aspects to their complaints which contain some genuine substance. The need to ensure an equitable approach is crucial.

b) To be able to identify the stage at which the complainant has become habitual or **vexatious.**

Purpose of the Guidance

The aim of the guidance is to identify situations where a complainant might be properly considered to be habitual or vexatious and to suggest ways of responding to these situations.

It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken to try and resolve complaints following the Trust’s complaints procedure, i.e., through local resolution.
Judgement and discretion must be used in applying the criteria to identify potential or vexatious complainants and in deciding action to be taken in specific cases.

The procedure should only be implemented following careful consideration of the actions and behaviour of a complainant by a Director of the Trust, in conjunction with the relevant Patient/Client Liaison Manager.

Definition of a Habitual or Vexatious Complaint

Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or vexatious where previous or current contact with them shows that they meet any one of the following criteria:

Where complainants:

a) persist in pursuing a complaint after the Complaints Procedure has been fully and properly implemented and exhausted (e.g. where investigation has been denied as ‘Out of time’)

b) change the substance of a complaint or continually raise additional issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response (Not all complainants who raise further concerns or questions on receipt of a response are vexatious. They may be doing so to seek clarification as part of the local resolution process. Care must be taken not to discard new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints)

c) are unwilling to accept documented evidence of treatment given as being factual, e.g. drug records, medical or computer records, or deny receipt of an adequate response in spite of correspondence specifically answering their questions, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed

d) do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of staff to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate

e) focus on a relatively minor matter to an extent, which is out of all proportion to its significance and continue to focus on this point (It is recognised that determining what a '*relatively minor*' matter can be is subjective, therefore careful judgement must be used in applying this criteria)

Dealing with habitual or Vexatious Complainants

A Director of the Trust and/or nominated deputies may decide to deal with complainants in one or more of the following ways:

a) Once it is clear a complainant meets any one of the criteria above, they should be informed in writing that they may be classified as habitual or vexatious complainants. This procedure should be copied to them and they should be advised to take account of the criteria in any further dealings with the Trust.

b) Decline any contact with the complainants either in person, by telephone, by fax, by email, by letter or any other combination of these, or restrict contact to liaison through a third party (If staff are to withdraw from a telephone conversation with a complainant, it may be helpful to have an agreed statement to be used at such times).

c) Notify the complainants in writing that a Director of the Trust has responded fully to the points raised, and have tried to resolve the complaint, that there is nothing more to add and continuing contact will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

d) Inform the complainants that in extreme circumstances, the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors or to the Police if violence or threats are made against staff.

e) Temporarily suspend all contact with the complainants regarding their complaint whilst seeking legal advice and advise the complainant accordingly. It may still be necessary however to continue providing a healthcare service.

Withdrawing 'Vexatious or Habitual' Status

Once a complainant has been identified as 'habitual or vexatious' there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate.

Staff should have used discretion in recommending 'habitual or vexatious' status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate.

Where this appears to be the case, a discussion between key staff and the Chief Executive and/or nominated deputies will take place. Subject to his/her approval, normal contact with the complainants and application of the Trust's complaints procedure will then be resumed.

Even correspondence from complainants who have been classified as habitual or vexatious should be screened to ensure that no new complaint has been raised and to determine if the Trust's discretion should be applied.

Appendix 14

UNACCEPTABLE ACTIONS POLICY

HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complainants, staff need to:

- Ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- Appreciate that even habitual complainants may have grievances which contain some substance;
- Ensure a fair approach; and
- Be able to identify the stage at which a complainant has become habitual.

The following Unacceptable Actions Policy should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

This policy sets out the approach to those complainants whose actions or behaviour HSC organisations consider unacceptable. The aims of the policy are to:

- Make it clear to all complainants, both at initial contact and throughout their dealings with the organisation, what the HSC organisation can or cannot do in relation to their complaint. In doing so, the HSC organisation aims to be open and not raise hopes or expectations that cannot be met;
- Deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered unacceptable. All complainants have the right to be heard, understood and respected. HSC staff have the same rights.
- Provide a service that is accessible to all complainants. However, HSC organisations retain the right, where it considers complainants' actions to be unacceptable, to restrict or change access to the service;
- Ensure that other complainants and HSC staff do not suffer any disadvantage from complainants who act in an unacceptable manner.

Defining Unacceptable Actions

People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is assertive or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, the actions of complainants who are angry, demanding or persistent may result in unreasonable demands on the HSC organisation or unacceptable behaviour towards HSC staff.
It is these actions that HSC organisations consider unacceptable and aim to manage under this policy. These unacceptable actions are grouped under the following headings:

Aggressive or abusive behaviour

Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance approach must be adopted. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

Complainants may make what the HSC consider unreasonable demands through the amount of information they seek, the nature and scale of service they expect or the number of approaches they make. What amounts to unreasonable demands will always depend on the circumstances surrounding the behaviour and the seriousness of the issues raised by the complainant. Examples of actions grouped under this heading include demanding responses within an unreasonable timescale, insisting on seeing or speaking to a particular member of staff, continual phone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

HSC organisations consider these demands as unacceptable and unreasonable if they start to impact substantially on the work of the organisation, such as taking up an excessive amount of staff time to the disadvantage of other complainants or functions.

Unreasonable persistence

It is recognised that some complainants will not or cannot accept that the HSC organisation is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the organisation persistently about the same issue. Examples of actions grouped under this heading include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the HSC organisation can or cannot do and continuing to pursue a complaint without presenting any new information.
The way in which these complainants approach the HSC organisation may be entirely reasonable, but it is their persistent behaviour in continuing to do so that is not.

HSC organisations consider the actions of persistent complainants to be unacceptable when they take up what the HSC organisation regards as being a disproportionate amount of time and resources.

Managing Unacceptable Actions

There are relatively few complainants whose actions a HSC organisation consider unacceptable. How the organisation manages these depends on their nature and extent. If it adversely affects the organisation's ability to do its work and provide a service to others, it may need to restrict complainant contact with the organisation in order to manage the unacceptable action. The HSC organisation will do this in a way, wherever possible, that allows a complaint to progress to completion through the complaints process. The organisation may restrict contact in person, by telephone, fax, letter or electronically or by any combination of these. The organisation will try to maintain at least one form of contact. In extreme situations, the organisation will tell the complainant in writing that their name is on a "no contact" list. This means that they may restrict contact with the organisation to either written communication or through a third party.

The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in the ending of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

HSC organisations do not deal with correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. When this happens the HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful. The HSC organisation will ask them to stop using such language and state that it will not respond to their correspondence if they do not stop. The HSC organisation may require future contact to be through a third party.

HSC staff will end telephone calls if the caller is considered aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that the behaviour is unacceptable and end the call if the behaviour does not stop.

Where a complainant repeatedly phones, visits the organisation, sends irrelevant documents or raises the same issues, the HSC organisation may decide to:

- Only take telephone calls from the complainant at set times on set days or put an arrangement in place for only one member of staff to deal with calls or correspondence from the complainant in the future;
- Require the complainant to make an appointment to see a named member of staff before visiting the organisation or that the complainant contacts the organisation in writing only;
- Return the documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed;
- Take other action that the HSC organisation considers appropriate. The HSC organisation will, however, tell the complainant what action it is taking and why.

Where a complainant continues to correspond on a wide range of issues and the action is considered excessive, then the complainant is told that only a certain number of issues will be considered in a given period and asked to limit or focus their requests accordingly.

Complainant action may be considered unreasonably persistent if all internal review mechanisms have been exhausted and the complainant continues to dispute the HSC organisation's decision relating to their complaint. The complainant is told that no future phone calls will be accepted or interviews granted concerning this complaint. Any future contact by the complainant on this issue must be in writing. Future correspondence is read

and filed, but only acknowledged or responded to if the complainant provides significant new information relating to the complaint.

Deciding to restrict contact

HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to modify their behaviour or action before a decision is taken. Complainants are told in writing why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place.

Appealing a decision to restrict contact

A complainant can appeal a decision to restrict contact. A senior member of staff who was not involved in the original decision considers the appeal. They advise the complainant in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

Recording and reviewing a decision to restrict contact

The HSC organisation will record all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact may be reconsidered if the complainant demonstrates a more acceptable approach. A senior member of staff will review the status of all complainants with restricted contact arrangements on a regular basis.

Appendix 15

VUNERABLE ADULTS

Definition of vulnerable adult

For the purposes of 'Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance' the term 'vulnerable adult' is defined as: *a person aged 18 years or over who is, or may be, in need of community care services **or** is resident in a continuing care facility by reason of mental or other disability, age or illness **or** who is, or may be, unable to take care of him or herself **or** unable to protect him or herself against significant harm or exploitation.*

Adults who 'may be eligible for community care services' are those who's independence and well being would be at risk if they did not receive appropriate health and social care support.

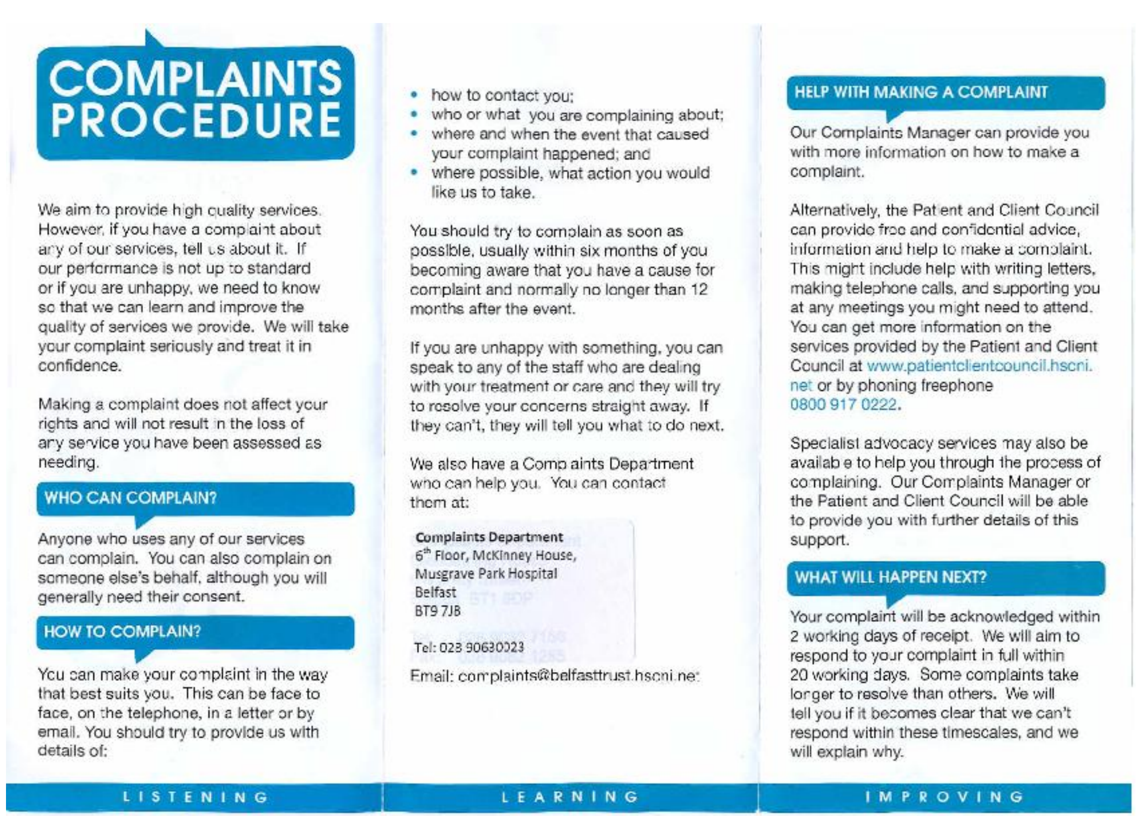
They include adults with physical, sensory and mental impairments and
learning disabilities, however those impairments have arisen; e.g. whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

Making a complaint about health and social care can be intimidating, especially for people with mental health problems, learning disabilities or for those who are old or frail. The Trust should have consistent, explicit arrangements in place for advising and supporting vulnerable adults including signposting to independent advice and specialist advocacy services.

Reportable offences and allegations of abuse

Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect then the regional *Safeguarding Vulnerable Adults Policy and Procedural Guidance (Sept 2006)* and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults (Dec 2003)* should be activated (see paragraph 1.26)

Appendix 16 – Complaints Leaflet



COMPLAINTS PROCEDURE

We aim to provide high quality services. However, if you have a complaint about any of our services, tell us about it. If our performance is not up to standard or if you are unhappy, we need to know so that we can learn and improve the quality of services we provide. We will take your complaint seriously and treat it in confidence.

Making a complaint does not affect your rights and will not result in the loss of any service you have been assessed as needing.

WHO CAN COMPLAIN?

Anyone who uses any of our services can complain. You can also complain on someone else's behalf, although you will generally need their consent.

HOW TO COMPLAIN?

You can make your complaint in the way that best suits you. This can be face to face, on the telephone, in a letter or by email. You should try to provide us with details of:

- how to contact you;
- who or what you are complaining about;
- where and when the event that caused your complaint happened; and
- where possible, what action you would like us to take.

You should try to complain as soon as possible, usually within six months of you becoming aware that you have a cause for complaint and normally no longer than 12 months after the event.

If you are unhappy with something, you can speak to any of the staff who are dealing with your treatment or care and they will try to resolve your concerns straight away. If they can't, they will tell you what to do next.

We also have a Complaints Department who can help you. You can contact them at:

Complaints Department
6th Floor, McKinney House,
Musgrave Park Hospital
Belfast
BT9 7JB

Tel: 028 90630023

Email: complaints@belfasttrust.hscni.net

HELP WITH MAKING A COMPLAINT

Our Complaints Manager can provide you with more information on how to make a complaint.

Alternatively, the Patient and Client Council can provide free and confidential advice, information and help to make a complaint. This might include help with writing letters, making telephone calls, and supporting you at any meetings you might need to attend. You can get more information on the services provided by the Patient and Client Council at www.patientclientcouncil.hscni.net or by phoning freephone 0800 917 0222.

Specialist advocacy services may also be available to help you through the process of complaining. Our Complaints Manager or the Patient and Client Council will be able to provide you with further details of this support.

WHAT WILL HAPPEN NEXT?

Your complaint will be acknowledged within 2 working days of receipt. We will aim to respond to your complaint in full within 20 working days. Some complaints take longer to resolve than others. We will tell you if it becomes clear that we can't respond within these timescales, and we will explain why.

LISTENING LEARNING IMPROVING

Appendix 17

<u>Children Order Representations And Complaints Procedure</u>

1. **<u>Complaint:</u> Does it fit the definition of a Children Order complaint as below?**

"Any representation (including any complaint) made to the Trust about the discharge of any of its functions under part IV of the Order or in relation to the child."
(Children (NI) Order 1995, Article 45 (3))

"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and paragraph 6 of Schedule 5 to, the Children Order."
(Guidance & Regulations – Vol.4, Para 12.5 – DHSS)

2. Does it meet the criteria of what may be complained about under Children Order?

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.

Complainant: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;
b. **Any child** who is not being looked after by the Trust, but is in need
c. A parent **of theirs**
d. Any person who is not a parent of theirs but who has **parental responsibility for them**
e. Any Trust foster parent
f. Such other person as the Trust considers has sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

The person who had the day to day care of the child within the past two years;

The child's Guardian Litem;

The person is a relative of the child (as defined by the Children Order, Article 2 (2));

The person is a significant adult in the child's life, and where possible, this is confirmed by the child;

A friend;

A teacher;

A general practitioner (Children (NI) Order 1995 Article 45 (3)).

Consent: *The (Trust) should always check with the child (subject to their understanding) that a complaint submitted reflects their views and that they wish the person submitting the complaint to act on their behalf* (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- The Health and Personal Social Services General Dental Services

  Regulations (NI) 1993;
- The General Ophthalmic Services Regulations (NI) 2007;
- The Pharmaceutical Services Regulations (NI) 1997.
- The Representation Procedure (Children) Regulations (NI) 1996

- **HPSS Complaints Procedure Directions:**

- The Health and Personal Social Services Complaints Procedures Directions (NI) 1996;

- The Miscellaneous Complaints Procedures Directions (NI) 1996;

- The Health and Personal Social Services (Special Agencies) Complaints Procedures Directions (NI) 1996;

- Directions to Health and Social Services Boards on Procedures for dealing with Complaints about Family Health Services Practitioners and Providers of Personal Medical Services or Personal Dental Services- issued 1998.

- **HPSS Complaints Procedure Amendment Directions:**

- Directions to the Health and Social Services Boards on Procedures for dealing with Complaints about Family Health Services

- Practitioners- issued Oct 1997;

- The Health and Personal Social Services Complaints Procedures (Amendment) Directions (NI) 1997- issued Oct 1997;

- The Health and Personal Social Services Complaints Procedures Directions (NI) 1998;
- Directions to the Health and Personal Social Services Bodies on Procedures for Dealing with Complaints- issued March 2000.

- **The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003**

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007;
- Fostering Agencies.

Appendix 18

CHILDREN'S ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

Under the Children (NI) Order 1995 (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under part IV of, and paragraph 4 of Schedule 5 to, the Order and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987.

1. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996.
2. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4
3. All staff should familiarise themselves with these requirements

TYPE OF DOCUMENT:

REFERENCE NUMBER	TP44/10
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Operational date	September 2013
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Version Number	2
Director Responsible	Dr A Stevens, Medical Director
Lead Author	Ms Adrienne McKimm
Lead Author, Position	Lead Manager for Complaints
Department/ Service Directorate	Medical Directors Group
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Date	Version	Author	Comments
10/02/10	0.1	Margaret McKee	Initial Draft
25/02/10	0.2	Margaret McKee	Amendments/ Comments
23/03/10	0.3	Margaret McKee	Amendments/ Comments
27/04/10	0.4	Louise Moore	Amendments
04/05/10	0.5	Louise Moore	Amendments/ Formatting
10/11/11	**1.1**	Margaret McKee Complaints Managers	Following Ombudsman recommendations, guidelines were developed for investigation and escalation of complaints. Circulated to Medical Director for consultation prior to Complaints Review Committee (CRC).
05/12/11	1.2	Margaret McKee	Initial Draft discussed at Complaints Review Committee.
14/05/12	1.3	Margaret McKee	Policy and Guidelines agreed and approved by CRC. Changes include - Wording to reflect organisational changes; New Complaints Leaflet added; Appendix 18 Complaints Guideline for investigation and escalation added; Appendix 7 Investigation and Resolution use of Lay Person; Grading of a complaint further guidance Appendix 6.
14/05/13	1.4	Margaret McKee	Following review of the HSC Guidance by the DHSSPS the following changes have been made; Local resolution Enhanced removed. Page 13 Interface between complaints and SAIs. Page 15 Revisited complaints timescale Page 33 Change of name

11/11/13	1.5	A McKimm	Following a Policy Review Workshop which included Carers Reference Group, changes include – 8.14 Children Order - Appendix 17 and 18 merged and Flowchart amended; 10.0 reference to HSC Complaints Procedure Amendment Directions (NI) 2009 and Revised Procedure for Reporting and Follow Up of SAIs Oct 13:
27/1/14	1.6	AMcKimm	Approval by CRC subject to any further comments; Paragraph 8.15 ISP guidance and Appendix 11 ISP Flowchart added Page 12 Independent Expert guidance

Approval By Trust Policy Committee – 17 February 2014

Executive Team - 19 February 2014

CONTENTS

1.0	Title	Page 6
2.0	Introduction	Page 6
3.0	Purpose	Page 6
4.0	The Scope	Page 6
5.0	Objectives	Page 7
6.0	Roles and Responsibilities	Page 7
7.0	Policy Description	Page 7
8.0	Policy Statements	Pages 7-9
9.0	Implementation / Resource Requirements	Page 9
10.0	Sources / Legal Framework	Page 9
11.0	Consultation Process	Page 10
12.0	Equality Statement	Page 10

APPENDICES

Appendix 1 Definitions Page 11-12
Appendix 2 Roles and Responsibilities Page 13-16
Appendix 3 Who can complain? Page 17-18
How can complaints be made?
Options for pursuing a complaint
Appendix 4 What information should be recorded when taking a complaint? Page 19
Appendix 5 Consent and Confidentiality Page 20-21
Appendix 6 Grading of the Complaint Page 22-23
Appendix 7 Investigation and Resolution Page 24
Appendix 8 Responding to a Complaint Page 25-26
Appendix 9 What the policy does not cover Page 27-28
Appendix 10 Flowchart summarising the process staff are to follow when dealing with Complaints Page 29-30
Appendix 11 Independent Sector Provider (ISP) Complaints Flowchart Page 31
Appendix 12 Service Directorate Complaint/ Enquiry Record Form Page 32
Appendix 13 Internal/ External Support Contacts Page 33-36

Appendix 14 Vexatious, Unreasonably Demanding or Persistent Complaints Page 37-39
Appendix 15 Unacceptable Actions Policy Page 40-43

Appendix 16 Vulnerable Adults Page 44
Appendix 17 Complaints Leaflet Page 45-48
Appendix 18 Children Order Representations and Complaints Procedure Page 49-51
Appendix 19 Guidance for Investigation and Escalation Protocol for Complaints Page 52-53

Reference No:

1. Title:

Policy and Procedure for the Management of Complaints and Compliments.

2. Introduction:

This policy has been developed and set within the Legal Framework for Complaints Management within Health and Social Services.

This policy covers complaints received about any aspect of Health and Social Care services provided or commissioned by the Belfast Health and Social Care Trust in hospital or community settings.

Any complaint relating to an application to obtain access to Health and Social Care records for deceased persons (under the Access to Health Records (NI) Order 1993) can be investigated through the Complaints Procedure. This would be an alternative to making an application to the Courts.

3. Purpose:

This Policy is designed to provide staff with a greater understanding and guidance on Complaint Management within the Belfast Health and Social Care Trust.

The Trust is committed to providing the best possible services for patients, clients, visitors and staff. Complaints should be used to inform and improve services. The Trust aims for continuous modernisation and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Learning from complaints can only take place when they are managed in a positive and open manner. It is the Trust's wish to promote an open, honest and just culture, where all staff can learn from complaints.

Complaints will be dealt with promptly and effectively in order to eliminate the need for a complicated and time-consuming investigation process.

4. Scope:

This Policy is applicable to all staff who provide services within the Belfast Health and Social Care Trust. This also includes services that are commissioned or provided by the Independent Sector.

5. Objectives:

- To provide information for all staff and service users on complaints management
- To ensure complaints are managed in a timely manner
- To ensure the Trust promotes a culture of openness and honesty when investigating all complaints
- To provide learning from complaints across the Trust
- To provide guidance on how to manage a complaint

6. Roles and Responsibilities:

See Appendix 2

7. Policy Description:

This Policy describes how Complaints, Enquiries or Compliments will be managed effectively within the Belfast Health and Social Care Trust. See Appendix 1for Definitions.

8. Policy Statements:

8.1 This policy provides the opportunity to put things right for service users as well as improving services.

8.2 All complaints will be treated in confidence, with due care and respect being paramount at all times.

8.3 It is essential that all staff are aware of their roles and responsibilities when dealing with complaints as outlined at Appendix 2. This will enable them to respond positively, and where possible, resolve the complaint at local level.

8.4 Support and advice is available from the Complaints Team upon request. Details on what information is required when recording a complaint are attached at Appendix 4.

8.5 All complaints must be formally acknowledged within two working days by a member of the Complaints Team.

8.6 Complaints must be responded to within a 20 working day timeframe and where this is not possible due to unforeseen circumstances a holding letter with the reasons for delay will be issued with the approval of the Complaints Manager.

8.7 The designated link person within each Service Directorate will be notified by the Complaints Team on receipt of the complaint. A copy of

the complaint correspondence will be forwarded to the link person in the Service Directorate attaching a complaints memo outlining the process to be followed to ensure a timely response.

8.8 The Complaints Team will provide a reminder to the link person via email or telephone 10 working days following notification of the complaint to prompt them to return the internal response.

8.9 Upon completion of the complaints investigation, the responsible link person must forward a draft response to the Complaints Team who will ensure that all aspects of the complaint have been addressed. Appendix 8

8.10 Once the content of the draft is deemed to have answered all aspects of the Complaint, the response will be sent to the designated service manager/ Director for approval and signature.

8.11 Where a third party wishes to make a complaint on behalf of someone else, consent must be sought. The Complaints Team will forward a consent form to the relevant person(s) requesting authorisation. Appendix 3 and 5

8.12 At all stages within the complaints process assistance from the Complaints Manager will be provided; independent advice and support for complainants is also available from the Patient Client Council and other independent specialist advocacy services. Appendix 12

8.13 Where a complaint is made locally, all attempts should be made to achieve local resolution. (Appendix 10). Local Resolution forms (Appendix 11) can be found on the Trust intranet and should be completed and forwarded for recording to the Complaints department complaints@belfasttrust.hscni.net. However, if local resolution has been unsuccessful, the complainant should be offered the option of contacting the Complaints Department. See Appendix 16 for Complaints Leaflet, Appendix 4 and 8 for Guidance and also Appendix 12 for internal and external support contact details.

8.14 For complaints in relation to Children Order Representations See Appendices 17

8.15 Complaints relating to Independent Sector Providers (ISPs) may be received directly by ISPs or by the complainant contacting the Trust. The general principle would be that in the first instance, the ISP investigates and responds directly to the complainant. If the complainant contacts the Trust about a complaint, the Trust will consider how best to proceed and if the matters raise serious concerns, the Trust may decide to investigate the complaint. In all cases the complainant must be kept informed of which organisation is to investigate their complaint. See Flowchart at Appendix 11.

8.16 Normally, a complaint must be made within 6 months of the occurrence of the matter giving rise for concern, or from when the complainant became aware of the matter as detailed in the complaints

leaflet. Full and proper investigation is hindered where timescales extend beyond a six-month period, however, this should not be stringently applied and advice should be sought from the relevant Complaints Manager.

8.17 Where a complaint relates to the actions of more than one Service Directorate the Complaints Manager along with the Service Directorate Manager will identify and agree who will take the lead in investigating the complaint and co-coordinating the response for the complaint.

8.18 All complaints will be investigated according to the level of grading applied initially by the Complaints manager. Not all complaints need to be investigated to the same degree. The grading of the complaint will identify the level of investigation required. Appendix 6 and 18.

8.20 Some matters are excluded from investigation through the Trusts Complaints Procedure. Appendix 9.

8.21 Information on dealing with vexatious, unreasonably demanding or persistent complaints can be found at Appendix 13 and the Acceptable Actions Policy at Appendix 14.

9.0 Implementation / Resource Requirements:

A programme of complaints awareness and management training will be ongoing throughout the Trust to ensure that this procedure is followed and that staff encourage service users to make their views known.

Complaints Training is part of the induction programme for new Trust employees and mandatory for all staff.

The Complaints department will explore the possibility of online learning.

10.0 Sources / Legal Framework:

HPSS Complaints Procedure Regulations: April 2009

Health and Social Care Complaints Procedure Amendment Directions (NI) 2009

HSC Complaints Procedure Directions

DHSSPSNI Complaints Standards and Guidelines for Local Resolution and Learning – April 2009 Amended June 2013

The Children (NI) Order 1995

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003

Procedure for the Reporting and Follow up of Serious Adverse Incidents October 2013

11.0 Consultation Process:

Risk and Governance Senior Managers
Service Directorates Governance Leads
Staff side
Human Resources and Equality Department
Independent Service User Group
Policy Review Workshop 11/11/13

12.0 Equality Statement:

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.

✓ Screening completed No action required.

☐ Full impact assessment to be carried out.

Signatories:

Dr Tony Stevens
Medical Director

Date 19 February 2014

Colm Donaghy
Chief Executive

Date 19 February 2014

Appendix 1 Definitions

Complaint

A complaint is "**an expression of dissatisfaction about care or services provided by The Trust, which requires a response".** Complainants may not always use the word complaint. They may offer a comment or suggestion that can be extremely helpful.

Enquiry

An enquiry is "**a request for information, explanation or clarification".**

Compliment

A compliment is **"an expression of praise, commendation, or admiration"**.

Promoting access

Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised of the types of help available through front line staff, the Complaints Managers and the Patient Client Council.

The Trust promotes and encourages an open and flexible access to the complaints procedure.

Complaints made outside of the 6 month to 1 year timeframe must be given careful consideration before the complaint is processed through the formal process.

Co-operation

Local arrangements must be such as to ensure that a full and comprehensive response is given to a complainant. Therefore co-operation in the handling and consideration of complaints is essential between Internal Services or Corporate Groups, other HSC organisations and Regulatory authorities.

This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

The Trust has assigned Complaints Managers to Service and Corporate Directorates who are readily accessible to both the public and members of staff. Names of these managers can be found on the Trusts internet site.

Lay Persons

A Lay Person is an independent person that does not act as an advocate, conciliator or investigator. Neither do they act on behalf of the complainant or complained about. Their involvement is to help bring about resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. Their involvement must be agreed by both the Trust and the Complainant.

A Lay Person may be beneficial in providing an independent perspective of no-clinical/technical issues within the local resolution process. Their input may be valuable to test key issues that are part of a complaint such as communication issues, quality of written documents, attitudes and relationships and access arrangements (appointments systems), etc.

Independent Expert

The use of an Independent Expert in the resolution of a complaint may be requested by the complainant or the Trust. Input will not be required in every complaint but will be considered according to the nature and complexity of the complaint and any attempts at resolution. Involvement of an Independent Expert may be considered beneficial where the complaint cannot be resolved locally; indicates a risk to public or patient/client safety; could give rise to serious breakdown in relationships, threaten public confidence in services or damage reputation; to give an independent perspective on clinical issues.

Appendix 2 Roles and Responsibilities

A. Chief Executive

As Accountable Officer, the Chief Executive is responsible for ensuring the Trust meets its statutory and legal requirements and adheres to relevant complaint guidance.

The Chief Executive will:

1. ensure that the Trust takes the necessary action to ensure that lessons are learned and where appropriate, improvements are made to the service

2. ensure a Committee structure is in place to monitor and review the organisation's performance in complaints management

B. Trust Board

The Trust Board is responsible for the implementation of the Policy and Procedure for the Management of Complaints and Compliments and to ensure compliance with the Trust's statutory obligations as described in the relevant complaints legislation.

The Board will:

1. ensure that the organisation arrangements contained within the policy and procedures are implemented

2. monitor and review the overall reporting performance and receive regular reports

3. ensure complaints management is integrated within the Trust's Performance and Assurance Framework

C. Medical Director

The Medical Director or his Deputy has the responsibility for the management of complaints throughout the Belfast Health and Social Care Trust.

The Medical Director has a shared responsibility with the Director of Nursing and Patient Experience for clinical quality.

The Medical Director will

- report to the Trust Board on the management of complaints at regular intervals

- develop suitable organisational arrangements for the management of complaints

- development and maintain systems to monitor and disseminate learning from complaints across the organisation

- put systems in place to ensure reporting of complaints to external agencies as required e.g. DHSSPSNI, Regional Health and Social Care Board and Regulation and Quality Improvement Authority

D. Co-Director Risk and Governance

The Co-Director will support the Medical Director in meeting his responsibility for complaints management of patients, clients, staff and public safety.

The Co-Director has Trust-wide lead for the co-ordination, implementation, and evaluation of risk management systems and the Trust Risk Management Strategy.

The Co-Director will:

- promote an open, honest and just culture for complaints management

- maintain systems for the reporting, recording and analysing of complaints

- ensure that subsequent learning from complaints is shared across the Trust, through appropriate management structures

- take account of relevant complaints when reviewing Service Directorate risk registers and ensure appropriate linkage to the corporate risk register

E. Directors

It is the responsibility of the Directors to:

- disseminate and promote this policy and procedure within their responsibility and ensure its implementation by providing support and advice to managers and staff

- ensure complaints are investigated thoroughly in accordance with existing policy and procedure

- ensure that complaints are monitored and reviewed within their Service Directorate and ensure any recommendations made as a result of investigations are implemented and monitored

- ensure that subsequent learning from complaints is shared across Service Directorates, through appropriate management structures

- take account of relevant complaints when reviewing their Risk register and ensure that this is linked appropriately to the Corporate Risk Register

- ensure staff have access to advice and training on complaint management and, where appropriate, investigation and review

- sign off complaint responses on behalf of the Chief Executive

F. Co-Directors

It is the responsibility of the Co-Directors to ensure that all complaints are managed efficiently and effectively within his/her span of responsibility.

The Co-Director will:

- deal with any queries Investigating Officers might have, including the need to contact or meet with the service user who made the complaint or enquiry

- agree the draft response with the Service Manager and forward this to the relevant Complaints Manager within identified timescales along with the supporting documentation

G. Service Directorate Managers

Service Directorate Managers are responsible and accountable to their Director to ensure complaints are thoroughly investigated with their clinical and managerial teams and responded to within given time scales. Service Managers should also ensure that their teams approve draft responses and receive copies of final responses

H. Complaints Managers

Complaints Managers are responsible for:

- obtaining consent where required in the case of third party complaints or enquiries

- quality assuring all responses received pertaining to complaints or enquiries

- providing service user feedback, related analyses and reports to services and Committees within the Governance Accountability Framework

- providing information as requested by RQIA, DHSSPS and HSC Board

- contributing to training in relation to complaints investigation and management

- ensuring final Complaint responses are sent to Service Managers and Co-Directors via team administrators.

I. All Staff

Staff are responsible for:

- discussing and attempting to resolve complaints as they arise within the service and to put things right where possible within identified timescales Appendix 3
- providing service users with a copy of the Trust's Complaints Leaflet at first contact with the service to encourage all types of user feedback. Staff should advise that any concerns can be raised directly with them or, if preferred the leaflet can be used. Where this is not appropriate, consideration must be given as to when service users should be informed about the Trust's service user feedback process
- referring the matter as soon as possible to their line manager if unable to deal with complaints raised directly with them or seeking advice from complaints staff on how to proceed
- keeping their line manager updated on complaints and enquiries they are currently dealing with and outcomes including improvements made
- contributing to the investigation of complaints and enquiries within the service/team and returning statements, reports and other information to Investigating Officers within requested timescales
- informing their line manager and other team members (if appropriate) when they receive a written compliment from service users
- making sure that information relating to service user feedback is displayed in facilities accessed by service users and made available in inspections/audits etc.

Appendix 3

Who can complain?

Any person can complain about any matter relating to the provision of services provided or commissioned by the Trust. Complaints may be made by:

- a patient/client;
- former patients/clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients/clients, providing they have obtained the patient/client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and any appropriate person in respect of a patient/client who is deceased e.g. the next of kin.

How can complaints be made?

Complaints may be made verbally or in writing and should also be accepted via any other method, for example, the telephone or electronically. The Trust will be mindful of technological advances and ensure local arrangements are in place to ensure there is no breach of patient/client confidentiality.

Complaints may be made to any member of staff, for example receptionists, medical or care staff. In many cases complaints are made orally and front-line staff may resolve the complaint "on the spot". If this is the case it should be recorded on the Service Directorate, Complaints Record Form (Local Resolution) along with the action taken and outcome and forwarded to the Complaints Department for entry onto the Datix system. This form can be found on the Trust's intranet site – Appendix 4 and 11.

Complaints that cannot be resolved "on the spot" must be forwarded to the Complaints Manager.

All front-line staff must be trained and supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere. Front-line staff should familiarise themselves with the Equality Good Practice Reviews principles for dealing with and managing complaints and the Standards for complaints handling.
dhsspsni.gov.uk/goodpractice reviews

dhsspsni.gov.uk/ Complaints in Health and Social care Standards and Guidelines for Resolution and Learning

Options for pursuing a complaint

Some complainants may prefer to make their complaint to someone within the Trust who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer to the Chief Executive. The Trust has named Complaints Managers. Names of these managers can be found on the Trusts internet site.

Appendix 4

What information should be recorded when taking a complaint?

A complaint need not be long or detailed but it must include:

- Contact details name, address, telephone number, DOB, where appropriate hospital number, Department/ Ward/ Facility.
- Who or what is being complained about, including the names of staff if known
- Where and when the events of the complaint happened, and where possible, what remedy is being sought e.g. an apology or an explanation or changes to services.
- Advice on consent when appropriate
- Once template is completed, forward to Complaints Department immediately for acknowledgement and action.

Appendix 5

Consent

Third party complaints may be made by a service user's relative, friend, carer, or other representatives such as their solicitor. Such complaints are acceptable provided the service user has given his/her written consent. In such circumstances the Complaints Department reserve the right to seek written consent from the service user prior to releasing information.

However, there will be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident, judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the individual is deceased.

The Complaints Manager, in discussion with the Service Directorate, Data Protection Officer, or other senior person, will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient/client. The Trust may consider the use of an advocate in these circumstances. If it is determined that a person is not suitable to act as a representative the Trust will provide information in writing to the person outlining the reasons the decision has been taken.

Where Consent has not been received, the complaints response will not be released. A second request letter will be sent to the complainant advising that consent is required within 4 weeks and if not received within this timeframe, the complaint will be closed.

Third party complainants who wish to pursue their own concerns can bring these to the Trust without compromising the identity of the patient/client and the Trust will consider and address the matters and investigate as fully as possible. A response will be provided to the third party on any possible issues without breaching patient/client confidentiality.

Children and Consent

The Trust should always check with the child (subject to their understanding) that a complaint submitted reflects their views and that they wish the person submitting the complaint, to act on their behalf. Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered.

More information on consent can be found in the DHSSPS' good practice in consent guidance. http://www.dhsspsni.gov.uk/public_health_consent

Confidentiality

Staff are required to promote and maintain service user and staff confidentiality and to comply with the requirements of legislation, for example, the Data Protection Act 1998 and the Human Rights Act 1998. The need for sensitivity and confidentiality is paramount. All staff must be particularly aware of requirements in this regard, given the nature of their work and the access they require in order to affect this procedure.

Staff are directed to the Code of Practice on Protecting the Confidentiality of Service Users DHSSPS www.dhsspsni.gov.uk/confidentiality-consultation

Appendix 6

Grading of the Complaint

It is the responsibility of the Complaints Manager to ensure that all complaints are graded using the risk grading process outlined in the Adverse Incident Reporting Policy and Procedure including Adverse Incident Investigation Procedure. The grading will also be agreed with the Service Directorate Manager.

If the complaint is of a serious nature due consideration will be given as to what level of investigation the complaint will follow. The complainant will be advised of this by the Complaints Department.

All complaints graded as high risk (red) will be highlighted immediately to the Senior Complaints Manager who will inform the Co-Director of Risk and Governance and the Co-Director of the Service Directorate who will be responsible in informing the relevant Director. It is the responsibility of the Director to inform the Chief Executive.

When the complaint is graded high risk (red) the Co-Director / Director will agree the level of investigation to be carried out e.g. Significant Event Audit (SEA), Root Cause Analysis (RCA), independent investigation, etc.

All other complaints will be investigated according to the degree of the grading.

Complaints and SAI interface[1]

Where a complaint is received and graded as red, consideration should also be given to ascertain if this will meet the Serious Adverse Incident (SAI) reporting criteria. This should be highlighted to the Risk and Governance Department and the Service Directorate.

While the complaint process is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by the Trust and a complaint is subsequently received relating to the same matter or alternatively a complaint may generate the reporting of an SAI. In these incidents the complaints handling staff will liaise closely with the staff who deal with SAIs and vice versa to agree if there are aspects of the complaint which can be managed under the Complaints procedure and that are not part of the SAI investigation. This will ensure that all aspects of the complaint are responded to effectively via the most appropriate means and in a timely manner.

The complainant will be advised and kept informed throughout the process by the Complaints manager. It is important that all aspects of the complaint are answered and that the final outcome of the investigation is shared with the complainant.

If the complainant remains unhappy with the process or aspects of the complaint remain unanswered, the complainant can re-engage with the complaints process.

Other Investigation processes

[1] Procedure for the Reporting and Follow up of Serious Adverse Incidents Paragraph 7.1 Complaints in the HSC

Where a complaint is received and the issues are already subject to another investigation eg Professional Body, Ombudsman, Police Inquiry, Legal Services, etc the complaint cannot be processed until this investigation is completed. The complainant will be advised of this by the Complaints Department.

In the event of a complaint already being investigated under the Trust Complaints Procedure and is subsequently referred to another body for investigation eg Professional Body, Ombudsman, Police Inquiry, Legal Services the complaints Procedure is suspended until this investigation is completed. If the complainant wishes they can then re-engage with the Trust Complaints Procedure should they remain dissatisfied.

Appendix 7

Investigation and Resolution

The purpose of the investigation is not only to ascertain what happened, to establish the facts, to learn, to detect misconduct or poor practice and to improve services but also to gain 'resolution' for the complainant.

The investigation should be undertaken by a suitable person and conducted in a manner that is supportive to all those involved. Consideration should be given to the use of an independent Lay Person (list available from the HSCB) or obtaining an Independent Expert opinion in complex cases to help resolve the complaint. Advice should be sought from the Complaints Manager / Senior Complaints Manger where necessary.

It may be more appropriate, depending on the complexity of the complaint, that a meeting would be offered to the family to discuss the outcome of the investigation. This decision would be agreed by the Complaints Manager and Service Directorate Manager.

The investigator should establish the facts relating to the complaint and assess the quality of the evidence and call upon the services of others if required.

Once the investigation is complete the investigator should prepare a draft response. The response should include and explain how the investigation was carried out and how the conclusions were reached. This draft response must be shared with the relevant staff to ensure factual accuracy and agreement. It should then be ratified by the Co Director / nominated person before being forwarded to the Complaints Department for formatting and forwarding to the Director for final signature.

Some complaints will take longer than 20 working days to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed due to the unavailability of a member of staff or a complainant as a result of personal or domestic arrangements, bereavement, a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure.

It is important that the Complaint Manager is informed of any reasons for the delay so that the Complainant can make the Complainant aware.

Appendix 8

Responding to a Complaint

It is the responsibility of the relevant Service Manager/Investigating Officer to prepare the draft response from the information obtained during the investigation. The response should be clear, accurate, balanced, simple, and easy to understand.

It should aim to answer all the issues raised by the complainant, in an open and honest way, explaining the situation, why it occurred and the action taken or proposed. Where possible this should be provided to the relevant Complaints Manager within 10 working days from receipt of the complaint.

The draft response should:

- address all of the concerns expressed and show that each element has been fully and fairly investigated
- explain what happened and why it happened
- detail any actions taken or proposed to prevent recurrence
- offer to meet the complainant
- where appropriate include an apology where things have gone wrong
- indicate that a named person is available to clarify any aspect of the response letter and that they should raise any concerns or request for clarity within 3 months of date on response letter
- inform of the right to escalate their complaint to the Commissioner for Complaints if they remain dissatisfied with the outcome of the complaints procedure.

When the Service Directorate manager and Co-Director / nominated person is satisfied that the complaint has been fully addressed and agree the draft response, this should be forwarded to the Complaints Manager along with all relevant documentation and copies of all investigative reports. Upon receipt of the ratified letter the Complaints Manager will then forward response for signature by the relevant Director.

In line with the DHSSPS guidance, complaints must be investigated and the person making the complaint, issued with a written response, signed by the relevant Director, on behalf of the Chief Executive, within 20 working days where possible. If for any reason this is not possible the complainant will be advised of the delay, the reason for it and when they are likely to receive a full reply.

When the final response is signed off by the Director the Director's secretary will then send the letter to the complainant and a copy of the signed letter to the Complaints Manager for the file. The complaint is then closed.

If the complainant remains dissatisfied they can contact the Complaints Department. This must be done within 3 months from the date on the Trust's response letter. Consideration will then be given to "revisit" the complaint for further local resolution. This may include advocacy, conciliation or the use of lay persons.

The Complainant can also contact the NI Commissioner for Complaints (the Ombudsman) at this stage.

Appendix 9

<u>What the policy does not cover</u>

In such circumstances the Complaints Department (acting on behalf of the Chief Executive) should inform the person why the exclusion applies.

Exclusions are as follows:

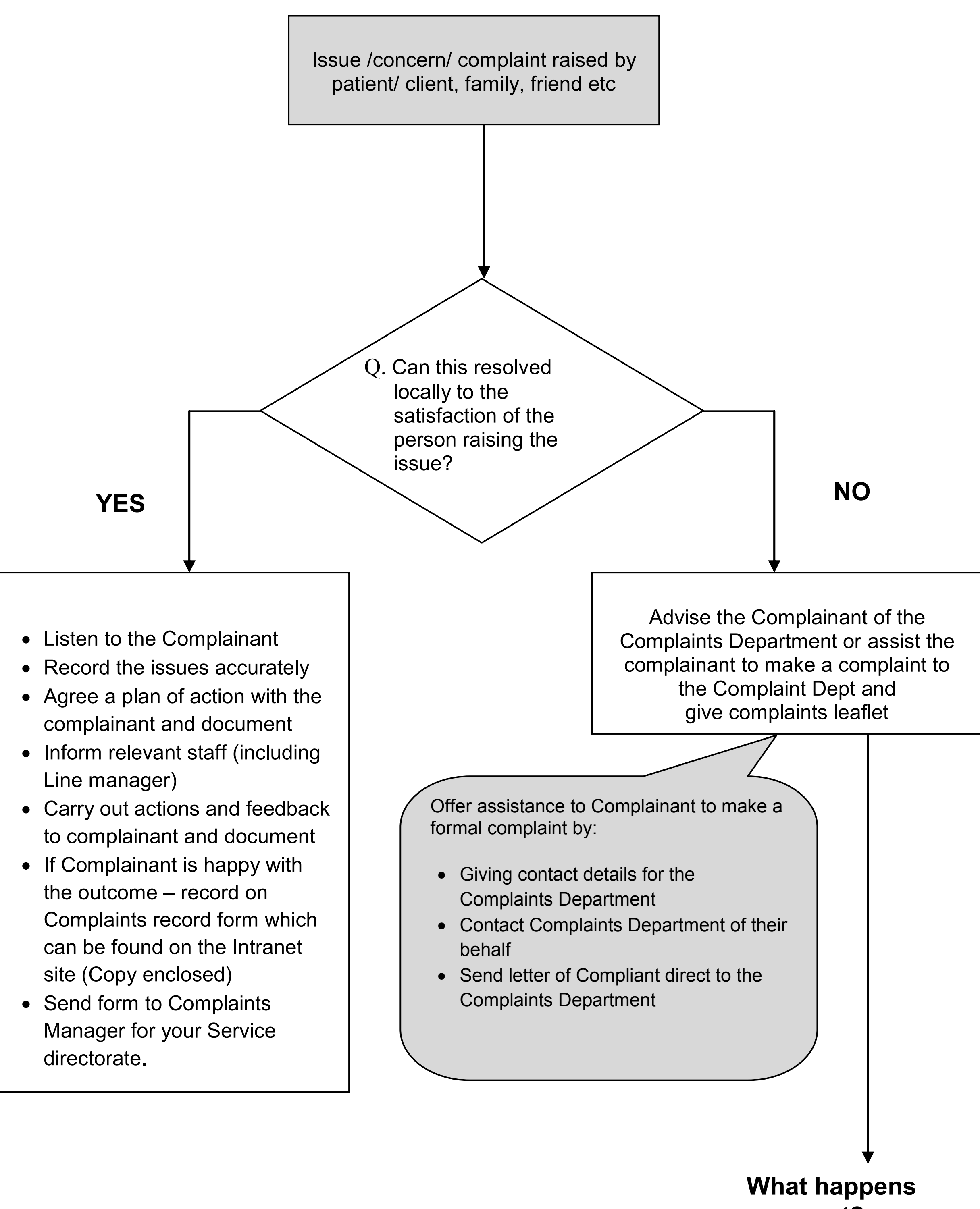
- private care and treatment or services including private dental care or privately supplied spectacles; except for those patients/clients having private care in one of the Trust's facilities and the complaint is about care and treatment.
- services not provided or funded by the HSC, for example, provision of private medical reports; or
- the independent regulated sector (except for those that are commissioned by the Trust)
- staff grievances / complaints
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- an investigation by one of the professional regulatory bodies
- services commissioned by Health and Social Care Board (HSCB)
- a request for information under Freedom of Information
- access to records under the Data Protection Act 1998
- an independent inquiry
- a criminal investigation
- The Children Order Representations and Complaints Procedure (see Appendix 17)
- protection of vulnerable adults (see Appendix 15)
- child protection procedures
- coroner's cases
- legal action

Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately be passed to the Complaints Manager for onward transmission to the correct department.

If any aspect of the complaint is not covered by the referral it will be investigated under the Trust Complaints procedure. In these circumstances, investigation under the Trust Complaints procedure will only proceed if it does not, or will not, compromise or prejudice the matter under investigation under any other process. The complainant must be informed of the need for referral.

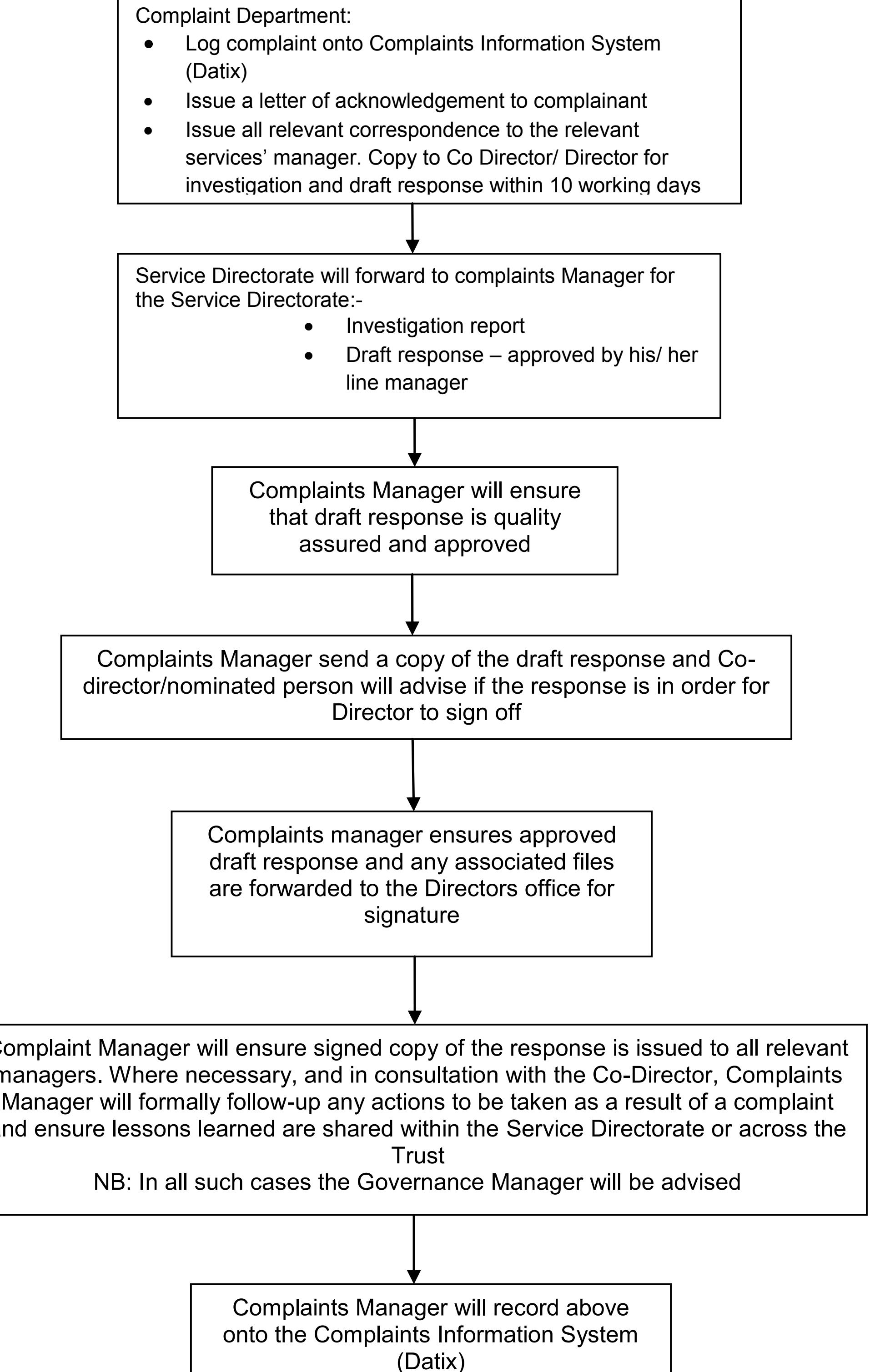
Appendix 10

Flowchart summarising the process for staff to follow when dealing with Complaints

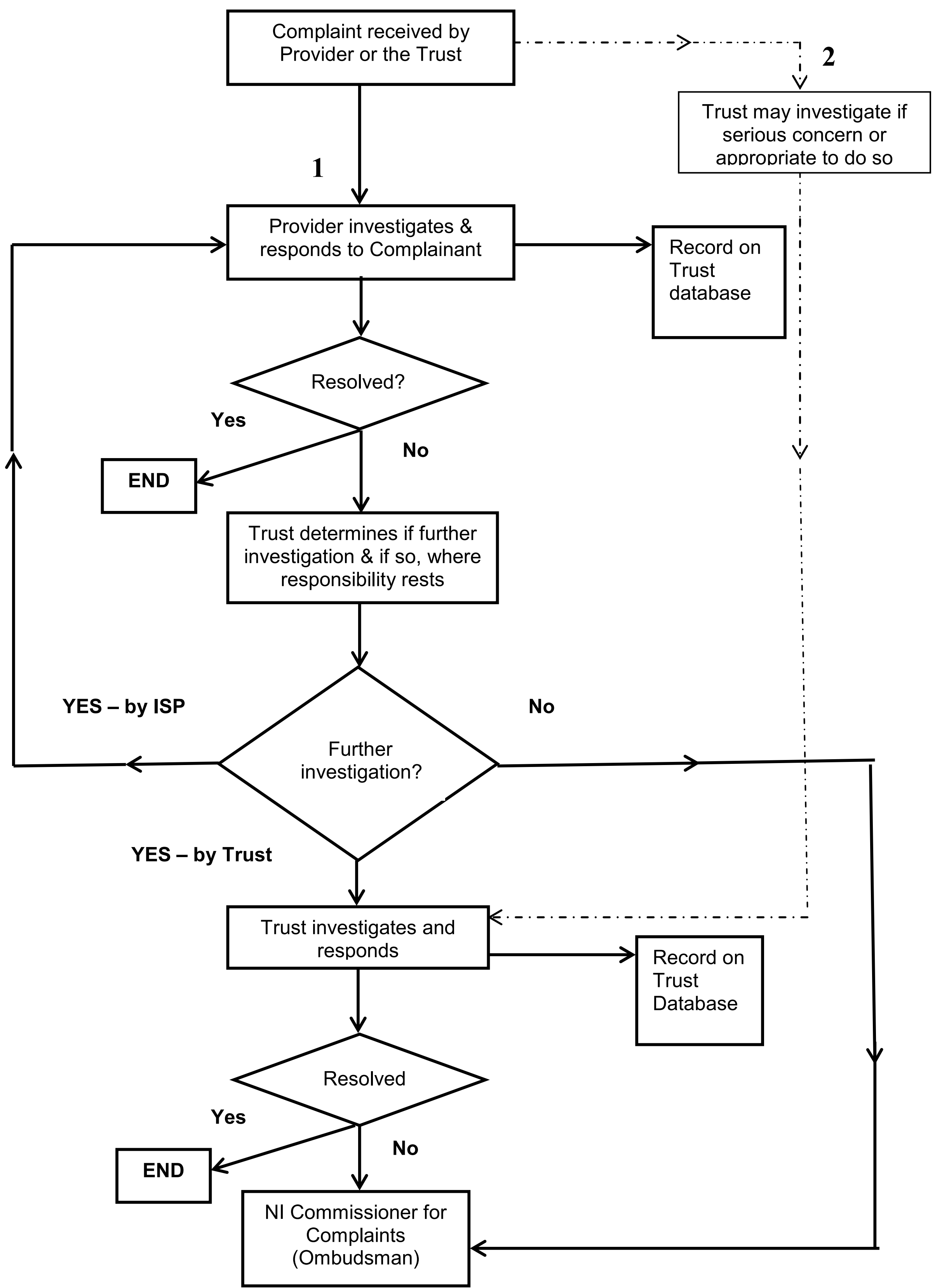


Appendix 10 continued...

Flowchart summarising the process for Service Directorates and Complaints Managers to follow when dealing with Complaints



Appendix 11 Independent Sector Provider (ISP) Complaints Flowchart



Appendix 12

Service Directorate Complaint/Enquiry Record Form

Date:
Time:
Details Taken By:
Location and Service Directorate:

Patient/Client Affected Details

Name:			
Address:			
Contact telephone number (if same person as complainant)			
Date of Birth: (if patient/client)		Hospital Number (if patient/client)	

Complainant Details (if different from above)

Name:	
Address:	
Contact number:	

NB: Consent – Advise complainant, if not patient, that consent may be required

Note of Complaint/Enquiry

Action Taken

Passed to Complaints Department: **NB: This information will be shared with the complaints department for statistical purposes only.**

Please return to: Complaints Department
6th Floor
McKinney House
Musgrave Park Hospital
Belfast
BT9 7JB

Or alternatively email us at: complaints@belfasttrust.hscni.net

Appendix 13

Internal/ External Support/ Contacts

COMPLAINTS DEPARTMENT
The BHSCT Complaints Department's contact details are:

Musgrave Park Hospital
McKinney House
Stockman's Lane
Belfast
BT9 7JB

Tel: 028(95) 048000
Fax: 028(90) 903018
Email: complaints@belfasttrust.hscni.net

THE NI COMMISSIONER FOR COMPLAINTS
The NI Commissioner for Complaints (the Ombudsman) can carry out independent investigations into complaints about poor treatment or services or the administrative actions of the Trust. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly and the Trust or practitioner has not put things right where they could have, the Ombudsman may be able to help.

The Ombudsman's contact details are:
Mr Tom Frawley
Northern Ireland Ombudsman
Freepost BEL 1478
Belfast
BT1 6BR

Tel: 028 90 233821
Freephone: 0800 34 34 24

Email: ombudsman@ni-ombudsman.org.uk
Web: www.ni-ombudsman.org.uk

THE PATIENT AND CLIENT COUNCIL
The Patient and Client Council (PCC) is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public
- promoting involvement of the public
- providing assistance to individuals making or intending to make a complaint

- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services

The PCC can provide free and confidential advice, information and assistance with complaints.

If a person feels unable to deal with a complaint alone, the PCC staff can offer a wide range of assistance and support. This assistance may take the form of:

- information on the Complaints Procedure and advice on how to take a complaint forward
- discussing the complaint and drafting letters
- making telephone calls
- helping prepare for a meeting and accompanying the complainant
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services;
- help on accessing medical/social services records.

PCC's contact details are:

Freepost
Patient Client Council
Freephone: 0800 917 0222
Email: info.pcc@hscni.net
Web: www.patientclientcouncil@hscni.net

THE REGULATION QUALITY IMPROVEMENT AGENCY - RQIA

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. RQIA will monitor how complaints about the regulated services are handled.

RQIA's Contact Details:

The Regulation and Quality Improvement Authority Headquarters
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Email: info@rqia.org.uk

Tel: 028 9051 7500
Fax: 028 9051 7501

ADVOCACY AND CONCILIATION

Advocacy

Some people who might wish to complain do not do so because they do not know how to, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their wishes and views known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

Within the Health and Social Care sector, advocacy has been available mainly for vulnerable groups, such as people with learning problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and can be intimidated by professional attitudes that may seem paternalistic and authoritarian.

The Trust will encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

Conciliation

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to gain a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations such as;

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the Trust and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of on-going care issues, to maintain the relationship between the complainant and the Trust;
- when there are misunderstandings with the relatives during the treatment and care of the patient/client.

All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each others' point of view and ask questions.

Complaints raised by unreasonable, vexatious or abusive complainants are **NOT** suitable for conciliation. (Refer to Appendix 14 and 15).

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, e.g. if there is a breakdown in the relationship between a doctor or practitioner and their patient/client.

Conciliation may be requested by the complainant or the Trust.

Appendix 14

Vexatious, Unreasonably Demanding or Persistent Complaints

All Trust staff should respond to complainants in an appropriate and professional manner. However, there may be times when nothing can reasonably be done to assist or where further contacts place inappropriate demands on resources.

In such cases and in consultation with Senior Manager/ Co-Director, the Trust will establish if the "Unacceptable Actions Policy" or Guidance for the Handling of Habitual or Vexatious complains should be considered.

Habitual or vexatious complainants are becoming an increasing problem for Healthcare Staff. The difficulty in handling such complainants places a strain on time and resources and can cause undue stress for staff that may need support in these difficult situations. Staff should respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further which can be reasonably done to assist them or to rectify a real or perceived problem.

In determining arrangements for handling such complainants, the Trust is presented with two key considerations:

a) To ensure that the complaints procedure has been correctly implemented so far as is possible and that no material element of a complaint is overlooked or inadequately addressed, and to appreciate that even habitual or vexatious complaints may have aspects to their complaints which contain some genuine substance. The need to ensure an equitable approach is crucial.

b) To be able to identify the stage at which the complainant has become habitual or "vexatious".

Purpose of the Guidance

The aim of the guidance is to identify situations where a complainant might be properly considered to be habitual or vexatious and to suggest ways of responding to these situations.

It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken to try and resolve complaints following the Trust's complaints procedure, i.e., through local resolution. Judgement and discretion must be used in applying the criteria to identify potential or vexatious complainants and in deciding action to be taken in specific cases.

The procedure should only be implemented following careful consideration of the actions and behaviour of a complainant by a Director of the Trust, in conjunction with the relevant Patient/Client Liaison Manager.

Definition of a Habitual or Vexatious Complaint

Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or vexatious where previous or current contact with them shows that they meet any one of the following criteria:

Where complainants:

a) persist in pursuing a complaint after the Complaints Procedure has been fully and properly implemented and exhausted (e.g. where investigation has been denied as ‘Out of time’)

b) change the substance of a complaint or continually raise additional issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response (Not all complainants who raise further concerns or questions on receipt of a response are vexatious. They may be doing so to seek clarification as part of the local resolution process. Care must be taken not to discard new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints)

c) are unwilling to accept documented evidence of treatment given as being factual, e.g. drug records, medical or computer records, or deny receipt of an adequate response in spite of correspondence specifically answering their questions, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed

d) do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of staff to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate

e) focus on a relatively minor matter to an extent, which is out of all proportion to its significance and continue to focus on this point (It is recognised that determining what a ‘*relatively minor*’ matter can be is subjective, therefore careful judgement must be used in applying this criteria)

Dealing with habitual or Vexatious Complainants

A Trust Director and/or nominated deputies may decide to deal with complainants in one or more of the following ways:

a) Once it is clear a complainant meets any one of the criteria above, they should be informed in writing that they may be classified as habitual or vexatious complainants. This procedure should be copied to them and they should be advised to take account of the criteria in any further dealings with the Trust.
b) Decline any contact with the complainants either in person, by telephone, by fax, by email, by letter or any other combination of these, or restrict contact to liaison through a third party (If staff are to withdraw from a telephone conversation with a complainant, it may be helpful to have an agreed statement to be used at such times).
c) Notify the complainants in writing that a Director of the Trust has responded fully to the points raised, and have tried to resolve the complaint, that there is nothing more to add and continuing contact will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

d) Inform the complainants that in extreme circumstances, the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors or to the Police if violence or threats are made against staff.

e) Temporarily suspend all contact with the complainants regarding their complaint whilst seeking legal advice and advise the complainant accordingly. It may still be necessary however to continue providing a healthcare service.

Withdrawing 'Vexatious or Habitual' Status
Once a complainant has been identified as 'habitual or vexatious' there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate.

Staff should have used discretion in recommending 'habitual or vexatious' status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate.

Where this appears to be the case, a discussion between key staff and the Chief Executive and/or Director will take place. Subject to his/her approval, normal contact with the complainants and application of the Trust's complaints procedure will then be resumed.

Even correspondence from complainants who have been classified as habitual or vexatious should be screened to ensure that no new complaint has been raised and to determine if the Trust's discretion should be applied.

Appendix 15

Unacceptable Actions Policy[2]

Trust staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complainants, staff need to:

- Ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- Appreciate that even habitual complainants may have grievances which contain some substance;
- Ensure a fair approach; and
- Be able to identify the stage at which a complainant has become habitual.

The following **"Unacceptable Actions Policy"** should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

This policy sets out the approach to those complainants whose actions or behaviour the Trust considers unacceptable. The aims of the policy are to:

- Make it clear to all complainants, both at initial contact and throughout their dealings with the organisation, what the Trust can or cannot do in relation to their complaint. In doing so, the Trust aims to be open and not raise hopes or expectations that cannot be met;
- Deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered unacceptable. All complainants have the right to be heard, understood and respected. Trust staff have the same rights.
- Provide a service that is accessible to all complainants. However, the Trust retain the right, where it considers complainants' actions to be unacceptable, to restrict or change access to the service;
- Ensure that other complainants and Trust staff do not suffer any disadvantage from complainants who act in an unacceptable manner.

Defining Unacceptable Actions

People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. The Trust does not view behaviour as unacceptable just because a complainant is assertive or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint.

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[2] See Page 85 DHSSPS Complaints in Health and Social Care Standards & Guidelines for Resolution & Learning April 2009; Unacceptable Actions Policy based on best practice guidelines by the Scottish Public Services Ombudsman –Revised January 2011 Inserted June 2011

However, the actions of complainants who are angry, demanding or persistent may result in unreasonable demands on the Trust or unacceptable behaviour towards staff.

It is these actions that the Trust consider unacceptable and aim to manage under this policy. These unacceptable actions are grouped under the following headings:

Aggressive or abusive behaviour
Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. The Trust also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

The Trust expects its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance approach must be adopted. Trust staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards staff.

Unreasonable demands
Complainants may make what the Trust consider unreasonable demands through the amount of information they seek, the nature and scale of service they expect or the number of approaches they make. What amounts to unreasonable demands will always depend on the circumstances surrounding the behaviour and the seriousness of the issues raised by the complainant. Examples of actions grouped under this heading include demanding responses within an unreasonable timescale, insisting on seeing or speaking to a particular member of staff, continual phone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

The Trust considers these demands as unacceptable and unreasonable if they start to impact substantially on the work of the organisation, such as taking up an excessive amount of staff time to the disadvantage of other complainants or functions.

Unreasonable persistence
It is recognised that some complainants will not or cannot accept that the Trust is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the organisation persistently about the same issue. Examples of actions grouped under this heading include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the Trust can or cannot do and continuing to pursue a complaint without presenting any new information.

The way in which these complainants approach the Trust may be entirely reasonable, but it is their persistent behaviour in continuing to do so that is not.

The Trust considers the actions of persistent complainants to be unacceptable when they take up what the Trust regards as being a disproportionate amount of time and resources.

Managing Unacceptable Actions

There are relatively few complainants whose actions the Trust considers unacceptable. How the Trust manages these depends on their nature and extent. If it adversely affects the Trust's ability to do its work and provide a service to others, it may need to restrict complainant contact with the organisation in order to manage the unacceptable action. The Trust will do this in a way, wherever possible, that allows a complaint to progress to completion through the complaints process. The Trust may restrict contact in person, by telephone, fax, letter or electronically or by any combination of these. The Trust will try to maintain at least one form of contact. In extreme situations, the Trust will tell the complainant in writing that their name is on a "no contact" list. This means that they may restrict contact with the organisation to either written communication or through a third party.

The threat or use of physical violence, verbal abuse or harassment towards Trust staff is likely to result in the ending of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

The Trust does not deal with correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. When this happens the Trust will tell the complainant that it considers their language offensive, unnecessary and unhelpful. The Trust will ask them to stop using such language and state that it will not respond to their correspondence if they do not stop. The Trust may require future contact to be through a third party.

Trust staff will end telephone calls if the caller is considered aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that the behaviour is unacceptable and end the call if the behaviour does not stop.

Where a complainant repeatedly phones, visits the organisation, sends irrelevant documents or raises the same issues, the Trust may decide to:

- Only take telephone calls from the complainant at set times on set days or put an arrangement in place for only one member of staff to deal with calls or correspondence from the complainant in the future;
- Require the complainant to make an appointment to see a named member of staff before visiting the organisation or that the complainant contacts the organisation in writing only;
- Return the documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed;
- Take other action that the Trust considers appropriate. The Trust will, however, tell the complainant what action it is taking and why.

Where a complainant continues to correspond on a wide range of issues and the action is considered excessive, then the complainant is told that only a certain number of issues will be considered in a given period and asked to limit or focus their requests accordingly.

Complainant action may be considered unreasonably persistent if all internal review mechanisms have been exhausted and the complainant continues to dispute the Trust 's decision relating to their complaint. The complainant is told that no future phone calls will be accepted or interviews granted concerning this complaint. Any future contact by the complainant on this issue must be in writing. Future correspondence is read and filed, but only acknowledged or responded to if the complainant provides significant new information relating to the complaint.

Deciding to restrict contact

Trust staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the Trust will give the complainant the opportunity to modify their behaviour or action before a decision is taken. Complainants are told in writing why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place.

Appealing a decision to restrict contact

A complainant can appeal a decision to restrict contact. A senior member of staff who was not involved in the original decision considers the appeal. They advise the complainant in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

Recording and reviewing a decision to restrict contact

The Trust will record all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact may be reconsidered if the complainant demonstrates a more acceptable approach. A senior member of staff will review the status of all complainants with restricted contact arrangements on a regular basis.

Appendix 16

Vulnerable Adults

Definition of vulnerable adult
For the purposes of 'Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance' the term 'vulnerable adult' is defined as: *a person aged 18 years or over who is, or may be, in need of community care services* ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation.*

Adults who 'may be eligible for community care services' are those whose independence and wellbeing would be at risk if they did not receive appropriate health and social care support.

They include adults with physical, sensory and mental impairments and learning disabilities, however those impairments have arisen; e.g. whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

Making a complaint about health and social care can be intimidating, especially for people with mental health problems, learning disabilities or for those who are old or frail.

The Trust should have consistent, explicit arrangements in place for advising and supporting vulnerable adults including signposting to independent advice and specialist advocacy services.

Reportable offences and allegations of abuse
Careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting.

Where it is apparent that a complaint relates to abuse, exploitation or neglect of a vulnerable adult then the regional *Safeguarding Vulnerable Adults – Regional Adult Policy and Procedural Guidance (Sept 2006)* and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults (Dec 2003)* should be activated according to Trust procedure. The Complaints procedure will be suspended pending the outcome of the safeguarding vulnerable adults investigation and complainant advised accordingly. At the conclusion of the investigation then consideration may be given to any outstanding issues.

Appendix 17 – Complaints Leaflet

Tell us what
YOU think
of our services

compliments....suggestions....comments....complaints

Put a
stamp
here

Complaints Department
Belfast Health and Social Care Trust
6th Floor, McKinney House
Musgrave Park Hospital
Stockman's Lane
Belfast
BT9 7JB

Within the Belfast Trust we want you to experience the best care we can provide. You can help us to improve by telling us what you think of the services you have received. Please use the form on this leaflet to give us your opinion.

You may want to

give a compliment about the service you have used

make a comment or suggestion for improvement

make a complaint

We value your opinions and will act on them whenever possible.

Comments and Suggestions

We will consider all your comments and suggestions, share them with all the relevant staff and make changes if possible.

Compliments

We will use your compliments to highlight good practise and will pass them on to the relevant department or person.

Complaints

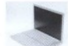
If you are not happy about any aspect of the care, treatment or service we have offered you, you should in the first instance contact the person who is dealing with you, or their manager, so that your complaint can be dealt with immediately. If you do this and you are still not satisfied, you can make a formal complaint to the Complaints Department. Once we receive your complaint we will send you information on how our complaints procedure works.

Your views are much appreciated and will be treated confidentially. You may contact us by

Completing the pre-addressed form below and posting

Writing to: Complaints Department, Belfast Health and Social Care Trust, 6th Floor, McKinney House, Musgrave Park Hospital, Stockman's Lane, Belfast, BT9 7JB

Telephone: (028) 9063 0023 or Fax (028) 9090 3018

 E-mail: complaints@belfasttrust.hscni.net

Please use this form and tick the appropriate box

I wish to make a: compliment ☐ suggestion/comment ☐ complaint ☐
(If writing on behalf of a patient/client, please also give his/her details)

Your name: ____________________ Patient/Client Name: ____________________

Address: ____________________ Address: ____________________

____________________ ____________________

Post Code: ____________________ Postcode: ____________________

Telephone: ____________________ Telephone: ____________________

Date of Birth: ____________________ Date of Birth: ____________________

Hospital Number if Known: ____________________

Please write your message below: *(Give as much detail as possible e.g. dates/times, location/area, staff title/name)*
Please include a separate sheet with any additional information.

____

____

____

____

____

____

____

Your signature: ____________________ Date: ____________________

Signature of patient/client: ____________________
(If a complaint is being made on behalf of patient/client, please include his/her signature)

你可以联系投诉部门（联系细节见背页）或透过我们的网站而得到以你语言说明我们制定的投诉程序。

你可以聯絡投訴部門（聯絡細節見背頁）或透過我們的網站而得到以你語言說明我們制定的投訴程序。

Jeśli chcecie Państwo uzyskać informacje na temat procedury skarg w swoim języku, należy skontaktować się z działem skarg (ich dane po drugiej stronie), lub też zgłosić to przez naszą stronę internetową.

Daugiau informacijos apie mūsų skundų nagrinėjimo tvarką Jūsų kalba galite gauti susisiekę su Skundų tyrimo skyriumi (duomenys pateikti kitame lape) arba apsilankę mūsų interneto svetainėje:

Para receber informações sobre os nossos procedimentos de queixas na sua língua, queira contactar o Departamento de Queixas (dados no verso desta página) ou através do nosso sítio da web:

You can get information about our Complaints Procedure via our website: www.belfasttrust.hscni.net.
This information can be made available in other formats if required.

Alternatively, the Patient and Client Council can provide free and confidential advice, information and help with writing letters, making telephone calls, and supporting you at any meetings you might need to attend. You can get more information on the services provided by the Patient and Client Council at www.patientclientcouncil.hscni.net or by phoning FREEPHONE 0800 917 0222.

Specialist advocacy services may also be available to help you through the process of complaining. Our Complaints Department will be able to provide you with further details of this support.

Appendix 18

Children Order Representations and Complaints Procedure

Under the Children (NI) Order 1995 (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under part IV of, and paragraph 4 of Schedule 5 to, the Order and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987.

The Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996.

Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 **(see flowchart below to aid decision making)**

All staff should familiarise themselves with these requirements.

1. Where it is apparent that a complaint relates to abuse, exploitation or neglect of a child then the Regional Child Protection Policy and Procedure 2005 should be activated.
2. Complaints in relation to children; were the matter is before the Court, will not be addressed until the judicial process has been completed.

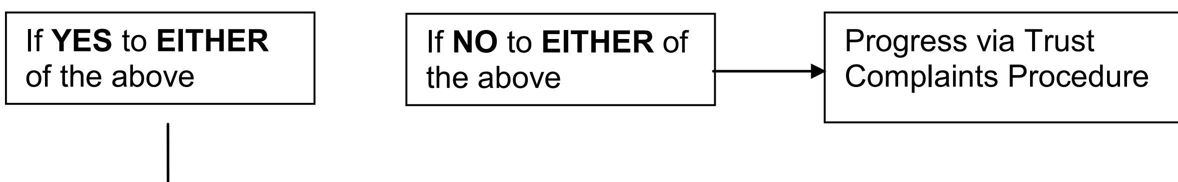
Children Order Representations and Complaints Procedure

1. **Complaint: Does it fit the definition of a Children Order complaint as below?**

"Any representation (including any complaint) made to the Trust…about the discharge of any of its functions under part IV of the Order or in relation to the child." (Children (NI) Order 1995, Article 45 (3))

OR

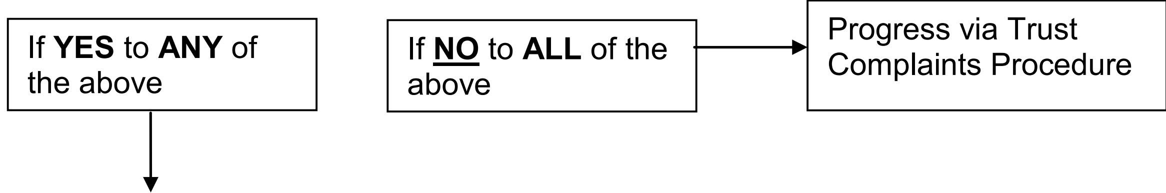
"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and paragraph 6 of Schedule 5 to, the Children Order." (Guidance and Regulations – Vol.4, Para 12.5 – DHSS)



2. **Does it meet the criteria of what may be complained about under Children Order?**

"..about Trust support for families and their children under Part IV of the Order."

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.



3. Complainant: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need

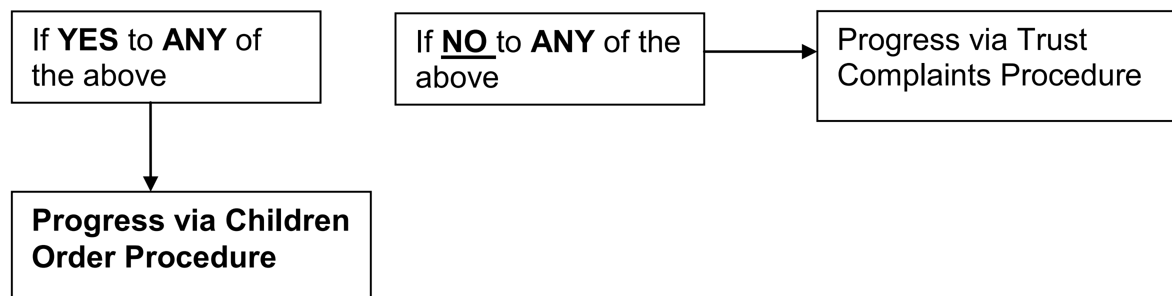
c. A parent **of his/her**

d. Any person who is not a parent of theirs but who has **parental responsibility for them**

e. Any Trust foster parent

f. Such other person as the Trust considers has sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- The person who had the day to day care of the child within the past two years;
- The child's Guardian Litem;
- The person is a relative of the child (as defined by the Children Order, Article 2 (2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- A friend;
- A teacher;
- A general practitioner
  (Children (NI) Order 1995 Article 45 (3))



NB: *For a complaint* ***to be eligible to be considered under the Children Order Procedure, the answer*** *to 1* ***and*** *2* ***and*** *3* ***MUST ALL BE YES.***

CHILDREN & CONSENT – See Appendix 5

Appendix 19

Guidance for Investigation and Escalation Protocol for Complaints

1. Complaint received, acknowledged, graded and sent to the Directorate for investigation and response.
2. The Directorate investigates the complaint. The Investigation must be proportionate to level of the grading of the complaint.
3. Complaints made in relation to Inequalities Human Rights or Disabilities will also be forwarded to the Health and Inequalities Manager for information only.
4. Where professional issues are identified in a complaint the appropriate Executive Director will be notified and sent a copy of the complaint and when available a copy of the draft response for information.

   Executive Directors

Nursing	Ms B Creaney
Social Work	Mr C Worthington
Medical	Dr T Stevens

5. On the occasion where an individual person is named more than twice within a period of one year the Director/ Co Director for the Directorate will be informed.
6. In relation to Medical and Dental staff the Medical Director and the Associate Medical Director and Clinical Directors for the Directorate will be informed.

Investigation

Where an individual is named in a complaint, the individual should be interviewed by any one of the following: -

- Line manager / Senior Manager with the appropriate level of seniority
- An independent person with appropriate level of seniority
- A relevant Medical, Clinical, Nursing or Professional person with the appropriate level of understanding and Seniority.
- Senior Manager Complaints and Legal Services / Complaints Manager where appropriate.
- Governance Manager where appropriate

In certain circumstances it may be preferable for two persons to interview the individual. Consideration must be taken to ensure that the interviews are carried out in a non-blame manner and that the interview is fair, independent and proportionate to the complaint.

The interviewing person should always review any relevant documentation that may have a bearing on the complaint. This will include medical, nursing, social work or any other patient /client notes that may be relevant; adverse incidents may also be relevant.

The interviewer will then formulate their report / response based on the information received. This must be clearly documented and form part of the investigation. Where it is not possible for an interview to take place, the individual named in the complaint will be asked to respond in writing. This response along with the relevant patient/client notes must always be peer reviewed by an appropriate person with the appropriate level of skills and understanding of the speciality. This peer review must be clearly documented and sent as part of the investigation.

All staff named in a complaint must be kept informed of the investigation and have the opportunity to review the draft response prior to the Director signing off. The investigating officer/person will collate the information and formulate into a response. This response is then ratified or signed off by the Co-Director /senior manager and forwarded to Complaints department.

All investigation correspondence should be sent to complaints and held on one corporate/central file.

Escalation guidance after 20 day delay

1. Reminders will be sent to the directorate10 working days before the response is due.
2. Where a delay is identified the Complaints department must be notified immediately of the delay and the reason why so that the complainant can be update.
3. If a response is not received and no information provided as to when the response is likely to be completed, a reminder will be sent to the Directorate and Co-director copied in.
4. If no response or contact has been made with the Complaints team by the 15th working day a final reminder will be sent to the Co-Director.

Complaints which have not been responded to within the 20 working day time frame will be escalated as follows:

- **Complaints outstanding after 20 working days** - A reminder will be sent to the Service Manager, Co-Director and Director stating this complaint is now outside the 20 working day timeframe.

- **Complaints outstanding after 30 working days** – A further notice will be sent to the Co Director and Director advising that the complaint is now well outside of the time frame, can you please action.

- When a complaint covers a number of areas / Directorates, the appropriate Directors will be advised.

- If the complaint remains outstanding after 30 working days the Medical Director and Co-Director should be made aware of the delay.

Reference No: TP 45/10

Title:	Policy and Procedure for the Management of Comments, Concerns, Complaints & Compliments			
Author(s)	Rachael Maxwell, Senior Manager			
Ownership:	Cathy Jack, Medical Director, Medical Director's Office			
Approval by:	Trust Policy Committee Executive Team		**Approval date:**	01 March 2017 15 March 2017
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Links to other policies	BHSCT Adverse Incident Reporting & Management Policy DHSS Complaints Standards and Guidelines BHSCT Shared Learning Policy BHSCT Being Open Policy			

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CONTENTS

1.0 Introduction/Purpose of Policy Page 3
1.1 Background
1.2 Purpose
1.3 Objectives

2.0 Scope of the Policy Page 4

3.0 Roles & Responsibilities Pages 4-9

4.0 Key Policy Principles Pages 10-13

5.0 Implementation of Policy Page 13-14
5.1 Dissemination
5.2 Resources
5.3 Exceptions

6.0 Monitoring Page 14-15

7.0 Evidence Base/References Page 15

8.0 Consultation Process Page 15

9.0 Appendices/Attachments Pages 16-54

1 Record keeping Page 16
2 Consent confidentiality, and third party confidence Page 17-18
3 Grading of a complaint Pages 19-22
4 Investigation and Resolution Pages 23-24
5 Responding to a comment, concern or complaint Pages 25-28
6 Complaints process Flowchart Pages 29-31
7 Service Directorate Complaint/ Enquiry Record Form Page 32
8 Internal/ External Support Contacts Pages 33-35
9 Unreasonable, vexatious or abusive complaints Pages 36-38
10 Unacceptable Actions Policy Pages 39-42
11 Vulnerable Adults Policy Page 43
12 Children Order Representations and Complaints Procedure Pages 44-46
13 Formal Complaints Escalation Process Page 47
14 NI Public Service Ombudsman Cases Page 48-53

10.0 Equality Statement Page 54

1.0 INTRODUCTION/PURPOSE OF POLICY

1.1 Background

In the patient-centred environment of the Belfast Trust, patients, relatives and carers are encouraged to express their views about the treatment and services that they receive.

We recognise the need to have an effective process for managing comments, concerns, complaints and compliments about any aspect of care or treatment provided or commissioned by the Belfast Trust in hospital or community settings.

It is essential that all concerns and complaints are received positively, investigated promptly and thoroughly, and responded to sympathetically. Timely and effective action should be taken where appropriate to prevent recurrence when services provided have fallen below acceptable standards.

1.2 Purpose:

The purpose of this document is to ensure that:

- complaints are dealt with in line with the DHSSPS “Complaints in Health and Social Care – Standards and Guidelines for Resolution and Learning”
- complaint management processes comply with the Parliamentary and Health Service Ombudsman’s Principles of Good Complaint Handling and Good Administration
- complaints are handled in a speedy and efficient manner, that is open, accessible, fair, flexible, conciliatory and without blame
- staff are provided with a greater understanding and guidance on Complaint Management procedures within the Belfast Trust to ensure complaints are managed in a positive manner and that learning can take place

The policy promotes local, prompt resolution with involvement of the complainant at the core of the process, and encourages continuous learning and identification of improvements in the quality and safety of services throughout the Trust.

1.3 Objectives

- To ensure that patients/relatives/carers are encouraged to provide feedback about their experiences of treatment and services - to tell us what is working, help identify any potential service improvements, and help identify problems and risk – and that individuals will not be treated differently as a result of making a complaint.
- To learn from comments, concerns, complaints and compliments as an organisation and use feedback effectively to improve the quality of our services and prevent a recurrence of factors giving rise to a concern or complaint.
- To ensure that Trust staff are aware of their roles and responsibilities in good customer care and complaints handling, including responding positively to complaints, actively listening, acknowledging, assessing, resolving and investigating concerns or complaints as quickly as possible.
- To ensure the Trust promotes a culture of openness, honesty and fairness when investigating all concerns and complaints.
- To ensure complainants receive open, honest and proportionate responses to their complaints where mistakes are acknowledged, explanations provided for what went wrong and appropriate and proportionate measures are considered to put things right.

2.0 SCOPE OF POLICY

This Policy is applicable to all staff providing services within the Belfast Health & Social Care Trust. This includes BHSCT employees, students, agency staff and volunteers, and includes services that are commissioned or provided by the Independent Sector.

The Formal Complaints Procedure applies only to complaints about care or treatment, or about issues relating to the provision of health and social care.

Comments, concerns, complaints and compliments may be received from patients; patient relatives, carers, visitors and other service users. The concerns and complaints excluded from the scope of this policy are identified in **5.3.**

3.0. ROLES/RESPONSIBILITIES

Chief Executive
As Accountable Officer, the Chief Executive has overall accountability for ensuring compliance with statutory and legal requirements and with relevant complaint guidance.

The Chief Executive will:

- ensure that the Trust takes the necessary action to ensure that lessons are learned and where appropriate, improvements are made to the service.
- ensure a Committee structure is in place to monitor and review the organisation's performance in complaints management.

Trust Board
The Trust Board has a monitoring and assurance role to ensure compliance with the Trust's statutory obligations as described in the relevant complaints legislation.

The Board will:

- ensure that the organisation arrangements contained within the policy and procedures are implemented
- monitor and review the overall reporting performance and receive regular reports
- ensure complaints management is integrated within the Trust's Performance and Assurance Framework

Medical Director
The Medical Director (or their deputy) is the lead Director on behalf of the Trust Board and Executive Team for the management of the complaints.

The Medical Director has a shared responsibility with the Director of Nursing and User Experience for clinical quality.

The Medical Director will:

- develop suitable organisational arrangements for the management of complaints
- development and maintain systems to monitor and disseminate learning from complaints across the organisation
- put systems in place to ensure reporting of complaints to external agencies as required e.g. DHSSPSNI, Regional HSC Board, RQIA
- regularly review a representative 5% sample of complaint responses for assurance purposes
- ensure identification of key issues and actions regarding the management of

complaints for progression via the Complaints Review Group and onward reporting to the Trust Board

Co-Director Risk and Governance

The Co-Director will support the Medical Director in meeting their responsibility for complaints management.

The Co-Director has Trust-wide lead for the co-ordination, implementation, and evaluation of risk management systems and the Trust Risk Management Strategy.

The Co-Director will:

- promote an open, honest and just culture for complaints management
- maintain systems for the reporting, recording and analysing of complaints
- ensure that subsequent learning from complaints is shared across the Trust, through appropriate management structures
- take account of relevant complaints when reviewing Service Directorate risk registers and ensure appropriate linkage to the corporate risk register

Directors

Directors are responsible for ensuring that the standards and processes referred to in this policy are followed within their Service Areas, thus ensuring that the Trust does not suffer reputational damage due to maladministration of complaints.

Directors will:

- disseminate and promote this policy and procedure within their areas of responsibility and ensure its implementation by providing support and advice to managers and staff
- ensure complaints are investigated timely and thoroughly in accordance with existing policy and procedure, including approving extensions to timescales as appropriate upon request from Service Areas
- review and amend draft complaint responses and sign off on behalf of the Chief Executive
- ensure that learning from complaints is shared across Service Areas, in keeping with the Shared Learning Policy through appropriate management structures
- ensure that learning with relevance beyond the Directorate is appropriately formulated and progressed for sharing in line with the shared learning procedure
- ensure that complaints are monitored and reviewed within their Service Areas
- implement action plans as required to ensure any recommendations made as a result of investigations are implemented and monitored, and provide assurance to the Complaints Review Group and subsequently to the Assurance Committee
- take account of relevant complaints when reviewing their Risk Register and ensure that this is linked appropriately to the Corporate Risk Register
- ensure staff have access to appropriate training on complaint management and, where appropriate, investigation of complaints.

Co- Directors

Co-Directors are responsible for ensuring that all complaints are managed efficiently and effectively in their Service Areas and all complaint responses are provided in a timely way

Co-Directors will:

- agree the grading of the complaint in conjunction with the Investigating and Complaints Managers
- ensure any complaint identified as high risk is assessed, reported to the Director and appropriately managed and investigated using Root Cause Analysis methodology. Consideration should be given to undertaking independent investigations into high risk complaints that do not meet the SAI criteria.
- deal with any queries Investigating Managers might have, including the need to contact or meet with the service user who raised the complaint or concern.
- maintain oversight of and implement effective performance management systems to ensure the quality and timeliness of responses provided by their Service Areas, reviewing complaints management data on an ongoing basis and prioritising actions to address issues identified regarding outstanding responses and any trends of excessive response times
- where a complaint relates to the actions of more than one Directorate the Co-Directors will liaise with the relevant Complaints Manager to identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint.
- agree the draft response with the Investigating Manager (ensuring that all aspects of the complaint are addressed, and that the Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling are reflected in the response) and forward this to the relevant Complaints Manager within identified timescales
- where appropriate, ensure action plans arising out of investigations (including Ombudsman's recommendations) are agreed, progressed, monitored and evaluated.
- ensure that the Directorate fosters an ethos of learning in order to minimise future occurrences of issues identified through complaints
- where serious allegations regarding staff performance and behaviour arise through the Complaints Procedure, ensure this is appropriately followed up.

Service Directorate Managers (Investigating Managers)

Service Directorate Managers are responsible and accountable to their Director to ensure that complaints are thoroughly investigated within their clinical and managerial teams and responded to within the given timescales.

Service Directorate Managers will:

- ensure that complaints investigations are conducted thoroughly in a manner that is supportive to those involved and takes place in a blame free atmosphere
- ensure that complaint responses are provided within agreed time scales, promptly escalating obstacles that may cause delays to Co-Directors as required
- ensure that their teams review and approve draft responses in a timely manner
- ensure appropriate action is taken when a health professional is identified in a concern or complaint. Where more than one concern or complaint raised about an

individual, ensure there is appropriate escalation to the relevant professional lead

- ensure that comprehensive records are maintained throughout all complaint investigation and management processes
- upon closure of each complaint ensure that the Complaints Department receives all relevant correspondence relating to the complaint (e.g. statements from staff, investigation notes, interview records etc.) to facilitate retrieval in a timely manner should the complaint be reviewed at a further stage for example by the Northern Ireland Public Services Ombudsman or the Trust legal department

The Investigating Manager will:

- agree grading of the complaint in conjunction with the relevant Complaints Manager
- undertake a preliminary assessment of how best to investigate the complaint
- liaise regularly with the relevant Complaints Manager
- ensure the investigation is carried out in a timely manner and notify the relevant Complaints Manager at the earliest opportunity of any delays
- provide support to staff during an investigation and ensure that staff named in the complaint are made aware of the content of both the complaint and the response. If a named member of staff has left the Trust, all reasonable efforts must be made by the Investigating Manager to contact them to obtain all relevant information.
- keep comprehensive records of all relevant supporting information arising throughout investigation of the complaint
- ensure response letters are compiled and fully address all issues raised by the complainant
- ensure that agreed action plans arising out of investigations are completed and any recommendations implemented across appropriate teams/departments

Senior Complaints Manager
The Senior Complaints Manager will support the Co-Director of Risk & Governance in executing those duties relating to the management of complaints.

Complaints Managers
Complaints Managers will:

- acknowledge complaints within 2 working days of receipt
- agree grading of complaints in conjunction with the Investigating Manager
- contact complainants to confirm and agree areas for investigation and expected outcomes
- ensure all complaints involving a sudden unexpected death, serious harm or potential safeguarding issues, are escalated to the relevant Director and Senior Complaints Manager immediately for consideration of independent investigation and to facilitate communication with the complainant
- where a complaint relates to the actions of more than one Directorate the Complaints Manager will liaise with the relevant Co-Directors to identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint.

- obtain consent where required in the case of third party complaints or enquiries
- notify the relevant Investigating Manager within 2 working days of receiving complaint
- record all relevant information about each complaint on DATIX and set up the agreed response timescales
- track complaints and send reminders to Service Areas to facilitate the meeting of deadlines, including informing the Investigating manager *10 working days* before the final response deadline, and escalating delayed responses to Co-Director and Director-level as required
- ensure that the preferred mode of contacting the complainant is agreed and ensure that the complainant is kept informed about progress with his/her response
- ensure that the relevant Executive Director is notified where a health professional has been identified in a complaint (including notification of the Medical Director's Office where a complaint involves medical
- detail the specific points in the complaint that require to be answered and subsequently quality assure that all points have been fully addressed by the Directorate before forwarding for signature (in addition to quality assurance checks ensuring accuracy of dates, names/titles and address of complainant etc)
- ensure final complaint responses are sent to Investigating Managers and Co-Directors for checking with contributing staff and final approval prior to being sent to the relevant Director
- provide service user feedback, related analyses and reports to services and Committees within the Governance Accountability Framework
- thematically review complaints for learning locally and across the Trust
- provide information as requested to external sources including RQIA, Department of Health and HSC Board.
- provide guidance and support to relevant managers, supervisors and staff to enable them to carry out their duties and responsibilities relating to complaint prevention and management
- provide training in relation to complaints investigation and management

All staff

A complaint can be made orally or in writing to any member of Trust staff (any complaints received in writing must be passed to the Complaints Team). The most satisfactory outcome from complaints often comes when the issues identified are dealt with fully and effectively within the Service Area. As such the Trust expects all staff to attempt to resolve issues on the front line speedily and to the complainant's satisfaction, with the assistance of a more senior member of staff when necessary.

The first responsibility of the recipient of a complaint is to ensure that the patient's immediate healthcare needs are being met. This may require urgent action before any matters relating to the complaint are tackled.

Complainants should be listened to and treated courteously with dignity and respect.

Reassurance should be given to the complainant that their concern is being taken seriously, that it will be dealt with confidentially and will not in any way adversely affect

their or their relative's treatment.

Where the issue raised is about a specific member of staff, the local manager should appoint another staff member to carry out an initial investigation and seek to resolve the matter speedily. The complainant should be approached in a non-defensive manner to ascertain their concerns.

Staff will:

- work to put things right and help resolve issues or concerns raised by complainants in an open, compassionate, constructive, non-judgemental and timely manner
- refer the matter as soon as possible to their line manager if unable to deal with complaints raised directly with them or seek advice from complaints staff on how to proceed
- keep their line manager updated on complaints and enquiries they are currently dealing with, and complaint outcomes (including resultant service improvements)
- provide patients, patient relatives, carers, visitors and other service users with appropriate information regarding how to give feedback and how to raise concerns or a complaint (this includes ensuring that information relating to service user feedback is displayed in facilities accessed by service users)
- co-operate fully with the investigation of complaints within the service/team particularly by returning statements, reports and other information to Investigating Officers in a timely and appropriate manner. This co-operation will still apply where staff members have left the Trust (for example due to retirement) since the events of the complaint.
- enable the process of organisational learning following a complaint
- release staff for relevant complaints awareness/ customer satisfaction training.
- maintain good record keeping (including updating Datix web with relevant information as required)
- inform their line manager and other team members (if appropriate) when they receive a written compliment from service users

4.0 KEY POLICY PRINCIPLES

Definitions

A **complaint** is an expression of dissatisfaction about care or services provided by the Trust, which requires a response. It can be made by a patient, relative, carer or representative acting on behalf of a patient. Complainants may not always use the word complaint.

A **complainant** is the person making the complaint, on behalf of themselves or another.

A **concern** is usually where an individual remarks, expresses an opinion or makes an observation about a patient's treatment/care that can be defined as a matter of interest, importance or anxiety.

An **enquiry** is a request for further information such as waiting times for appointments

A **compliment** is an expression of praise, commendation, or admiration.

4.1 Key Policy statements:

This policy has been developed and set within the Legal Framework for Complaints Management within Health and Social Services.

The Belfast Trust is committed to providing safe, effective and high quality services and welcomes feedback from patients/relatives/carers/visitors and other service users about their experience of care to improve quality. This policy provides the opportunity to put things right for service users as well as improving services.

It is recognised that there may be times when treatment and or services do not meet expectations particularly when something has gone wrong or fallen below standard. By listening to people about their experience of healthcare, the Trust can learn new ways to improve the quality and safety of services and prevent problems happening in the future. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Learning from comments, concerns, complaints and compliments can only take place when they are managed in a positive and open manner. It is the Trust's wish to promote an open, honest, just and fair culture, where all staff can learn from complaints.

Patients/service users/relatives/carers/visitors can bring comments, concerns and compliments to the attention of any member of staff. Wherever possible, staff at a local level will actively seek to resolve dissatisfaction in a sensitive manner at the earliest opportunity. In circumstances where such frontline resolution is not possible, this policy outlines the process to ensure complaints are handled in an efficient and effective manner.

Effective communication is essential in good complaint handling. Complainants must be involved in deciding how the issues they have raised are handled and, where appropriate, advised of what will be done as a result of their feedback. A meeting with the Service Area should be offered to complainants upon conclusion of any investigation to allow an opportunity for discussion of the findings.

All complaints will be treated in confidence, with openness, honesty and respect being paramount at all times.

Complaints provide a rich source of information and form a vital part of the Trust's performance management systems. Positive action will be taken as a result of complaints, and learning from complaints will be embedded in the Trust's governance and risk management arrangements. Where something has gone wrong or fallen below standard

the Trust will take the opportunity to improve and avoid a recurrence.

4.2 Compliments
All compliments received by the Chief Executive or Complaints Department are acknowledged and shared with the staff/department named and recorded on Datix web. It is recognised that many more compliments are received directly by wards/departments and these should be recorded on Datix web.

4.3 How can complaints be made?
Every assistance will be given to individuals who wish to make a complaint, including the provision of interpreter services or any other service that may enhance the communication of the complaint to the organisation. Patients must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint.

Complaints may be made verbally or in writing and should also be accepted via any method, for example, the telephone or electronically. The Trust should be mindful of technological advances and ensure local arrangements are in place to ensure there is no breach of patient/client/staff confidentiality.

All complaints will be treated in confidence, with due care and respect being paramount at all times.

Complaints may be made to any member of staff - for example receptionists, medical or care staff. In many cases complaints are made orally and front-line staff may resolve the complaint "on the spot". As such, all front-line staff must be trained and supported to respond sensitively to comments; concerns and complaints raised and be able to distinguish those issues that would be better referred elsewhere.

Front line staff should familiarise themselves with the Equality Good Practice Reviews' principles for dealing with and managing complaints and the HSC Standards for complaints handling.

It is essential that all staff are aware of their roles and responsibilities when dealing with complaints. This will enable them to respond positively, and where possible, resolve the complaint at local level.

4.4 Complaint Management processes
Where a concern or complaint is made locally, every attempt should be made to achieve local resolution.[1] Where frontline resolution has been unsuccessful, the complainant should then be offered the option of contacting the Complaints Department.

All complaints must be formally acknowledged within 2 working days. Where possible the complainant's issues and expected outcomes from the complaint will be clarified and a timescale for response agreed. The format of the response will also be agreed with the complainant, this may be verbal (by phone or at a meeting), by email or written letter.

All complaints will be investigated according to the category of grading in which they fall, as referred to in the Regional matrix (see Appendix 3). Where a complaint involves the death of a patient/service user complainants should be offered a meeting with the Service Area to discuss their concerns

The Trust will investigate the complaint in a manner appropriate to the nature of the issues

[1] All complaints raised with front line staff should be recorded on Local Resolution forms (these can be found on the Trust intranet, see Appendix 7) including details of any actions taken and the outcome of such. Completed Local Resolution forms should be forwarded to the Complaints Department for entry onto the Datixweb system.

raised, aim to complete the investigation as efficiently and effectively as possible and ensure that the complaint response is provided within the agreed timescales. Where it is unavoidable that the response will not be provided within the agreed timescales the Service Area will notify the Complaints Department immediately with a clear explanation as to the reason(s) for the delay. The Service Area will continue to provide progress updates to the Complaints Department to enable the complainant to be kept regularly informed as to the progress of the investigation and response. Whilst a holding letter may be considered, it is preferred practice to maintain (as far as reasonably practicable) verbal contact with the complainant.

At all stages within the complaints process the Complaints Manager will provide support and assistance to the complainant and staff involved. Independent advice and support for complainants is also available from the Patient Client Council and Independent advocacy and specialist advocacy services, (see Appendix 8*).*

Regular reports will be provided to Directorates by the Complaints Department highlighting key issues such as trends in complaint subjects, length of response times, identifying any multiple complaints about individual employees / departments, and multiple complaints from individual complainants.

Joint Complaints

Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify the other organisation(s) involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the HSC Board or HSC Trust that commissioned the service or purchased the care for that service user is responsible for coordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

4.5 Complaint Investigation

The designated Investigating Manager within each Service Directorate will be notified by the Complaints Team on receipt of the complaint. A copy of the complaint correspondence will be forwarded to the Investigating Manager attaching a complaints memo outlining the process to be followed to ensure a timely response.

The Complaints Team will provide a reminder to the Investigating Manager via email 10 working days before the final response is due to prompt them to return the internal response, and will subsequently escalate delayed responses to Co-Director or Director level as required (see Appendix 15 below).

Upon completion of the complaint investigation, the Investigating Manager must forward a draft response to the relevant Complaints Manager who will ensure that all aspects of the complaint have been addressed. Where the quality check of the draft identifies significant changes or omissions, the response will be sent to the relevant Co-Director for checking and approval prior to forwarding to the relevant Director for final approval and signature.

A complaint should be made as soon as possible after the action giving rise to it, normally within 6 months of the event. There may be occasions when a complainant was not aware that there was cause for complaint at the time. In such circumstances a complaint should normally be made within 6 months of the complainant becoming aware of the cause for complaint.

Full and proper investigation is hindered where timescales extend beyond a 6 month period. Complainants should be advised that the time delay may impact on the investigation and any response would be based largely on a review of records. Advice should be sought from the relevant Complaints Manager in conjunction with the relevant Co-Director when deciding whether to investigate a complaint older than 6 months. Any serious allegations should be investigated if at all possible, regardless of timescale. A decision not to proceed with an investigation rests with the relevant Director and a letter explaining this decision (signed off by the Director) should be sent to the complainant.

4.6 Children Order Representations and Complaints Procedure
Under the Children (NI) Order 1995 HSC Trusts are statutorily required to follow established procedures for considering any representations (including any complaint) made to the Trust about the discharge of its functions under part IV or, and paragraph 4 of Schedule 5 to, the Order; and matters in relation to children accommodated by voluntary organisations and privately run children's homes; and personal social services to children provided under the Adoption Order (NI) 1987. Further details regarding complaints in relation to Children Order Representations can be found at *Appendices 13 &14.*

4.7 Independent Sector Providers (ISPs)
Complaints relating to Independent Sector Providers may be received directly by ISPs or by the complainant contacting the Trust. Generally, in the first instance, the ISP investigates and responds directly to the complainant. If the complainant contacts the Trust directly, the Trust will consider how best to proceed and if the matters raise serious concerns, the Trust may decide to investigate the complaint.

In all cases the complainant must be kept informed and advised of which organisation will investigate their complaint. Where a complaint relates to the actions of more than one Directorate the Complaints Manager in conjunction with the Co-Directors will identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination
This policy has relevance for all Belfast Trust staff, and applies equally to those in permanent, temporary, voluntary or contractor roles.

The policy will be available for download from the Trust central policy intranet page and the Trust website, and will be circulated by e-mail to all Directors for cascading to their relevant areas of responsibility.

5.2 Resources
A programme of complaints awareness and management training will be ongoing throughout the Trust to ensure that this procedure is followed and that staff encourage service users to provide feedback about their treatment and care experiences.

Complaints' Training is part of the mandatory induction programme for all new Belfast Health & Social Care Trust employees.

Further information and resources can be found in the Complaints section on the Hub, and in the Appendices below.

5.3 Exceptions

In certain circumstances, concerns and complaints may be excluded from the scope of this policy.

Such exclusions are as follows:

- private care and treatment or services (including private dental care or privately supplied spectacles); except for those patients having private care in one of the Trust's facilities and the complaint is about care and treatment.
- services not provided or funded by the HSC, e.g., provision of private medical reports;
- the independent regulated sector (except for services commissioned by the Trust)
- staff grievances (the Trust has separate procedures for handling staff grievances. Staff may, however, complain about the way they have been dealt with under the HSC Complaints Procedure and, provided they have exhausted the local grievance procedure, may take the matter up with the Ombudsman)
- staff complaints
- an investigation under the disciplinary procedure
- an investigation under SAI investigation
- an investigation by one of the professional regulatory bodies
- services directly commissioned by Health & Social Care Board (HSCB)
- a request for information under Freedom of Information
- access to records under the Data Protection Act 1998
- an independent inquiry
- a criminal investigation
- protection of vulnerable adults
- child protection procedures
- Coroners cases
- legal action

In such circumstances the Chief Executive (or relevant delegated Director) should inform the person outlining why the exclusion applies.

6.0 MONITORING

Implementation / Resource requirements:

The effectiveness of this policy is monitored and reported through:

Governance Structure

There are designated groups with operational responsibility for the oversight and monitoring of complaints process within the Trust Assurance Framework, including the Learning from Experience Group, Assurance Group and Assurance Committee, a standing committee of Trust Board.

The Complaints Review Group meet quarterly to review the number of on-going complaints, spot trends, discuss cases of specific concern and agree shared learning.

At a service level, governance meetings are held on a regular basis and complaints are

included as a standard agenda item for these meetings. The learning from complaints is incorporated on the agenda and discussed at these meetings.

An annual Comments, Concerns, Complaints and Compliments Report is generated and reported through the Trust Assurance Framework structures and published on the Trust website as required by statutory regulation.

Compliance with this policy will be undertaken through the Complaints Review Group who will continuously monitor the number of complaints received, any trends, and the results of complainant satisfaction surveys, the number and outcome of Ombudsman cases, the number of re-visited complaints together with training records for front-line health care staff.
Any identified areas of non-compliance or gaps in assurance arising from the monitoring of this policy will result in recommendations and proposal for change to address areas of non-compliance and/or embed learning.

7.0 EVIDENCE BASE/REFERENCES

DHSSPSNI Complaints Standards and Guidelines for Local Resolution and Learning – April 2009 - Amended June 2013
HPSS Complaints Procedure Regulations: April 2009
The Children (NI) Order 1995:
Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling and Good Administration

8.0 CONSULTATION PROCESS:

Senior Managers within Risk & Governance
Governance Leads within the Service Directorates
Staff side
Human Resources and Equality Department
Independent Service User Group.

9.0 APPENDICES / ATTACHMENTS

Listed in contents

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☐

SIGNATORIES

[signature]

________________________________ **Date: ____March 2017____**

Director

Appendix 1- Record Keeping

1. Complaint records and correspondence about complaints will be kept separately from clinical records, subject to the need to record information which is strictly relevant to patient's health in clinical records.

2. A record of a complaint should include:

   - the name of the complainant,
   - DOB
   - address
   - contact details
   - where appropriate Health and Care number, Dept/ Ward/ Facility and GP details
   - clear details of all issues identified in the complaint
     - who or what is being complained about, including the names of staff if known
     - where and when the events of the complaint happened
     - where possible, what remedy is being sought- e.g. an apology or an explanation or changes to services
   - confirmation of advice given on consent when appropriate

3. When the Directorate Complaint / Enquiry Record Form (Appendix 7) is completed this should be forwarded to the Complaints Department immediately for acknowledgement and action.

4. A complaint file has the same status as any other record created by a healthcare organisation and is therefore a confidential record.

5. The Trust will ensure that the management and storage of complaint files is consistent with relevant guidance including Data Protection, and Good Management Good Records

6. All correspondence regarding the complaint will be marked 'confidential'.

7. The minimum recommended period for retaining a complaint file is *ten years* from the date on which action was completed. For complaint about children and young people the file must be kept until the patient's 25th birthday.

8. Files must be disposed of under confidential conditions (Records Management)

9. Confidential information sent outside the Trust must have the appropriate level of security applied (e.g. encryption, password protection etc).

Appendix 2- Consent, confidentiality, and third party confidence

Staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information as set out in the Data Protection Act and the Human Rights Act.

Where a service user is the complainant, it is good practice to explain that information from health and social care records may need to be disclosed to those involved in investigation of the complaint. If the service user objects to this, it should be explained that this could compromise the investigation and potentially result in an unsatisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is a significant public interest in continuing with the matter.

Where the complainant is not the patient it is necessary to obtain the patient's written consent to use personal information when investigating a complaint. Third party complaints may be made by a service user's relative, friend, carer, or other representatives (such as their solicitor) provided the service user has given his/her written consent. In such circumstances the Complaints Team will forward a consent form to the relevant person(s) requesting authorisation. The Complaints Manager, in discussion with the Service Directorate Director, Data Protection Officer, or other senior person, will determine whether the complainant has sufficient interest to act as a representative.

The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative the Trust will provide information in writing to the person outlining the reasons the decision has been taken. Where Consent has not been received, the complaints response will not be released. A second request letter to the complainant will be sent advising that consent is required. If consent has not been received, a third and final letter will be sent advising that the complaint will be closed within a stated timeframe.

There may, however, be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the individual is deceased.

Third Party Confidence

The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social service professional. Only that information which is relevant to the complaint should be considered for disclosure, and then only to those within the HSC who have a demonstrable need to know in connection with the complaint investigation.

Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure. Disclosure of information provided by a third party outside the HWSC also requires the express consent of the third party. If the third party objects, then it can only be disclosed where there is an overriding public interest to do so.

Information on consent can be found in the Department of Health Good Practice in Consent guidance. Staff are also directed to the Department of Health Code of Practice on Protecting the Confidentiality of Service Users.

Use of Anonymised Information

Where anonymised information about a patient/client and/or third parties would suffice, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use information, then it can only be used where there is an overriding public interest in doing so.

Appendix 3-Grading of a Complaint

It is the responsibility of the Complaints Manager to ensure that all complaints are graded using the risk grading process as outlined in the Adverse Incident Reporting Policy and Procedure including Adverse Incident Investigation Procedure. The grading will also be agreed with the Service Directorate Manager. This will determine the level of investigation required and whether any additional actions need to be taken, such as a Serious Adverse Incident Review by Root Cause Analysis, or liaison through the Coroner or involvement of the Trust Safeguarding Team.

All complaints graded as high or extreme risk will immediately be highlighted to the Senior Complaints Manager who will inform the Co-Director of Risk and Governance and the Co-Director of the Service Directorate who will be responsible in informing the relevant Director. It is the responsibility of the Director to inform the Chief Executive.

Where a complaint is received and graded as high or extreme risk, consideration should also be given to ascertain if this will meet the SAI reporting criteria. This should be highlighted to the Risk and Governance Manager and the Service Directorate. In cases where the complaint is graded as high risk (red) the Co-Director / Director will agree the level of investigation to be carried out e.g. Root Cause Analysis (RCA). If the complaint is high risk but does not meet SAI criteria, consideration should be given by the Director to undertaking an independent investigation.

Where a complaint falls into the SAI criteria, the complaint investigation can continue if the complaint does not involve the serious adverse incident investigation. It is the responsibility of the appointed Chair of the Serious Adverse Incident Panel to agree a communication plan and ensure the complainant is contacted at the earliest opportunity and provided with information contained in the serious adverse incident leaflet. The final outcome of the investigation will be shared with the complainant.

Complaints can be escalated to Serious Adverse Incident (SAI) status. Where this occurs, the Chief Executive (or designated Director), must advise the complainant in writing that an SAI investigation is under way and that although the complaints process will be suspended for any SAI-related element(s) of the complaint pending completion of appropriate investigation, any aspect of the complaint not covered by the SAI process will continue to be investigated under the HSC Complaints Procedure.

The overall consideration must be to ensure that when the investigation has moved into the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

All other complaints will be investigated accordingly to the degree of the grading.

Where a complaint is received and the issues are already subject to another investigation (e.g. Professional Body, Ombudsman, Police Inquiry) the complaint cannot be processed until this investigation is completed. The complainant will be advised of this by the Complaints Department. If the complainant wishes they can then re-engage with the HSC Procedure should they remain dissatisfied.

APPENDIX 3 continued- BHSCT Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016)

BHSCT RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table				
Likelihood **Scoring Descriptors**	**Score**	**Frequency** **(How often might it/does it happen?)**	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

	Consequence Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

- **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.**
- **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
- **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
- **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Appendix 4 - Investigation and Resolution

1. The purpose of the complaint investigation process is to establish the facts, to identify areas for improvement, and gain 'resolution' for the complainant. On occasion this process may identify areas of individual concern that will then be investigated separately.
2. The nature and grade of the complaint will influence the level of investigation and notification/cascade throughout the Trust. All complaints will be thoroughly investigated in a manner appropriate to resolving the issues in an efficient and effective manner within the agreed timeframes.
3. Higher graded complaints require prompt action and a robust investigation. They may require the involvement of investigating contributors external to the Directorate or even external to the organisation. In complex cases consideration should be given to the use of Independent Persons to help resolve the complaint. Any requests for factual amendments to independent expert reports (including SAIs) must be fully reasoned, explained and recorded. Only an independent expert or SAI panel (as appropriate) can agree and sign off on amendments to their report.
4. On receipt of the complaint from the Complaints Department, the Service Manager will ensure the appropriate person(s) are promptly identified to carry out the investigation. The level of investigation must be proportionate to the grading of the complaint. Complaints made in relation to Inequalities Human Rights or Disabilities should also be forwarded to the Health and Inequalities Manager for information.
5. All investigations should be undertaken by a suitably trained person and conducted in a manner that is supportive to all those involved. The Investigating Officer will oversee the quality and timeliness of the investigation to ensure it has been thorough and addresses all the issues raised by the complainant. The Complaints Manager's role is to continuously monitor progress and escalate any delays or difficulties to the Co-Director if necessary.
6. The Investigating Manager will assess the complaint, and plan the scope and approach to the investigation. They should contact the complainant to introduce themselves and where appropriate, clarify any issues in the complaint. They should also provide a point of contact should the complainant wish to raise any questions during the course of the investigation.
7. A scoping meeting should be held **within 48 hours** of receipt of each complaint to identify any immediate actions and support the investigation planning. This includes identifying the key staff who will be required to contribute to the investigation. The Investigating Manager should establish the facts relating to the complaint and assess the quality of the evidence and call upon the services of others if required.
8. Where staff are directly involved in the complaint, statements will be taken at the time of the investigation as an accurate account of events. Individuals may be interviewed by: -
   - Line manager / Senior Manager with the appropriate level of seniority
   - An independent person with appropriate level of seniority
   - A relevant Medical, Clinical, Nursing or Professional person with the appropriate level of understanding and Seniority.
   - Senior Manager Complaints & Legal Services / Complaints Manager where appropriate.
   - Governance Manager where appropriate
9. In certain circumstances it may be preferable for two persons to interview the individual. Consideration must be taken to ensure that the interviews are carried out in a non- blame manner and that the interview is fair, proportionate to the complaint and independent.
10. The interviewing person should always review any relevant documentation that may have bearing on the complaint. This will include medical, nursing, social work or any other patient

/client notes that may be relevant. The interviewer(s) will then formulate their report / response based on the information received and forward to the Investigating Manager.

11. Where it is not possible for an interview to take place the individual named in the complaint will be asked to respond in writing. This response together with the relevant patient/client notes must always be peer reviewed by an appropriate person with the appropriate level of skills and understanding of the speciality. This peer review must be clearly documented and sent as part of the investigation to the Investigating Manager.

12. It is recognised that involvement in both the complaints and investigation processes can be distressing for staff. It is therefore important that staff named in a complaint are appropriately supported throughout, and if necessary following, the investigation process.

13. On the occasion where an individual person is named more than twice within a period of one year the Director/ Co-Director for the Directorate will be informed.

14. Where professional issues are identified in a complaint the appropriate Executive Director will be notified and sent a copy of the complaint and when available a copy of the draft response for information.

    If the staff member is a Doctor or a Dentist, the Medical Director, Associate Medical Director and relevant Clinical Directors for the Directorate will be informed.

    If the staff member is a Nurse, the Director of Nursing and User Experience will be informed.

    Information will be provided by the Complaints Department annually regarding all medical and nursing staff named in complaints for inclusion in the appraisal process.

    If the member of staff is a Social Worker, the Director of Children's Community Services and Adult Social and Primary Care will be informed.

    If the member of staff is an Allied Health Professional the Director of Unscheduled and Acute Care will be informed.

15. The Investigating Manager will collate the information and formulate into a response. This response is then ratified or signed off by the Co-director /senior manager and then forwarded to complaints department. Staff must also be kept informed of the investigation and have the opportunity to review the draft response prior to the Director signing off. All investigation correspondence should be uploaded onto DATIX web.

16. It may be appropriate depending on the complexity of the complaint that a meeting is offered to the family to discuss the outcome of the investigation. This decision would be agreed by the Complaints Manger and Service Directorate Manager. A meeting should be offered as routine in every complaint relating to the death of a patient / service user.

17. On completion of the investigation, the Investigating Manager should prepare a draft response. The response should include and explain how the investigation was carried out and how the conclusions were reached. This draft response must be shared with the relevant staff to ensure factual accuracy and agreement. It should then be ratified by the Co Director / nominated person before being forwarded to the Complaints Department for quality checking and then forwarded to the Director for final signature.

18. Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. It is important that the Complaints Manager is informed of any delays to ensure that the Complainant is kept updated.

Appendix 5 -Responding to a comment, concern or complaint

Comments, concerns, complaints and compliments from patients/ relatives/carers and the public are encouraged and welcomed.

Should patients/relatives/carers or the public be dissatisfied with the care provided by the Trust they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously.

Under no circumstances should patients/relatives/carers be treated any differently as a result of making a complaint. At the outset of any comment, concern or complaint, it is imperative that the complainant is actively listened to and asked to establish the outcome he/she is seeking.

1. Early Local Resolution

When something has gone wrong, patients/relatives/carers are encouraged to raise concerns or make a complaint as soon as possible and directly to the staff involved. This is often front line staff in wards, clinic, and reception. All Trust staff, as a means of improving service provision, will deal with concerns or complaints in a positive manner.

In the majority of circumstances the quickest and most effective way of resolving a concern or complaint is to deal with the issues when they arise as soon as possible. Usually this is best undertaken as close to the point of care/service delivery as possible.

If the concern or complaint requires further investigation or if the complainant wishes to address their concerns to somebody not involved, the complainant will be referred to the Complaints Department.

On receipt of a concern or complaint, the first responsibility is to ensure that the patient's immediate health needs are being met.

Records should be kept of all discussions, local actions taken etc and forwarded to the Complaints Department upon resolution of the issues.

2. Formal Complaints

In cases where early/frontline resolution has not been possible, the Complaints Department will be notified and will offer assistance to the complainant. Concerns and complaints received into the Trust by other means (eg sent directly to CEO office) will be promptly forwarded to the Complaints Department.

At the outset, the Complaints Department will identify a named Complaints Manager to be the single point of contact for the complainant, with whom they can liaise throughout the process. The Complaints Manager should establish with the complainant the outcome he/she is seeking.

The nature and grade of the complaint will influence the level of investigation and the level of notification/cascade throughout the organisation. A framework to support this decision-making can be found in the Trust Risk Matrix, *(see Appendix 3).* Higher graded complaints require prompt action, more robust investigations and may require the involvement of external investigators.

It is the responsibility of the relevant Investigating Officer to prepare the draft complaint response from the information obtained during the investigation. The response should be clear, accurate, balanced, simple, and easy to understand. It should aim to answer all the issues raised by the complainant, in an open and honest way, explaining the situation, why it occurred and the action taken or proposed action. Where possible this should be provided to the relevant Complaints Manager within 10 working days from receipt of the complaint.

3. Meeting a Complainant

If a meeting is arranged with a complainant at any point in the complaint management process the Investigating Officer in collaboration with the Complaints manager will ensure that:-

- an appropriate time and venue for the meeting is arranged
- the complainant receives details of the meeting a minimum of 5 working days prior to the meeting
- an agreed agenda is sent to the complainant and attendees a minimum of 5 working days prior to the meeting
- arrangements are made to meet the complainant prior to the meeting
- the relevant Trust staff are present at the meeting
- where appropriate a Complaint's Manager is present at the meeting
- a record is kept of the meeting (this may be in the form of written notes or a digital recording). The Service Area should provide a minute-taker at family meetings. A copy of the meeting notes should be sent to the Complaints Department for issue to the complainant (if requested) no later than 10 working days from the date of the meeting.

4. Complaint Response

All complaints will receive an open, fair and honest response. The complainant may prefer to receive their response via letter, email, at a meeting or by a telephone call (telephone conversations will usually be followed up in writing or via an email). A response does not need to be long or to provide a detailed account of dates/times of events, however it should:

- include an apology for the poor experience
- address the issues raised in a proportionate and fair manner
- acknowledge the importance of receiving feedback
- avoid abbreviations, and if possible use of technical jargon. Explain any technical words, phrases or procedures
- provide a full explanation of all issues raised
- acknowledge if the service/treatment provided fell below the expected standards of the Trust.
- detail any learning, actions taken or proposed to put the matter right and prevent recurrence
- offer to meet the complainant if appropriate
- indicate that a named person is available to clarify any aspect of the letter
- indicate the right to escalate their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

In line with DHSSPS guidance, complaints must be investigated and the complainant issued with a written response (signed by the relevant Director, on behalf of the Chief Executive) within 20 working days where possible. If for any reason this is not possible the complainant must be advised of the delay as soon as possible, including an explanation of the reason(s) for the delay and a time frame within which they are likely to receive a full reply.

When the Service Directorate Manager and Co-Director / nominated person is satisfied that the complaint has been fully addressed and has agreed the draft response, this should be promptly forwarded to the Complaints Manager together with all relevant documentation and copies of all investigative reports.

Upon receipt of the ratified response letter, the Complaints Manager will quality check the response to ensure accuracy of details and that the letter adequately addresses all issues raised by the complainant before promptly forwarding the final draft response for signature by the relevant Director.

When the final response is signed off by the Director, the Director's secretary will promptly send the letter to the complainant and return a copy of the signed letter to the Complaints Manager for the complaint file. The complaint is then closed.

If upon receiving the response letter the complainant remains dissatisfied they can contact the Complaints Department. This must be done within 3 months from the date of the Trust's response. Consideration will then be given to revisit the complaint for further local resolution. This may include advocacy, conciliation or the use of lay persons. The Complainant can also contact the Northern Ireland Public Services Ombudsman (the Ombudsman) at this stage.

5. Closure of Complaints

When a final letter has been sent by the relevant Director, or the process agreed with the complainant has been completed, the complaint is closed on the DATIXweb

In those occasions where a complainant highlights issues that have not been addressed, this is known as a're-visited' complaint. This should be investigated as soon as possible and the investigation and letter should follow the process as for the original complaint. If the complainant raises new issues, the designated Complaints Manager will formally determine whether the complaint should be deemed as a new complaint and update DATIXweb accordingly.

While every effort must be made to ensure that a response has covered all the issues raised by the complainant in an open, honest and fair manner, it may not be possible to resolve a complaint where the complainant's expectations of the outcome are unrealistic. In these circumstances the relevant Director should consider referring the complaint to the Ombudsman as an independent arbitrator.

6. Learning from complaints

The Trust is strongly committed to the concept of continuous learning, and to listening to the views of patients/relatives/carers and the public about the care and services we provide. We welcome all form of feedback and recognise that comments, concerns, complaints and compliments provide opportunities for organisational learning and improvement to occur.

All trends and themes that are identified through concerns, complaints and compliments are reported through the Complaints Review Group, Learning from Experience Group, Assurance Group and to the Trust Board.

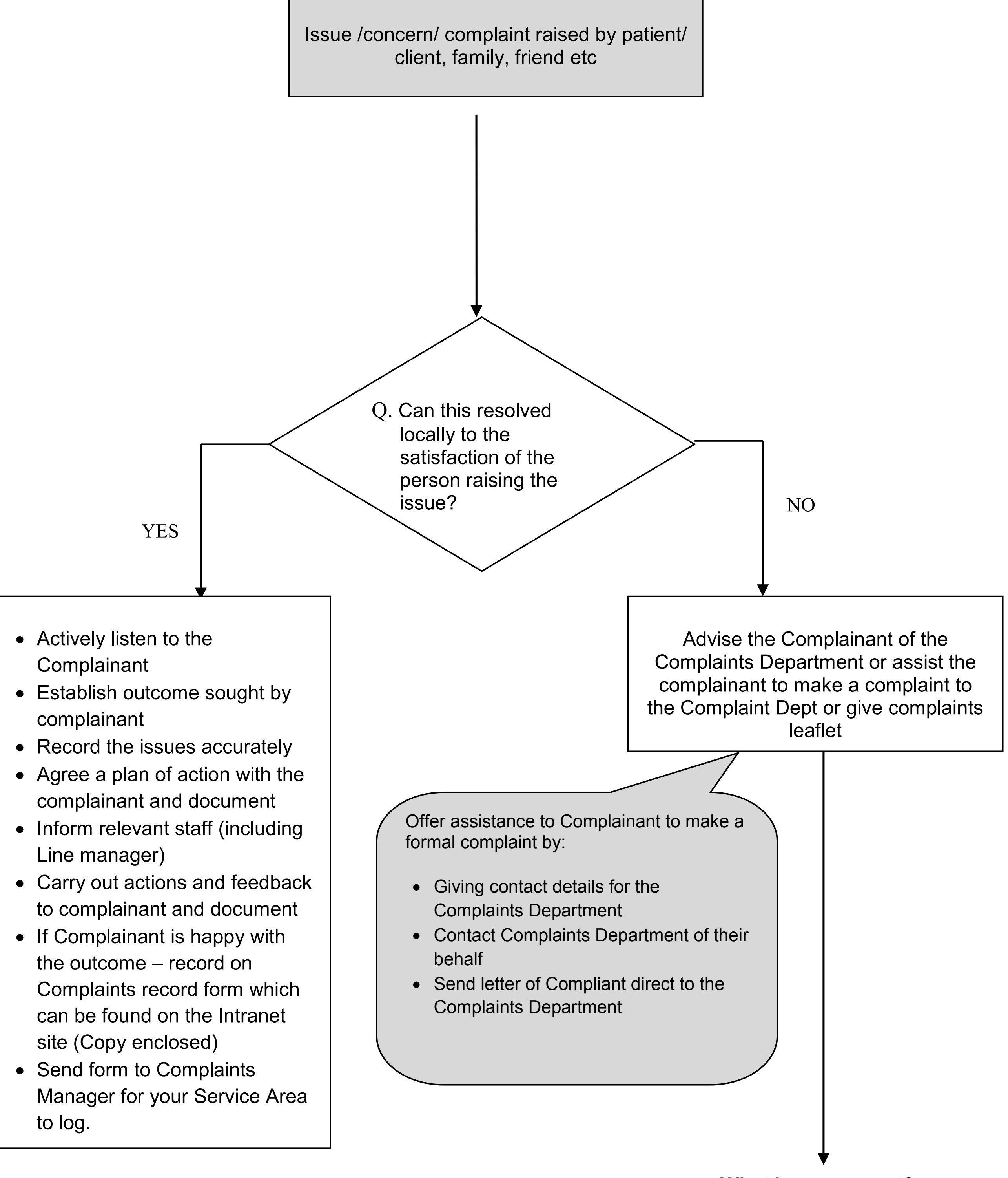
For Directorate complaints with a more local focus, the Investigating Officer for the complaint will produce an action plan for the service area in order to bring about improvements and avoid repetitions of the incident(s) giving rise to the complaint.

Complaints often provide learning that will be relevant to a number of wards / departments beyond that in which the complaint originated. Examples of such Trust-wide learning are presented by Directorates for discussion at quarterly Complaints Review Group meetings and thereafter for consideration by the Learning from Experience Group. Examples of learning are also highlighted in the Trust's quarterly and annual complaints reports.

Feedback should always be given to the individual involved in the circumstances giving rise to the complaint. The Co-Director will identify the most appropriate means of providing such feedback including consideration of necessary measures in response to the complaint investigation findings (such as further training, disciplinary procedures) or advising that no further action will be required.

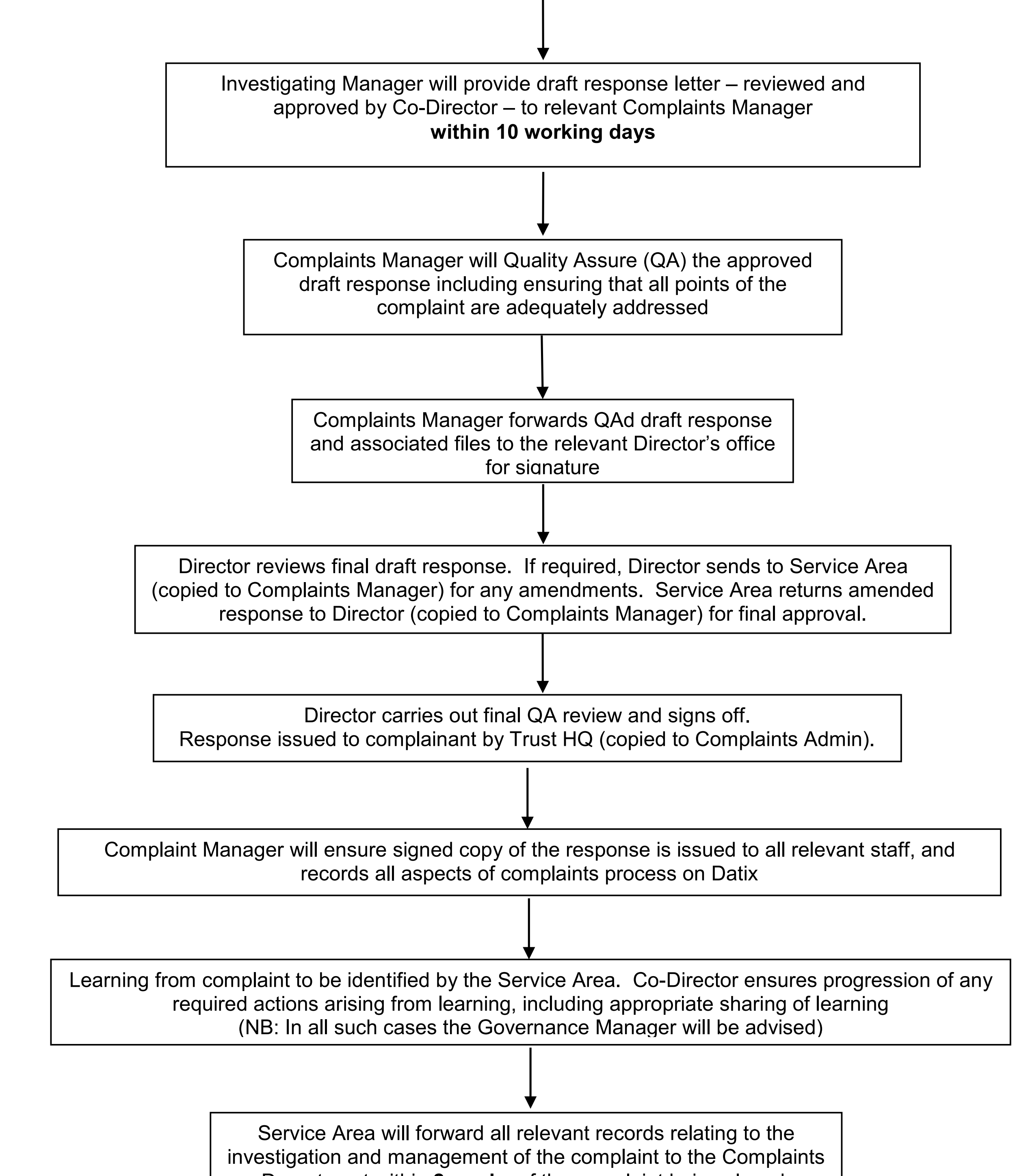
Appendix 6

Flowchart summarising the process for staff to follow when dealing with Complaints



Appendix 6 continued...

Flowchart summarising the process for Service Directorates and Complaints Managers to follow when dealing with Complaints



Appendix 7

Directorate Complaint/Enquiry Record Form

Date:
Time:
Details Taken By:
Location & Service Directorate:

Patient/Client Affected Details

Name:			
Address:			
Contact telephone number (if same person as complainant)			
Date of Birth: (if patient/client)		Hospital Number (if patient/client)	

Complainant Details (if different from above)

Name:	
Address:	
Contact number:	

NB: Consent – Advise complainant, if not patient, that consent may be required

Note of Complaint/Enquiry

Action Taken

Passed to Complaints Department: **NB: This information will be shared with the complaints department for statistical purposes only.**

Please return to: Complaints Department
6th Floor
McKinney House
Musgrave Park Hospital
Belfast
BT9 7JB
Or alternatively email us at: complaints@belfasttrust.hscni.net

Appendix 8 – Internal/ External Support/ Contacts

ADVOCACY AND CONCILIATION

Some people who might wish to complain do not do so because they do not know how to, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their wishes and views known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

Within the Health and Social Care sector, advocacy has been available mainly for vulnerable groups, such as people with learning problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and can be intimidated by professional attitudes that may seem paternalistic and authoritarian.

The Trust should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to gain a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations such as:

- where staff or practitioners feel the relationship with the complainant is difficult
- when trust has broken down between the Trust and both parties feel it would assist in the resolution of the complaint
- where it is important, e.g. because of on-going care issues, to maintain the relationship between the complainant and the Trust
- when there are misunderstandings with the relatives during the treatment of the patient

All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

Complaints raised by unreasonable, vexatious or abusive complainants are NOT suitable for conciliation.

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, e.g. if there is a breakdown in the relationship between a doctor or practitioner and their patient.

Conciliation may be requested by the complainant or the Trust.

COMPLAINTS DEPARTMENT

The BHSCT Complaints Department is located at:

Musgrave Park Hospital
McKinney House
Stockman's Lane
Belfast
BT9 7JB

Tel: 028(95) 048000
Fax: 028(90) 903018

LAY PERSONS

A Lay Persons is an independent person that does not act as an advocate, conciliator or investigator. Neither do they act on behalf of the complainant or complained about. Their involvement is to help bring about resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised.

NORTHERN IRELAND PUBLIC SERVICES OMBUDSMAN

The Northern Ireland Public Services Ombudsman (the Ombudsman) can carry out independent investigations into complaints about poor treatment or services or the administrative actions of the Trust. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly- and the Trust or practitioner has not put things right where they could have- the Ombudsman may be able to help.

The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman

Freepost NIPSO
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Tel: 028 90 233821
Freephone: 0800 34 34 24
Text phone: 028 90 897789

email: nipso@nipso.org.uk

PATIENT AND CLIENT COUNCIL

The Patient and Client Council (PCC) is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public
- promoting involvement of the public
- providing assistance to individuals making or intending to make a complaint
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services

If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the Complaints Procedure and advice on how to take a complaint forward
- discussing the complaint and drafting letters
- making telephone calls
- helping prepare for a meeting and accompanying the complainant
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services;
- help on accessing medical / social services records.

All advice, information and assistance with complaints are provided free of charge and are confidential. Further information can be obtained from; **www.patientclientcouncil@hscni.net** or Freephone 0800 917 0222

REGULATION AND QUALITY IMPROVEMENT AUTHORITY - (RQIA)

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. The Regulation and Quality Improvement Authority will monitor how complaints about the regulated services are handled.

Contact Details:

The Regulation and Quality Improvement Authority Headquarters
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Email: info@rqia.org.uk

Telephone number: 028 9051 7500
Fax: 028 9051 7501

Appendix 9 – Unreasonable, vexatious or abusive complaints

All Trust staff should respond to complainants in an appropriate and professional manner. However, there may be times when nothing can reasonably be done to assist a complainant and where further contact with a complainant places inappropriate demands on resources.

In such cases and in consultation with Senior Manager/ Co-Director will establish if the “Unacceptable Actions Policy”. Or Guidance for the handling of Habitual or Vexatious complains should be considered.

1. Introduction

The difficulties in handling unreasonable, vexatious or abusive complainants place an unreasonable strain on time and resources and can cause undue stress for staff that may need support in these difficult situations. Staff should respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further which can be reasonably done to assist them or to rectify a real or perceived problem.

In determining arrangements for handling such complainants, the Trust is presented with two key considerations:

a) To ensure that the complaints procedure has been correctly implemented so far as is possible and that no material element of a complaint is overlooked or inadequately addressed, and to appreciate that even habitual or vexatious complaints may have aspects to their complaints which contain some genuine substance. The need to ensure an equitable approach is crucial.

b) To be able to identify the stage at which the complainant has become habitual or vexatious.

2. Purpose of the Guidance

The aim of the guidance is to identify situations where a complainant might be properly considered to be habitual or vexatious and to suggest ways of responding to these situations.

It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken to try and resolve complaints following the Trust’s complaints procedure, i.e., through local resolution.
Judgement and discretion must be used in applying the criteria to identify potential or vexatious complainants and in deciding action to be taken in specific cases.

The procedure should only be implemented following careful consideration of the actions and behaviour of a complainant by a Director of the Trust, in conjunction with the relevant Patient/Client Liaison Manager.

3. Definition of an unreasonable, vexatious or abusive complainants

Complainants (and/or anyone acting on their behalf) may be deemed to be unreasonable, vexatious or abusive where previous or current contact with them shows that they meet any one of the following criteria:

Where complainants:

a) persist in pursuing a complaint after the Complaints Procedure has been fully and properly implemented and exhausted (e.g. where investigation has been denied as 'Out of time')

b) change the substance of a complaint or continually raise additional issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response (Not all complainants who raise further concerns or questions on receipt of a response are vexatious. They may be doing so to seek clarification as part of the local resolution process. Care must be taken not to discard new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints)

c) are unwilling to accept documented evidence of treatment given as being factual, e.g. drug records, medical or computer records, or deny receipt of an adequate response in spite of correspondence specifically answering their questions, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed

d) do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of staff to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate

e) focus on a relatively minor matter to an extent, which is out of all proportion to its significance and continue to focus on this point (It is recognised that determining what a '*relatively minor*' matter can be is subjective, therefore careful judgement must be used in applying this criteria)

4. Dealing with unreasonable, vexatious or abusive complainants

A Director of the Trust and/or nominated deputies may decide to deal with complainants in one or more of the following ways:

a) Once it is clear a complainant meets any one of the criteria above, they should be informed in writing that they may be classified as habitual or vexatious complainants. This procedure should be copied to them and they should be advised to take account of the criteria in any further dealings with the Trust.

b) Decline any contact with the complainants either in person, by telephone, by fax, by email, by letter or any other combination of these, or restrict contact to liaison through a third party (If staff are to withdraw from a telephone conversation with a complainant, it may be helpful to have an agreed statement to be used at such times).

c) Notify the complainants in writing that a Director of the Trust has responded fully to the points raised, and have tried to resolve the complaint, that there is nothing more to add and continuing contact will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

d) Inform the complainants that in extreme circumstances, the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors or to the Police if violence or threats are made against staff.

e) Temporarily suspend all contact with the complainants regarding their complaint whilst seeking legal advice and advise the complainant accordingly. It may still be necessary however to continue providing a healthcare service.

5. Withdrawing 'unreasonable, vexatious or abusive' Status

Once a complainant has been identified as 'habitual or vexatious' there needs to be a mechanism in place for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate.

Staff should use discretion in recommending 'habitual or vexatious' status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate.

Where this appears to be the case, a discussion between key staff and the Chief Executive and/or nominated deputies will take place. Subject to his/her approval, normal contact with the complainants and application of the Trust's complaints procedure will then be resumed.

Even correspondence from complainants who have been classified as habitual or vexatious should be screened to ensure that no new complaint has been raised and to determine if the Trust's discretion should be applied.

Appendix 10-Unacceptable Actions Policy

1. Introduction

HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complainants, staff need to:

- Ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- Appreciate that even habitual complainants may have grievances which contain some substance;
- Ensure a fair approach;
- Be able to identify the stage at which a complainant has become habitual.

The following Unacceptable Actions Policy should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

This policy sets out the approach to those complainants whose actions or behaviour HSC organisations consider unacceptable. The aims of the policy are to:

- Make it clear to all complainants, both at initial contact and throughout their dealings with the organisation, what the HSC organisation can or cannot do in relation to their complaint. In doing so, the HSC organisation aims to be open and not raise hopes or expectations that cannot be met;
- Deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered unacceptable. All complainants have the right to be heard, understood and respected. HSC staff have the same rights.
- Provide a service that is accessible to all complainants. However, HSC organisations retain the right, where it considers complainants' actions to be unacceptable, to restrict or change access to the service;
- Ensure that other complainants and HSC staff do not suffer any disadvantage from complainants who act in an unacceptable manner.

2. Defining Unacceptable Actions

People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is assertive or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint.

The actions of complainants who are angry, demanding or persistent may however result in unreasonable demands on the HSC organisation or unacceptable behaviour towards HSC staff. It is such actions that HSC organisations consider unacceptable and aim to manage under this policy.

These unacceptable actions are grouped under the following headings:

a) Aggressive or abusive behaviour

Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance approach must be adopted. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

b) Unreasonable demands

Complainants may make what the HSC consider unreasonable demands through the amount of information they seek, the nature and scale of service they expect or the number of approaches they make. What amounts to unreasonable demands will always depend on the circumstances surrounding the behaviour and the seriousness of the issues raised by the complainant. Examples of actions grouped under this heading include demanding responses within an unreasonable timescale, insisting on seeing or speaking to a particular member of staff, continual phone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

HSC organisations consider these demands as unacceptable and unreasonable if they start to impact substantially on the work of the organisation, such as taking up an excessive amount of staff time to the disadvantage of other complainants or functions.

c) Unreasonable persistence

It is recognised that some complainants will not or cannot accept that the HSC organisation is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the organisation persistently about the same issue. Examples of actions grouped under this heading include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the HSC organisation can or cannot do and continuing to pursue a complaint without presenting any new information.

The way in which these complainants approach the HSC organisation may be entirely reasonable, but it is their persistent behaviour in continuing to do so that is not. HSC organisations consider the actions of persistent complainants to be unacceptable when they take up what the HSC organisation regards as being a disproportionate amount of time and resources.

3. Managing Unacceptable Actions

There are relatively few complainants whose actions a HSC organisation consider unacceptable. How the organisation manages these depends on their nature and extent. If it adversely affects the organisation's ability to do its work and provide a service to others, it may need to restrict complainant contact with the organisation in order to manage the unacceptable action. The HSC organisation will do this in a way, wherever possible, that allows a complaint to progress to completion through the complaints process. The organisation may restrict contact in person, by telephone, fax, letter or electronically or by any combination of these. The organisation will try to maintain at least one form of contact. In extreme situations, the organisation will tell the complainant in writing that their name is on a "no contact" list. This means that they may restrict contact with the organisation to either written communication or through a third party.

The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in the ending of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

HSC organisations do not deal with correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. When this happens the HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful. The HSC organisation will ask them to stop using such language and state that it will not respond to their correspondence if they do not stop. The HSC organisation may require future contact to be through a third party.

HSC staff will end telephone calls if the caller is considered aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that the behaviour is unacceptable and end the call if the behaviour does not stop.

Where a complainant repeatedly phones, visits the organisation, sends irrelevant documents or raises the same issues, the HSC organisation may decide to:

- Only take telephone calls from the complainant at set times on set days or put an arrangement in place for only one member of staff to deal with calls or correspondence from the complainant in the future;
- Require the complainant to make an appointment to see a named member of staff before visiting the organisation or that the complainant contacts the organisation in writing only;
- Return the documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed;
- Take other action that the HSC organisation considers appropriate. The HSC organisation will, however, tell the complainant what action it is taking and why.

Where a complainant continues to correspond on a wide range of issues and the action is considered excessive, then the complainant is told that only a certain number of issues will be considered in a given period and asked to limit or focus their requests accordingly.

Complainant action may be considered unreasonably persistent if all internal review mechanisms have been exhausted and the complainant continues to dispute the HSC organisation's decision relating to their complaint. The complainant is told that no future phone calls will be accepted or interviews granted concerning this complaint. Any future contact by the complainant on this issue must be in writing. Future correspondence is read and filed, but only acknowledged or responded to if the complainant provides significant new information relating to the complaint.

4. Deciding to restrict contact

HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy.

With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff.

Wherever possible, the HSC organisation will give the complainant the opportunity to modify their behaviour or action before a decision is taken.

Complainants are told in writing why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place.

5. Appealing a decision to restrict contact

A complainant can appeal a decision to restrict contact. A senior member of staff who was not involved in the original decision considers the appeal. They advise the complainant in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

6. Recording and reviewing a decision to restrict contact

The HSC organisation will record all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact may be reconsidered if the complainant demonstrates a more acceptable approach. A senior member of staff will review the status of all complainants with restricted contact arrangements on a regular basis.

Appendix 11- Vulnerable Adults

Definition of vulnerable adult

For the purposes of 'Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance' the term 'vulnerable adult' is defined as: *a person aged 18 years or over who is, or may be, in need of community care services* ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation.*

Adults who 'may be eligible for community care services' are those who's independence and well being would be at risk if they did not receive appropriate health and social care support.

They include adults with physical, sensory and mental impairments and
learning disabilities, however those impairments have arisen; e.g. whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

Making a complaint about health and social care can be intimidating, especially for people with mental health problems, learning disabilities or for those who are old or frail. The Trust should have consistent, explicit arrangements in place for advising and supporting vulnerable adults including signposting to independent advice and specialist advocacy services.

Reportable offences and allegations of abuse

Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect then the regional *Safeguarding Vulnerable Adults Policy and Procedural Guidance (Sept 2006)* and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults (Dec 2003)* should be activated (see paragraph 1.26)

Appendix 12- Children Order Representations And Complaints Procedure

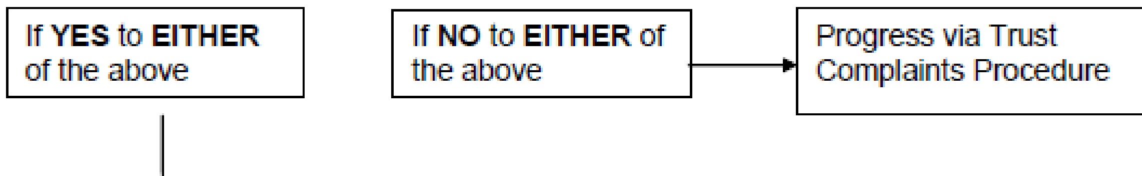
Children Order Representations and Complaints Procedure

1. **Complaint: Does it fit the definition of a Children Order complaint as below?**

"Any representation (including any complaint) made to the Trust…about the discharge of any of its functions under part IV of the Order or in relation to the child." (Children (NI) Order 1995, Article 45 (3))

OR

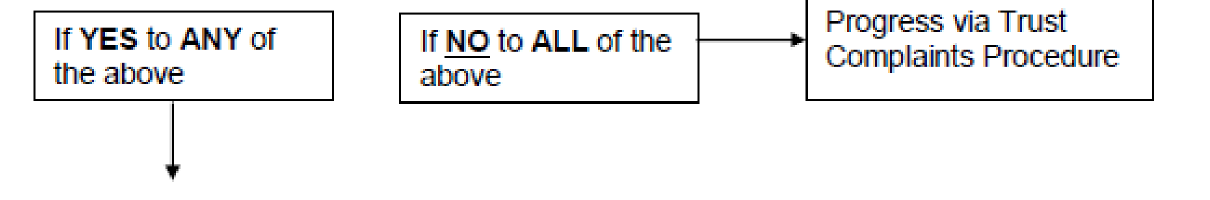
"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and paragraph 6 of Schedule 5 to, the Children Order." (Guidance and Regulations – Vol.4, Para 12.5 – DHSS)



2. **Does it meet the criteria of what may be complained about under Children Order?**

"..about Trust support for families and their children under Part IV of the Order."

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.



3. **<u>Complainant:</u> Does he/she fit the definition of a Children Order complainant?**

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need

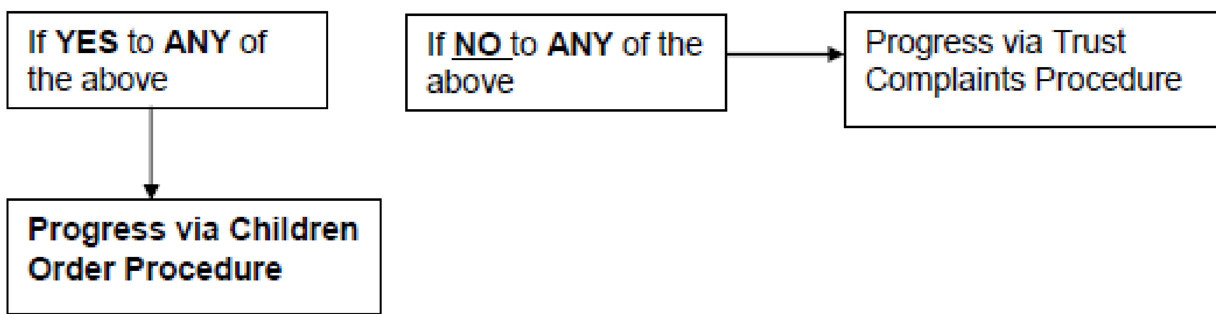
c. A parent **of his/her**

d. Any person who is not a parent of theirs but who has **parental responsibility for them**

e. Any Trust foster parent

f. Such other person as the Trust considers has sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- The person who had the day to day care of the child within the past two years;
- The child's Guardian Litem;
- The person is a relative of the child (as defined by the Children Order, Article 2 (2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- A friend;
- A teacher;
- A general practitioner
  (Children (NI) Order 1995 Article 45 (3))



NB:** For a complaint **to be eligible to be considered under the Children Order Procedure, the answer** to 1 **<u>and</u>** 2 **<u>and</u>** 3 **MUST ALL BE YES.

The Trust should always check with the child (subject to their understanding) that a complaint submitted reflects their views and that they wish the person submitting the

complaint to act on their behalf (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Under the Children (NI) Order 1995 (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under part IV of, and paragraph 4 of Schedule 5 to, the Order and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987.

1. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996.
2. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4
3. All staff should familiarise themselves with these requirements

Appendix 13 - Formal Complaints Escalation Process

Every effort should be made to ensure complaints are responded to within 20 working days. Efficient processes for the prioritisation and management of complaints must be established in all Directorates, with every effort being made by staff to promptly identify potential obstacles to provision of responses within 20 days and to take action (escalating to more senior staff as necessary) to ensure the prompt handling of complaint investigation and response writing.

It is recognised however that there may be instances when, for example the complaint is complex and/or involves several Directorates, that it becomes apparent 20 working days will not afford adequate time to fully investigate the concerns raised. It is vitally important to identify likely delays at the earliest opportunity and to immediately notify the relevant Complaints Manager to allow prompt communication with the complainant.

1. Reminders should be sent by the Complaints Department to the relevant **Service Manager/ Investigating Manager 10 working days** following receipt of the complaint.

2. If a response is not received and no information provided when the response is likely to be completed within **12 working days** from receipt of the complaint, the relevant **Co-Director** will be informed.

3. If no response or contact has been made with the complaints team by the **15th working day,** the relevant **Director** will be informed.

4. Complaints which have not been responded to within the 20 working day time frame will be escalated as follows:

   - Complaints outstanding **after 20 working days**
     A reminder will be sent to the **Service Manager, Co-Director and Director*** highlighting that the complaint is now outside the 20 working day timeframe.

   - Complaints outstanding **after 30 working days**
     A further notice will be sent to the **Co-Director and Director*** advising that the complaint is now well outside of the time frame and urgently requires action. The Medical Director and Co-Director Risk & Governance will be made aware of the delay.

   - Complaints outstanding **after 40 working days**
     An escalation notice will be sent to the Chief Executive

* When a complaint covers a number of Service Areas / Directorates the appropriate Directors will be advised.

Appendix 14 - Northern Ireland Public Service Ombudsman Cases

Receiving Correspondence

1. The Chief Executive's Office will scan correspondence from the Northern Ireland Public Services Ombudsman on the day of receipt and email to complaints@belfasttrust.hscni.net with a copy sent to the relevant Complaints Manager.
2. A hard copy of correspondence will be sent to the Complaints Department via post.
3. Complaints Manager will acknowledge receipt of Ombudsman correspondence from the Chief Executive's Office via email, and initiate appropriate action on the day of receipt.
4. Complaints Admin will acknowledge receipt of correspondence to Ombudsman's Office within 1 working day and confirm the name of the designated Complaints Manager. *Correspondence with the Ombudsman's Office is to be password protected at all times.*

Consideration Stage

The Ombudsman reviews details of the case to decide whether to instigate an investigation.

1. Complaints Admin will open a File to hold all documentation in relation to the Ombudsman's correspondence.
2. Senior Complaints Manager and Complaints Manager will discuss and agree an action plan and confirm which Co-Director will take responsibility for overseeing a response.
3. Complaints Admin will forward to the Service Group for action. A copy will also be sent to the relevant Director/Co-Director.
4. Complaints Manager will remove all duplications from the Complaints File and arrange for a copy to be sent to the Ombudsman's Office within 2 working days.
5. Complaints Manager will provide copies of any relevant complaints information required to the Ombudsman throughout the process. *If original notes are requested, ensure that these are requested and tracked in line with Trust procedures.*
6. Complaints Manager will identify actions with the Co-Director and lead Service Group Manager, and confirm a timeframe for responses to be received by the Complaints Department.
7. Service Group Manager will liaise with Health Records staff, within 2 working days, to arrange for copy of medical records to be sent to Complaints Manager.
8. Service Group Manager will prepare a draft response which addresses all of the issues raised within the agreed timeframe.
9. Complaints Manager will quality assure draft response. They will then send the draft response to the relevant Co-Director for approval, before being signed off by the Director.
10. Chief Executive Office will email the signed response to the Ombudsman's Office and send the hard copy, and any other documents requested, to the Ombudsman's Office via secure transport.
11. Complaints Admin staff will keep information on DATIX up-to-date. *An Ombudsman case should not be closed on DATIX until the final decision is made by the Ombudsman.*

12. The Co-Director will ensure any areas of good practice or issues for concern are highlighted with the relevant managers.
13. All staff will adhere to the Ombudsman's timescales. If there is any reason to anticipate delays that cannot be resolved through escalation measures, approval must be sought from the relevant Director to seek an extension from the Ombudsman's office (see process overview and associated templates below).

Investigation Stage

At this second stage, the Ombudsman has made a decision to accept the complaint for Investigation by the NIPSO Investigation Officers.

BHSCT staff will follow the same steps required during the Consideration Stage above plus:

1. Complaints Managers will review all documentation previously sent to the Ombudsman.
2. Complaints Managers will collate and quality assure any additional information requested.
3. Complaints Admin will arrange a meeting with the relevant staff, including Complaints Manager, to approve draft Trust response and associated enclosures.
4. Complaints Managers will highlight any areas of concern and work with Directorates to draft an Action Plan using the agreed Trust template.

Ombudsman's Draft Report

The Ombudsman provides the Trust with a confidential copy of the draft findings, and allows a short review period for the Trust to respond.

1. On receipt of the Ombudsman's Draft Report, the Complaints Manager will email a copy of the Draft report to all key stakeholders and advise of timescale for response.
2. Complaints Manager may arrange a meeting of all relevant staff to:
   a) Consider and agree the issues raised in the draft findings report
   b) Consider any factual inaccuracies
   c) If appropriate, review all documentation relating to the case
3. Complaints Manager will draft an Action Plan to address any areas of concern highlighted.
4. Service Group Manager will prepare a draft response for the Director's approval.
5. Following the Co-Director's approval of draft response, the relevant Director's Personal Assistant will forward it to the Director/Chief Executive for signature.
6. If appropriate, Complaints staff will prepare for informal meeting with Ombudsman's Office including pre meeting if deemed necessary.

Ombudsman's Final Report

1. The Complaints Manager will acknowledge the final report within 2 working days of receipt.
2. Complaints Manager will draft a letter of apology, to be approved and signed by Director/Chief Executive.
3. Chief Executive Office will issue the letter of apology to the complainant on the Ombudsman's instructions and send a copy to the Ombudsman's office.
4. Complaints Manager will ensure requests for financial redress are processed and appropriately approved and will ensure that the Action Plan is approved and sent to the Ombudsman along with any other documents, if requested.
5. Complaints Manager will record the outcome of the Ombudsman's investigation on the DATIX database investigation screen and close the complaint.
6. Complaints Manager will document Ombudsman cases in the Trust Quarterly and Annual Complaints Reports and other reports as required.
7. Senior Complaints Manager will discuss all Ombudsman cases at Complaints Manager meetings and Complaints Review Group, and will ensure recommendations and learning are shared as required.
8. Action Plans arising from Ombudsman recommendations will be presented by Directorates at Complaints Review Group to ensure shared learning and to provide assurance regarding progression of necessary corrective / preventative actions.

Day	Action	Notes
DAY 1	**NIPSO correspondence received via e-mail**	*1 copy to Trust HQ, 1 copy to Complaints Team*
DAY 1	**Complaints Team extract all points of requested information / documentation into template (see Appendix A below) and e-mail to relevant Service Area(s) along with copy of original NIPSO letter.**	*e-mail will be sent to relevant Co-Director(s) and CCd to relevant Director(s)*
DAY 3	**Service Area(s) return completed template to Complaints Team confirming details of staff responsible for each element of the response (including identifying lead person to co-ordinate overall response), and identifying any anticipated delays**	*Completed template to be CCd to relevant Co-Director(s) and Director(s). Agreement to be reached between relevant Directors to assign lead responsibility for complaints involving multiple Directorates*
DAY 3 - 11	**Service Area(s) gather required information and produce draft response to address all points identified by NIPSO.** **Service Area(s) liaise with Complaints Team to provide updates confirming ability to submit response by required deadline.** **Complaints Team issue reminders / update requests to named contact points in Service Area(s) at 7 and 9 working days after receipt of NIPSO request** **Complaints Team escalate non-response to update requests, or indication of delays from Service Area***	*Non-responses will be escalated to Co-Director after 2 working days; identified delays immediately escalated to Co-Director & Director*
DAY 11	**Service Area(s) submits draft response to Complaints Team – <u>all draft responses to be ratified by relevant Co-Director prior to submission to Complaints Team.</u>**	
DAY 12	**Complaints Team QA draft response for completeness, accuracy of personal details and tone and forward to relevant Director.**	*Completed QA Checklist (Appendix C) to be sent to Director with draft response*
DAY 13 – 15	**Director reviews final draft and liaises with Complaints Team regarding any required amendments.** **Director signs off final response**	
DAY 15	**Complaints Team issue response via secure e-mail to NIPSO**	

**If extension to NIPSO deadline is required, request template (see Appendix 2 below) must be completed by Service Area and submitted to Director for sign off. Complaints Team will then submit to NIPSO.*

Complaint C/xxxx/xx NIPSO Ref xxxxx		RESPONSE DUE – BHSCT HQ Deadline __/__/____ – NIPSO Deadline __/__/____					
Lead Contact for final Complaint Response: Directorate ______________________________			Named point of contact______________________________				
NIPSO information / documentation requested			Organisation / Directorate / Service Area	Lead Contact for each query		Any anticipated delays / difficulties in providing the required information by [Insert BHSCT HQ Deadline]?	Any required escalation to ensure provision of required information by [Insert BHSCT HQ Deadline]?
				Name	Contact details		
1	Populated by Complaints Team – to be reviewed by Service Area						
2							
3							
4							
Any additional issues identified by Service Area requiring provision of information as part of NIPSO response:							
5							
6							

Complaint C/xxxx/xx NIPSO Ref xxxxx **DATE REQUESTED BY NIPSO : ____/____/______** **DATE RESPONSE DUE – NIPSO Deadline ____/____/______**					
Outstanding information / documentation*		**Reason(s) for delay**	**Details of escalation / measures taken to address delays**	**Current Status / Comments**	**Expected date response available**
1					
2					
3					
4					
5					
Completed by: (Signature) ______________________________ (Printed Name) ______________________________ Role: _________________________ Date:____________					
I confirm that the information / documentation detailed above is unable to be provided to the Ombudsman within the required timeframe and as such request an extension to the indicated deadline. Signed (Director):____ Name :____ Date:______________________					
Received Complaints Department: Date ________________ Complaints Manager: _________________________ Date submitted to NIPSO: ____________________					

**NB Extension requests should only be made in exceptional circumstances where the requested information remains unavailable despite every reasonable effort having been made by the Service Area to provide a response. Full reasons for delays must be detailed, and the extension request signed off by the relevant Director. Extension requests should be made as promptly as possible once an unavoidable delay has been identified. Where multiple pieces of information / documents have been requested by the Ombudsman, a partial response incorporating all available elements should be submitted by the required deadline, with the extension request only applying to outstanding areas.*

Complaint C/xxxx/xx NIPSO Ref xxxxx Response Due: BHSCT HQ Deadline __/__/____					NIPSO Request Date __/__/____ NIPSO Deadline __/__/____
	Response element	Y	N	N/A	Comments / Action Taken
1	Is font Arial, size 12 used and are all paragraphs fully justified?	☐	☐	☐	
2	Are reference number, date, address, salutation line and complainant details accurate throughout?	☐	☐	☐	
3	Does the response fully address all the points raised by the Ombudsman's Office?				
	i	☐	☐	☐	
	ii	☐	☐	☐	
	iii	☐	☐	☐	
	iv	☐	☐	☐	
	v	☐	☐	☐	
	vi	☐	☐	☐	
	vii	☐	☐	☐	
	viii	☐	☐	☐	
4	Are there any spelling mistakes	☐	☐	☐	
5	Are there any disparities / conflicting statements	☐	☐	☐	
6	Is the tone of the response appropriate and are apologies included where appropriate?	☐	☐	☐	
8	Does the response include information detailing corrective action taken, or where learning and improvement have been identified if relevant?	☐	☐	☐	
9	Is plain English used, and medical terminology and jargon kept to a minimum and explained fully if necessary?	☐	☐	☐	
10	If policies, procedures or good practice guides are being specifically relied upon, are they clearly identified and enclosed where required?	☐	☐	☐	

Complaints Department

Completed by: ______________________________________ *Role:* _____________________________ *Date:*_____________

Trust HQ

Comments: (about any required amendments or other concerns)

Signed……………………………………………………………………. (Director) **Date……………………………**

Reference No: TP 45/10

Title:	**Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments**				
Author(s)	Rachel Maxwell, Senior Manager, Licensing and Regulations, Complaints, Bereavement, Tel: [redacted] [redacted]				
Ownership:	Dr Chris Hagan, Medical Director				
Approval by:	Trust Policy Committee Executive Team Meeting			Approval date:	2 April 2020 8 April 2020
Operational Date:	April 2020			**Next Review:**	April 2025
Version No.	4	**Supersedes**	V3 – March 2017		
Key words:	Complaint, comment, concern, compliment, investigation, learning, action plan, shared learning, professional assurance, Ombudsman				
Links to other policies	BHSCT Adverse Incident Reporting and Management Policy TP 08/08 (2018) BHSCT Policy for Sharing Learning TP 98/14 (2016) BHSCT Being Open policy – saying sorry when things go wrong SG 56/11 (2018) DoH Complaints Standards and Guidelines				

Date	**Version**	**Author**	**Comments**
25/06/2019	3.1	Rachel Maxwell	Initial Draft
20/09/2019	3.2	Rachel Maxwell	Amendments / Comments
08/01/2020	3.3	Rachel Maxwell	Amendments to reflect Medical Director's Comments

CONTENTS

1.0	**Introduction/Purpose of Policy**	**Page 3**
2.0	**Scope of the Policy**	**Page 4**
3.0	**Roles and Responsibilities**	**Pages 4-11**
4.0	**Key Policy Principles**	**Pages 11-14**
5.0	**Implementation of Policy**	**Page 16**
6.0	**Monitoring**	**Page 17**
7.0	**Evidence Base/References**	**Page 17**
8.0	**Consultation Process**	**Page 17**
9.0	**Appendices / Attachments**	**Page 18**
10.0	**Equality Statement**	**Page 18**
11.0	**Data Protection Impact Assessment**	**Page 18**
12.0	**Rural Impact Assessments**	**Page 19**
13.0	**Reasonable Adjustments Assessment**	**Page 19**

Appendices/Attachments:

1	Responding to a comment, concern or complaint	**Pages 20-30**
Frontline Complaint Record Form		*21*
Complaint Response QA Checklists		*23*
Complaint Closure Form		*24*
Shared Learning Template		*30*
2	Grading of a complaint	**Pages 31-34**
Risk Matrix		*33-34*
3	Complaint Investigation and Resolution	**Pages 35-38**
Clinical Record Review Flowchart		*37*
Clinical Record Template		*38*
4	Complaints Process Flowcharts	**Pages 39-41**
Complaints Management Process		*39-40*
Professional Assurance Process – Complaints		*41*
5	Vulnerable Adults Policy	**Page 42**
6	Children Order Representations and Complaints Procedure	**Pages 43-45**
7	Formal Complaints Escalation Process	**Page 46**
8	Northern Ireland Public Service Ombudsman Cases	**Pages 47-66**
NIPSO pathway flowchart		*50*
NIPSO Correspondence Protocol		*51*
NIPSO Response Tracker		*52*
NIPSO Extension Request Template		*53*
NIPSO Response QA checklist		*54*
9	Record Keeping	Page 56
10	Consent confidentiality, and third party confidence	Page 57
11	Internal/ External Support Contacts	Pages 58 - 60
12	Unreasonable, vexatious or abusive complaints	Pages 61 - 63
13	Unacceptable Actions Policy	Pages 64 - 67

1.0 INTRODUCTION/PURPOSE OF POLICY

1.1 Background

In the patient-centred environment of the Belfast Trust, patients, relatives and carers are encouraged to express their views about the treatment and services that they receive.

We recognise the need to have an effective process for managing comments, concerns, complaints and compliments about any aspect of care or treatment provided or commissioned by the Belfast Trust in hospital or community settings. The purpose of the complaint investigation process is to establish the facts, to identify areas for improvement, and gain 'resolution' for the complainant. On occasion this process may identify areas of individual concern that will then be investigated separately.

It is essential that all concerns and complaints are received positively, investigated promptly and thoroughly, and responded to sympathetically. Timely and effective action should be taken where appropriate to prevent recurrence when services provided have fallen below acceptable standards.

1.2 Purpose:

The purpose of this document is to ensure that:

- complaints are dealt with in line with the DoH Guidance in relation to the Health and Social Care Complaints Procedure

- complaint management processes comply with the Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling and Good Administration

- complaints are handled in a speedy and efficient manner, that is open, accessible, fair, flexible, conciliatory and without blame

- staff are provided with a greater understanding and guidance on Complaint Management procedures within the Belfast Trust to ensure complaints are managed in a positive manner and that learning can take place

The policy promotes local, prompt resolution with involvement of the complainant at the core of the process, and encourages continuous learning and identification of improvements in the quality and safety of services throughout the Trust.

1.3 Objectives

- To ensure that patients/relatives/carers are encouraged to provide feedback about their experiences of treatment and services - to tell us what is working, help identify any potential service improvements, and help identify problems and risk – and that individuals will not be treated differently as a result of making a complaint.

- To learn from comments, concerns, complaints and compliments and use feedback effectively to improve the quality of our services, prevent recurrence of factors giving rise to a concern or complaint, and inform professional assurance processes including identifying areas of individual concern that need separate investigation.

- To ensure that Trust staff are aware of their roles and responsibilities in good customer care and complaints handling, including responding positively to complaints, actively listening, acknowledging, assessing, resolving and investigating concerns / complaints quickly as possible.

- To ensure the Trust promotes a culture of openness, honesty and fairness when investigating all concerns and complaints.
- To ensure complainants receive open, honest and proportionate responses to their complaints where mistakes are acknowledged, explanations provided for what went wrong and appropriate and proportionate measures are considered to put things right.

2.0 SCOPE OF POLICY

This Policy is applicable to all staff providing services within the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency staff and volunteers, and includes services that are commissioned or provided by the Independent Sector.

The Formal Complaints Procedure applies only to complaints about care or treatment, or about issues relating to the provision of health and social care.

Comments, concerns, complaints and compliments may be received from patients; patient relatives, carers, visitors and other service users. The concerns and complaints excluded from the scope of this policy are identified in **5.3.**

3.0 ROLES/RESPONSIBILITIES

Chief Executive
As Accountable Officer, the Chief Executive has overall accountability for ensuring compliance with statutory and legal requirements and with relevant complaint guidance.

The Chief Executive will:

- promote an open, honest and just culture for complaints management
- ensure that the Trust takes the necessary action to ensure that lessons are learned and where appropriate, improvements are made to the service.
- ensure a Committee structure is in place to monitor and review the organisation's performance in complaints management.

Trust Board

The Trust Board has a monitoring and assurance role to ensure compliance with the Trust's statutory obligations as described in the relevant complaints legislation.

The Board will:

- promote an open, honest and just culture for complaints management, and ensure that the arrangements contained within the policy and procedures are implemented
- monitor and review the overall reporting performance and receive regular reports
- ensure complaints management is integrated within the Trust's Performance and Assurance Framework

Medical Director

The Medical Director (or their deputy) is the lead Director on behalf of the Trust Board and Executive Team for the management of complaints. The Medical Director has a shared responsibility with the Director of Nursing and User Experience for clinical quality.

The Medical Director will:

- develop suitable organisational arrangements for the management of complaints and promote an open, honest and just culture for complaints management

- develop and maintain professional assurance systems, and processes to monitor and disseminate learning from complaints across the organisation

- put systems in place to ensure reporting of complaints to external agencies as required e.g. DoH, Regional HSC Board, RQIA

- regularly review a representative sample of complaint responses for assurance purposes

Co-Director Risk and Governance

The Co-Director will support the Medical Director in meeting their responsibility for complaints management.

The Co-Director has Trust-wide lead for the co-ordination, implementation, and evaluation of risk management systems and the Trust Risk Management Strategy.

The Co-Director will:

- promote an open, honest and just culture for complaints management

- maintain systems for the reporting, recording and analysing of complaints including in relation to professional assurance

- ensure that subsequent learning from complaints is shared across the Trust, through appropriate management structures

- take account of relevant complaints when reviewing Service Directorate risk registers and ensure appropriate linkage to the corporate risk register

Directors

Directors are responsible for ensuring that the standards and processes referred to in this policy are followed within their Service Areas, thus ensuring that the Trust does not suffer reputational damage due to maladministration of complaints.

Directors will:

- disseminate and promote this policy and procedure within their areas of responsibility and ensure its implementation by providing support and advice to managers and staff and promoting an open, honest and just culture for complaints management

- ensure complaints are investigated thoroughly and in a timely manner in accordance with existing policy and procedure, including approving extensions to timescales as appropriate upon request from Service Areas
- review and amend draft complaint responses and sign off on behalf of the Chief Executive
- ensure that appropriate actions are taken, where required, in response to professional assurance issues identified through complaints
- ensure that learning from complaints is shared across Service Areas, in keeping with the Shared Learning Policy through appropriate management structures
- ensure that learning with relevance beyond the Directorate is appropriately formulated and progressed for sharing in line with the shared learning procedure
- ensure that complaints are monitored and reviewed within their Service Areas
- implement action plans as required to ensure recommendations made as a result of investigations are implemented and monitored, and provide assurance to the Service User Experience Feedback Group and subsequently to the Assurance Committee
- take account of relevant complaints when reviewing their Risk Register and ensure that this is linked appropriately to the Corporate Risk Register
- ensure staff have access to appropriate training on complaint management and, where appropriate, investigation of complaints.
- ensure identification of key issues and actions regarding the management of complaints for progression via the Service User Experience Feedback Group and onward reporting to the Trust Board

Chairs of Division, Clinical Directors and Professional Leads

Chairs of Division, Clinical Directors and Professional Leads (ie Divisional Nurses, Divisional Social Workers etc) will review all complaints correspondence sent to them in relation to named staff members and will initiate appropriate actions / review mechanisms as required to ensure effective Professional Assurance governance systems are being robustly implemented within their respective areas.

Clinical Directors and Professional Leads will maintain oversight of Clinical Record Reviews and other assurance systems and reports regarding staff named in complaints, and will escalate to Directors and Chairs of Division as necessary to advise of any concerns and of progress with associated actions.

Co- Directors

Co-Directors are responsible for ensuring that all complaints are managed efficiently and effectively in their Service Areas and all complaint responses are provided in a timely way

Co-Directors will:

- agree the grading of the complaint in conjunction with the Investigating and Complaints Managers

- ensure any complaint identified as high risk is assessed, reported to the Director and appropriately managed and investigated using Root Cause Analysis methodology. Consideration should be given to undertaking independent investigations into high risk complaints that do not meet the SAI criteria.

- ensure that Clinical Record Reviews are conducted for complaints relating to Quality of Treatment and Care and that Chairs of Division and relevant Clinical Directors are informed of the review outcomes

- deal with any queries Investigating Managers might have, including the need to contact or meet with the service user who raised the complaint or concern.

- maintain oversight of and implement effective performance management systems to ensure the quality and timeliness of responses provided by their Service Areas, reviewing complaints management data on an ongoing basis and prioritising actions to address issues identified regarding outstanding responses and any trends of excessive response times

- where a complaint relates to the actions of more than one Directorate the Co-Directors will liaise with the relevant Complaints Manager to identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint.

- agree the draft response with the Investigating Manager (ensuring that all aspects of the complaint are addressed, and that the Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling are reflected in the response) and forward this to the relevant Complaints Manager within identified timescales

- where appropriate, ensure action plans arising out of investigations (including Ombudsman's recommendations) are agreed, progressed, monitored and evaluated.

- ensure that the Directorate fosters an ethos of learning in order to minimise future occurrences of issues identified through complaints

- where serious allegations regarding staff performance and behaviour arise through the Complaints Procedure, ensure this is appropriately followed up.

Service Directorate Managers (Investigating Managers)

Service Directorate Managers are responsible and accountable to their Director to ensure that complaints are thoroughly investigated within their clinical and managerial teams and responded to within the given timescales.

Service Directorate Managers will:

- ensure that complaints investigations are conducted thoroughly in a manner that is supportive to those involved and takes place in a blame free atmosphere

- ensure that complaint responses are provided within agreed time scales, including ensuring that their teams review and approve draft responses in a timely manner and promptly escalating obstacles that may cause delays to Co-Directors as required

- work in conjunction with relevant Clinical Directors (or deputies) to initiate the Clinical Record Review process for all complaints relating to quality of treatment and care

- ensure appropriate action is taken when a health professional is identified in a concern or complaint. Where more than one concern or complaint raised about an individual, ensure there is appropriate escalation to the relevant professional lead

- ensure that comprehensive records are maintained throughout all complaint investigation and management processes

- ensure that upon closure of each complaint the Complaints Department is provided with details of any staff members where the complaint investigation process has identified potential concerns (in order to facilitate effective implementation of the Trust's Professional Assurance mechanisms)

The Investigating Manager will:

- agree grading of the complaint in conjunction with the relevant Complaints Manager

- undertake a preliminary assessment of how best to investigate the complaint (scoping process to take place within 48 hours of receipt of complaint where possible) including consideration of Independent Review where appropriate

- liaise regularly with the relevant Complaints Manager

- ensure the investigation is carried out in a timely manner and notify the relevant Complaints Manager at the earliest opportunity of any delays

- ensure that panels interviewing staff members as part of the complaints investigation process include suitable professionals with similar expertise to the individual being interviewed

- provide support to staff during an investigation and ensure that staff named in the complaint are made aware of the content of both the complaint and the response. If a named member of staff has left the Trust, all reasonable efforts must be made by the Investigating Manager to contact them to obtain all relevant information.

- keep comprehensive records of all relevant supporting information arising throughout investigation of the complaint

- ensure response letters are compiled and fully address all issues raised by the complainant

- ensure that agreed action plans arising out of investigations are completed and any recommendations implemented across appropriate teams/departments

Senior Complaints Manager

The Senior Complaints Manager will support the Co-Director of Risk and Governance in executing those duties relating to the management of complaints.

The Senior Complaints Manager will:

- ensure implementation of audit and quality assurance mechanisms to support effective and high functioning complaints management processes within the complaints department

- ensure provision of data at corporate and Directorate level to support oversight of complaints and shared learning

- ensure appropriate systems are in place for the identification and escalation of professional assurance issues arising from complaint investigations

Complaints Managers

Complaints Managers will:

- acknowledge complaints within 2 working days of receipt

- agree grading of complaints in conjunction with the Investigating Manager

- contact complainants to confirm and agree areas for investigation and expected outcomes

- ensure all complaints involving a sudden unexpected death, serious harm or potential safeguarding issues, are escalated to the relevant Director and Senior Complaints Manager immediately for consideration of independent investigation and to facilitate communication with the complainant

- where a complaint relates to issues across more than one Directorate the Complaints Manager and / or Service Manager will liaise with the complainant to clarify the main issues of concern to assist identification of who should take the lead in investigating the complaint and co-ordinating the response for the complaint

- obtain consent where required in the case of third party complaints or enquiries

- notify the relevant Investigating Manager within 2 working days of receiving complaint

- record all relevant information about each complaint on Datix and set up the agreed response timescales

- track complaints and send reminders to Service Areas to facilitate the meeting of deadlines, including informing the Investigating manager *10 working days* before the final response deadline, and escalating delayed responses to Co-Director and Director-level as required

- ensure that the preferred mode of contacting the complainant is agreed and ensure that the complainant is kept informed about progress with his/her response

- ensure that the relevant Executive Director is notified where a health professional has been identified in a complaint or has subsequently been identified during the complaint investigation process (including notification of the Medical Director's Office where a complaint involves medical staff)

- ensure that the relevant Divisional professional lead (ie Divisional Nurse, Divisional Social Worker etc) is notified where a health professional has been identified in a complaint or has subsequently been identified during the complaint investigation process

- detail the specific points in the complaint that require to be answered and subsequently quality assure that all points have been fully addressed by the Directorate before forwarding for signature (in addition to quality assurance checks ensuring accuracy of dates, names/titles and address of complainant etc)

- ensure final complaint responses are sent to Investigating Managers and Co-Directors for checking with contributing staff and final approval prior to being sent to the relevant Director

- provide service user feedback, related analyses and reports to services and Committees within the Governance Accountability Framework

- thematically review complaints for learning locally and across the Trust

- provide information as requested to external sources including RQIA, Department of Health and HSC Board.

- provide guidance and support to relevant managers, supervisors and staff to enable them to carry out their duties and responsibilities relating to complaint prevention and management

- provide training in relation to complaints investigation and management

All staff

A complaint can be made orally or in writing to any member of Trust staff. The most satisfactory outcome from complaints often comes when the issues identified are dealt with fully and effectively on the frontline within the Service Area. As such the Trust expects all staff to attempt to resolve issues on the front line speedily and to the complainant's satisfaction, with the assistance of a more senior member of staff when necessary.

The first responsibility of the recipient of a complaint is to ensure that patients' immediate healthcare needs are being met. This may require urgent action before any matters relating to the complaint are tackled.

Complainants should be listened to and treated courteously with dignity and respect, and should be approached in a non-defensive manner to ascertain their concerns.

Reassurance should be given to the complainant that their concern is being taken seriously, that it will be dealt with confidentially and will not in any way adversely affect their or their relative's treatment.

Where the issue raised is about a specific member of staff, the local manager should appoint another staff member with appropriate expertise to carry out an initial investigation and seek to resolve the matter speedily.

Staff will:

- work to put things right and help resolve issues or concerns raised by complainants in an open, compassionate, constructive, non-judgemental and timely manner

- refer as soon as possible to their line manager if unable to deal with complaints raised directly with them or seek advice from complaints staff on how to proceed

- keep their line manager updated on complaints and enquiries they are currently dealing with, and complaint outcomes (including resultant service improvements)

- provide patients, patient relatives, carers, visitors and other service users with appropriate information regarding how to give feedback and how to raise concerns or a complaint (this includes ensuring that information relating to service user feedback is displayed in facilities accessed by service users)

- co-operate fully with the investigation of complaints within the service/team particularly by returning statements, reports and other information to Investigating Officers in a timely manner – even where staff members have left the Trust (for example due to retirement) since the events of the complaint.

- enable the process of organisational learning following a complaint

- release staff for relevant complaints awareness/ customer satisfaction training.

- maintain good record keeping (including updating Datix with relevant details as require

- inform their line manager and other team members (if appropriate) when they receive a written compliment from service users

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

A **complaint** is an expression of dissatisfaction about care or services provided by the Trust, which requires a response. It can be made by a patient, relative, carer or representative acting on behalf of a patient. Complainants may not always use the word complaint.

A **complainant** is the person making the complaint, on behalf of themselves or another.

A **concern** is usually where an individual remarks, expresses an opinion or makes an observation about a patient's treatment/care that can be defined as a matter of interest, importance or anxiety.

An **enquiry** is a request for further information such as waiting times for appointments

A **compliment** is an expression of praise, commendation, or admiration.

4.2 Key Policy statements:

This policy has been developed and set within the Legal Framework for Complaints Management within Health and Social Care Services.

The Belfast Trust is committed to providing safe, effective and high quality services and welcomes feedback from patients/relatives/carers/visitors and other service users about their

experience of care to improve quality. This policy provides the opportunity to put things right for service users as well as improving services.

It is recognised that there may be times when treatment and or services do not meet expectations particularly when something has gone wrong or fallen below standard. By listening to people about their experience of healthcare, the Trust can learn new ways to improve the quality and safety of services and prevent problems happening in the future. Such learning from comments, concerns, complaints and compliments can only take place when they are managed in a positive and open manner. The Trust will therefore promote an open, honest, just and fair culture, where all staff can learn from complaints.

Patients/service users/relatives/carers/visitors can bring comments, concerns and compliments to the attention of any member of staff. Wherever possible, staff at a local level will actively seek to resolve dissatisfaction in a sensitive manner at the earliest opportunity. In circumstances where such frontline resolution is not possible, this policy outlines the process to ensure complaints are handled in an efficient and effective manner.

Where complaints raise concerns regarding the conduct or performance of staff, these will be escalated to the relevant Director / Professional Lead (ie Divisional Nurse, Divisional Social Worker etc), with Clinical Record Reviews or Independent Case Reviews being conducted as appropriate and escalated to Chairs of Division as required.

Copies of completed Clinical Record Reviews will be sent to the relevant Executive Lead for tracking.

Effective communication is essential in good complaint handling. Complainants must be involved in deciding how the issues they have raised are handled and, where appropriate, advised of what will be done as a result of their feedback. A meeting with the Service Area should be offered to complainants upon conclusion of any investigation to allow an opportunity for discussion of the findings.

All complaints will be treated in confidence, with openness, honesty and respect being paramount at all times.

Complaints form a vital part of the Trust's performance management systems. Positive action will be taken as a result of complaints, and learning from complaints will be embedded in the Trust's governance and risk management arrangements. Where something has gone wrong or fallen below standard the Trust will take every opportunity to improve and avoid a recurrence.

4.3 Compliments

Details of compliments received by Service Areas must be provided to the Complaints Department (via compliments@belfasttrust.hscni.net) to ensure accurate onward reporting.

Figures must be submitted on an ongoing basis in relation to the following areas for collation and inclusion in the Trust's formal reports to the Department of Health each quarter :

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Telephone
Quality of Treatment and Care						
Staff Attitude and Behaviour						

Information and Communication						
Environment						
Other						

**Social Media refers to compliments received by official Facebook and Twitter accounts only*

All compliments received by the Chief Executive or Complaints Department will be acknowledged and shared with the staff/department named, and details recorded on Datix.

4.4 How can complaints be made?

Every assistance will be given to individuals who wish to make a complaint, including the provision of interpreter services or any other service that may enhance the communication of the complaint to the organisation. Patients must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint.

Complaints may be made verbally or in writing and should also be accepted via any method, for example, telephone or e-mail. The Trust should be mindful of technological advances and ensure local arrangements are in place to ensure there is no breach of patient/client/staff confidentiality.

All complaints will be treated in confidence, with due care and respect being paramount at all times.

Complaints may be made to any member of staff - for example receptionists, medical or care staff. In many cases complaints are made orally and front-line staff may resolve the complaint “on the spot”. As such, all front-line staff must be trained and supported to respond sensitively to comments; concerns and complaints raised and be able to distinguish those issues that would be better referred elsewhere.

Front line staff should familiarise themselves with the the DoH Guidance in relation to the Health and Social Care Complaints Procedure, and the Parliamentary Health Service Ombudsman’s principles for dealing with and managing complaints.

It is essential that all staff are aware of their roles and responsibilities when dealing with complaints. This will enable them to respond positively, and where possible, resolve the complaint at local level.

4.5 Complaint Management processes

Where a concern or complaint is made within a Service Area, every attempt should be made to achieve resolution at that time.[1] Where frontline resolution has been unsuccessful, the complainant should then be offered the option of contacting the Complaints Department.

All formal complaints must be formally acknowledged within 2 working days. Where possible the complainant’s issues and expected outcomes from the complaint will be clarified and a timescale for response agreed. The format of the response will also be agreed with the complainant, this may be verbal (by phone or at a meeting), by email or written letter.

[1] All complaints raised with front line staff should be recorded on “Frontline Resolution” forms (these can be found on the Trust intranet, see Appendix 7) including details of any actions taken and the outcome of such. Completed forms should be forwarded to the Complaints Department for entry onto the Datix system.

All complaints will be investigated according to the category of grading in which they fall, as referred to in the Regional matrix (see Appendix 2). Where a complaint involves the death of a patient/service user complainants should be offered a meeting with the Service Area to discuss their concerns at both the start and the end of the complaints process.

The Trust will investigate the complaint in a manner appropriate to the nature of the issues raised, aim to complete the investigation as efficiently and effectively as possible and ensure that the complaint response is provided within the agreed timescales.

Where it is unavoidable that the response will not be provided within the agreed timescales the Service Area will notify the Complaints Department immediately with a clear explanation as to the reason(s) for delay, and will appoint a key contact within the service area for the duration of the complaint investigation and response process. The Service Area will continue to update the Complaints Department to enable the complainant to be kept regularly informed as to the progress of the investigation and response. Whilst a holding letter may be issued, it is preferred practice to maintain (as far as reasonably practicable) verbal contact with the complainant.

At all stages within the complaints process the Complaints Manager will provide support and assistance to the complainant and staff involved. Independent advice and support for complainants is also available from the Patient Client Council and from Independent and specialist advocacy services, (see Appendix 11*)*.

Regular reports will be provided to Directorates by the Complaints Department highlighting key issues such as trends in complaint subjects, length of response times, Ombudsman cases, and identifying any multiple complaints about individual employees / departments.

Joint Complaints

Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify the other organisation(s) involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations.

In cases of this nature there is a need for co-operation and partnership to agree how best to approach the investigation and resolution of the complaint. It is possible that various aspects of complaints can be divided easily, with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the HSC Board or HSC Trust that commissioned the service or purchased the care for that service user is responsible for coordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

4.6 Complaint Investigation

The designated Investigating Manager within each Service Directorate will be forwarded a copy of the complaint correspondence by the Complaints Team on receipt of the complaint. Copies of key guidance documents will also be enclosed as appropriate to support thorough and timely investigation of, and response to the complaint issues.

The Complaints Team will provide a reminder to the Investigating Manager via email 10 working days before the final response is due to prompt them to return the internal response, and will subsequently escalate delayed responses to Co-Director or Director level as required (see Appendix 7 below).

Upon completion of the complaint investigation, the Investigating Manager must forward a draft response to the relevant Complaints Manager who will ensure that all aspects of the complaint have been addressed. Where the quality check of the draft identifies significant changes or omissions, the response will be sent to the relevant Co-Director for checking and approval prior to forwarding to the relevant Director for final approval and signature.

A complaint should be made as soon as possible after the action giving rise to it, normally within 6 months of the event. There may be occasions when a complainant was not aware that there was cause for complaint at the time. In such circumstances a complaint should normally be made within 6 months of the complainant becoming aware of the cause for complaint.

Full and proper investigation is hindered where timescales extend beyond a 6 month period. Complainants should be advised that the time delay may impact on the investigation and any response would be based largely on a review of records.

Advice should be sought from the relevant Complaints Manager in conjunction with the relevant Co-Director when deciding whether to investigate a complaint older than 6 months. Any serious allegations should be investigated if at all possible, regardless of timescale.

Any decision not to proceed with an “out of time” investigation rests with the relevant Director and a letter explaining this decision (signed off by the Director) should be sent to the complainant.

4.7 Children Order Representations and Complaints Procedure

Under the Children (NI) Order 1995 HSC Trusts are statutorily required to follow established procedures for considering any representations (including any complaint) made to the Trust about the discharge of its functions under part IV or, and paragraph 4 of Schedule 5 to, the Order; and matters in relation to children accommodated by voluntary organisations and privately run children’s homes; and personal social services to children provided under the Adoption Order (NI) 1987. Further details regarding complaints in relation to Children Order Representations can be found at *Appendix 6.*

4.8 Independent Sector Providers (ISPs)

Complaints relating to Independent Sector Providers may be received directly by ISPs, or the complainant may contact the Trust directly. Generally, in the first instance, the ISP investigates and responds directly to the complainant. If the complainant contacts the Trust directly, the Trust will consider how best to proceed and if the matters raise serious concerns, the Trust may decide to investigate the complaint.

In all cases the complainant must be kept informed and advised of which organisation will investigate their complaint. Where a complaint relates to the actions of more than one Directorate the Complaints Manager in conjunction with the Co-Directors will identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy has relevance for all Belfast Trust staff, and applies equally to those in permanent, temporary, voluntary or contractor roles.

The policy will be available for download from the Trust central policy intranet page and the Trust website, and will be circulated by e-mail to all Directors for cascading to their relevant areas of responsibility.

5.2 Resources

A programme of complaints awareness and management training will be ongoing throughout the Trust to ensure that this procedure is followed and that staff encourage service users to provide feedback about their treatment and care experiences.

Complaints Awareness Training is part of the mandatory induction programme for all new Belfast Health and Social Care Trust employees.

Further information and resources can be found in the Complaints section on the Hub, and in the Appendices below.

5.3 Exceptions

In certain circumstances, concerns and complaints may be excluded from the scope of this policy.

Such exclusions are as follows:

- private care and treatment or services (including private dental care or privately supplied spectacles); except for those patients having private care in one of the Trust's facilities and the complaint is about care and treatment.
- services not provided or funded by the HSC, e.g., provision of private medical reports;
- the independent regulated sector (except for services commissioned by the Trust)
- staff grievances (the Trust has separate procedures for handling staff grievances. Staff may, however, complain about the way they have been dealt with under the HSC Complaints Procedure and, provided they have exhausted the local grievance procedure, may take the matter up with the Ombudsman)
- staff complaints
- an investigation under the disciplinary procedure
- an investigation under SAI investigation
- an investigation by one of the professional regulatory bodies
- services directly commissioned by Health and Social Care Board (HSCB)
- a request for information under Freedom of Information
- access to records under the Data Protection Act
- an independent inquiry
- a criminal investigation
- protection of vulnerable adults
- child protection procedures
- Coroners cases
- legal action

In such circumstances the Chief Executive (or relevant delegated Director) should inform the person outlining why the exclusion applies.

6.0 MONITORING

Implementation / Resource requirements:

The effectiveness of this policy is monitored and reported through:

Governance Structure
At a service level, governance meetings are held on a regular basis and complaints are included as a standard agenda item for these meetings. The learning from complaints is incorporated on the agenda and discussed at these meetings.

Complaints data is provided as part of a wider governance information system underpinning the Trust's Professional Assurance mechanisms

There are designated groups with operational responsibility for the oversight and monitoring of complaints process within the Trust Assurance Framework, including the Learning from Experience Group, Assurance Group and Assurance Committee, a standing committee of Trust Board.

The Service User Experience Feedback Group meet regularly to review the number of on-going complaints, spot trends, discuss Key Performance Indicators in relation to complaints, consider cases of specific concern and agree shared learning.

An annual Complaints Report is generated and reported through the Trust Assurance Framework structures and published on the Trust website. Complaints information is also included in the Trust's Annual Quality Report.

Compliance with this policy at Service Level will be overseen by Governance Leads who will continuously monitor the number of complaints received, any trends, and the results of complainant satisfaction surveys, the number and outcome of Ombudsman cases, and a range of Key Performance Indicators relating to complaints.

Any identified areas of non-compliance or gaps in assurance arising from the monitoring of this policy will result in recommendations and proposal for change to address areas of non-compliance and/or embed learning.

7.0 EVIDENCE BASE/REFERENCES

DoH Guidance in relation to the Health and Social Care Complaints Procedure
Revised April 2019
HPSS Complaints Procedure Regulations: April 2009
The Children (NI) Order 1995:
Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling and Good Administration

8.0 CONSULTATION PROCESS

Senior Managers within Risk and Governance
Governance Leads within the Service Directorates
Staff side

Human Resources and Equality Department
Independent Service User Group.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 Responding to a comment, concern or complaint
Appendix 2 Grading of a Complaint
Appendix 3 Complaint Investigation and Resolution
Appendix 4 Complaint Process Flowcharts
Appendix 5 Vulnerable Adults
Appendix 6 Children Order Representations And Complaints Procedure
Appendix 7 Formal Complaints Escalation Process
Appendix 8 Northern Ireland Public Service Ombudsman Cases
Appendix 9 Record Keeping
Appendix 10 Consent, confidentiality, and third party confidence
Appendix 11 Internal/ External Support/ Contacts
Appendix 12 Unreasonable, vexatious or abusive complaints
Appendix 13 Unacceptable Actions Policy

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact ☐

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link**.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

<u>If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.</u>

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_________________________________ **Date:** 8 April 2020

Chris Hagan
Interim Medical Director

_________________________________ **Date:** 8 April 2020

Cathy Jack
Chief Executive

Appendix 1 -Responding to a comment, concern or complaint

Comments, concerns, complaints and compliments from patients/ relatives/carers and the public are encouraged and welcomed.

Should patients/relatives/carers or the public be dissatisfied with the care provided by the Trust they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously.

Under no circumstances should patients/relatives/carers be treated any differently as a result of making a complaint. At the outset of any comment, concern or complaint, it is imperative that the complainant is actively listened to and asked to establish the outcome he/she is seeking.

1. Frontline Resolution

When something has gone wrong, patients/relatives/carers are encouraged to raise concerns or make a complaint as soon as possible and directly to the staff involved. This is often to front line staff in wards, clinic, and reception. All Trust staff, as a means of improving service provision, should deal with concerns or complaints in a positive manner.

In the majority of circumstances the quickest and most effective way of resolving a concern or complaint is to deal with the issues when they arise as soon as possible. Usually this is best undertaken as close to the point of care/service delivery as possible.

If the concern or complaint requires further investigation or if the complainant wishes to address their concerns to somebody not involved, the complainant will be referred to the Complaints Department.

On receipt of a concern or complaint, the first responsibility is to ensure that the patient's immediate health needs are being met.

Records should be kept of all discussions, local actions taken etc and forwarded to the Complaints Department upon resolution of the issues.

A Frontline Resolution form should be completed with details of the complaint, the corrective / remedial actions taken to resolve the complaint, confirmation that the complainant is content that their issues and concerns have been satisfactorily resolved, and identifying any potential professional assurance concerns indicated by the complaint (see below).

Frontline Complaint Record Form

Date:
Time:
Details Taken By:
Location and Service Directorate:

Details of Patient/Client/Service User:

Name			
Address			
Date of Birth		Hospital Number	
Contact number (if patient is complainant)			
Contact e-mail address (if patient is complainant)			

Complainant Details (if different from Patient/Client/Service User above):

Name	
Address	
Contact number	
Contact e-mail address	

NB: Advise complainant, if they are not the patient, that written consent will be required before the complaint investigation can begin

Note of Complaint/Enquiry

Action Taken

Is the complainant happy that their complaint has been satisfactorily resolved? **Yes** ☐ **No** ☐

Please identify any staff where the issues identified by this complainant have highlighted potential concerns. This information is critical to the Trust's Professional Assurance governance mechanisms:

Staff member Surname	Staff member Forename(s)	Job Title	Specialty	Nature of Concern	Comments
e.g. Smith	*John, Robert*	*Consultant*	*Orthopaedics*	*Quality of Treatment and Care* *Staff attitude / behaviour*	*Concern regarding failure to diagnose patient's cancer and dismissive attitude towards family member*

Please return to: Complaints Department, 7th Floor, McKinney House, Musgrave Park Hospital, Belfast, BT9 7JB, or email to: complaints@belfasttrust.hscni.net

2. Formal Complaints

In cases where frontline resolution has not been possible, the Complaints Department will be notified and will offer assistance to the complainant. Concerns and complaints received into the Trust by other means (eg sent directly to CEO office) will be promptly forwarded to the Complaints Department.

At the outset, the Complaints Department will identify a named Complaints Manager as single point of contact for the complainant, with whom they can liaise throughout the process. The Complaints Manager should establish with the complainant the outcome he/she is seeking. *NB Where the complainant is not the service user affected by the issues of complaint, written consent must be secured from the service user before investigation of the complaint can only proceed.*

The nature and grade of the complaint will influence the level of investigation and the level of notification/cascade throughout the organisation. A framework to support this decision-making can be found in the Trust Risk Matrix, *(see Appendix 2).* Higher graded complaints require prompt action, more robust investigations and may require the involvement of external investigators. Complaints relating to Quality of Treatment and care should be investigated in conjunction with the Clinical Record Review process (*see Appendix 3*)

It is the responsibility of the relevant Investigating Officer to prepare the draft complaint response from the information obtained during the investigation. The response should be clear, accurate, balanced, simple, and easy to understand. It should aim to answer all the issues raised by the complainant, in an open and honest way, explaining the situation, why it occurred and the action taken or proposed action. Where possible this should be provided to the relevant Complaints Manager within 10 working days from receipt of the complaint.

3. Meeting a Complainant

If a meeting is arranged with a complainant at any point in the complaint management process the Investigating Officer in collaboration with the Complaints manager will ensure that:-

- an appropriate time and venue for the meeting is arranged (taking cognisance of the sensitivities of the complaint)
- the complainant receives details of the meeting a minimum of 5 working days prior to the meeting
- an agreed agenda is sent to the complainant and attendees a minimum of 5 working days prior to the meeting
- arrangements are made to meet the complainant prior to the meeting
- the relevant Trust staff are present at the meeting
- where appropriate a Complaint's Manager is present at the meeting
- a record is kept of the meeting. The Service Area should provide a minute-taker at family meetings. A copy of the meeting notes should be sent to the Complaints Department for issue to the complainant (if requested) no later than 10 working days from the date of the meeting.

4. Complaint Response

All complaints will receive an open, fair and honest response. The complainant may prefer to receive their response via letter, email, at a meeting or by a telephone call (telephone conversations will usually be followed up in writing or via an email). A response does not need to be long or to provide a detailed account of dates/times of events, however it should:

- include an apology for the poor experience
- explain who has investigated the complaint
- address all the issues raised in a proportionate and fair manner
- acknowledge the importance of receiving feedback
- avoid abbreviations, and if possible use of technical jargon. Explain any technical words, phrases or procedures
- provide a full explanation of all issues raised
- acknowledge if the service/treatment provided fell below the expected standards of the Trust.
- detail any learning, actions taken or proposed to put the matter right and prevent recurrence
- offer to meet the complainant if appropriate
- indicate that a named person is available to clarify any aspect of the letter
- indicate the right to escalate their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

A series of checklists have been produced to support the provision of high quality responses to complainants:

Quality Assurance Criteria - Complaint Responses

Service Area QA

	QA Criteria	☑	☒	N/A	Comments
1	All points of complaint are fully addressed including clear explanation of investigation findings into each issue raised				
2	Independent Peer Review (Clinical Record Review process) has been conducted (*if complaint relates to quality of treatment and care*)				
3	If Professional issues have been identified in the complaint, the response has been reviewed and signed off by the relevant Professional Lead				
4	Plain English is used, medical / technical terminology kept to a minimum and explained fully if necessary				
5	Appropriate language is used – personalised, sincere, non-defensive tone, empathetic, courteous and sensitive Tone of letter matches nature of complaint.				
6	Acknowledgement of failures, apology and acceptance of responsibility made to complainant where appropriate				
7	Response includes description of changes made / actions put in place to minimise risk of reoccurrence as a result of the complaint included (eg changes in policy or clinical practice, re-training of staff)				
8	Offer of remedy made where appropriate (eg offer of further clinical appointment; reimbursement of car parking fees)				
9	Response thanks complainant for raising the complaint				
10	Response includes expression of condolence if the complainant has been bereaved				
11	Response offers complainant an opportunity to meet and discuss outcome of the complaint investigation				
12	Response includes an apology and explanation if not within 20 working days				
13	Response reflects Trust Values				
14	I would be happy for my loved one to receive this response				

OTHER COMMENTS:

Completed by: ______________________________ (Name) ______________________________(Role) ______________(Date)

Complaints Administrative QA

	QA Criteria	☑	☒	N/A	Comments
1	Font – Arial Size 12, paragraphs fully justified, 1.15 line spacing				
2	Name & address details correct				
3	Date correct				
4	Correct Title(s) used				
5	Consistent naming conventions throughout letter: - Complainant / family members - Staff members				

Completed by: ______________________________ (Name) ______________________________(Role) ______________(Date)

Complaints Managers QA

QA Criteria		☑	☒	N/A	Comments
1	All points of complaint are fully addressed including clear explanation of investigation findings into each issue raised				
2	Independent Peer Review (Clinical Record Review process) has been conducted (*if complaint relates to quality of treatment and care*)				
3	If Professional issues have been identified in the complaint, the response has been reviewed and signed off by the relevant Professional Lead				
4	Appropriate language is used – personalised, sincere, non-defensive tone, empathetic, courteous and sensitive. Tone of letter matches nature of complaint.				
	Consistent style and use of terminology throughout letter - particularly for cross-Directorate responses				
5	Consistent naming conventions and correct titles used throughout letter: - Complainant / family members Staff members				
6	Acknowledgement of failures, apology and acceptance of responsibility made to complainant where appropriate				
7	Response offers complainant an opportunity to meet and discuss outcome of the complaint investigation				
8	Includes details of complainant's option to revisit the complaint within 1 month				
9	Includes signposting to NIPSO				
10	Reflects Trust Values				
11	I would be happy for my loved one to receive this response				
Completed by: ____________________________ **(Name)** ____________________________**(Role)** _____________**(Date)**					

Complaint Closure QA - Complaints Administration

QA Criteria		☑	☒	N/A	Comments
1	Named Professional Template Issued and Returned				
2	Details of Named Professionals added to Datix				
3	Relevant Professional Assurance Lead notified				
4	Key complaint documents (inc signed Trust response) saved to Datix				
General Comments:					
Completed by: ____________________________ **(Name)** ____________________________**(Role)** _____________**(Date)**					

Quality Assurance Criteria - Complaint Ref:

Chief Executive / Director QA

	QA Criteria	☑	☒	N/A	Comments
1	All points of complaint are fully addressed including clear explanation of investigation findings into each issue raised				
2	Plain English used, medical / technical terminology kept to a minimum and explained fully if necessary				
3	Appropriate language is used – personalised, sincere, non-defensive tone, empathetic, courteous and sensitive. Tone of letter matches nature of complaint.				
4	Acknowledgement of failures, apology and acceptance of responsibility made to complainant where appropriate				
5	Description of changes made as a result of the complaint included				
6	Offer of remedy made where appropriate (eg offer of further clinical appointment; reimbursement of car parking fees)				
7	Thank you to complainant for raising their complaint				
8	Expression of condolence included if the complainant has been bereaved				
9	Reflects Trust Values				
10	I would be happy for my loved one to receive this response				
General Comments:					

In line with DoH guidance, complaints must be investigated and the complainant issued with a written response (signed by the relevant Director, on behalf of the Chief Executive) within 20 working days where possible.

If for any reason this is not possible the complainant must be advised of the delay as soon as possible, including an explanation of the reason(s) for the delay and a time frame within which they are likely to receive a full reply.

When the Service Directorate Manager and Co-Director / Divisional Professional Lead is satisfied that the complaint has been fully addressed and has agreed the draft response, this should be promptly forwarded to the Complaints Manager together with all relevant documentation and copies of all investigative reports.

Upon receipt of the Service Area's ratified response letter, the Complaints Manager will quality check the response to ensure accuracy of details and that the letter adequately addresses all issues raised by the complainant before promptly forwarding the final draft response for signature by the relevant Director.

When the final response is signed off by the Director, the Director's secretary will promptly send the letter to the complainant and return a copy of the signed letter to the Complaints Manager for the complaint file. The complaint is then closed.

If upon receiving the response letter the complainant remains dissatisfied they can contact the Complaints Department to request that their complaint be re-opened. This must be done within 1 month from the date of the Trust's response. Consideration will then be given to revisit the issues of complaint for further local resolution. This may include advocacy, conciliation or the use of lay persons. The Complainant or the Trust can also contact the Northern Ireland Public Services Ombudsman (the Ombudsman) at this stage.

5. Closure of Complaints

When a final letter has been sent by the relevant Director, or any alternative complaint resolution process that has been agreed with the complainant has been completed, the complaint is recorded as being closed on Datix.

On those occasions where a complainant subsequently highlights issues that have not been addressed, this is known as a 're-visited' complaint. Such complaints should be investigated as soon as possible and follow the same process as for the original complaint. If the complainant raises new issues, the designated Complaints Manager will formally determine whether the complaint should be deemed as a new complaint and update Datix accordingly.

While every effort must be made to ensure that a response has covered all the issues raised by the complainant in an open, honest and fair manner, it may not be possible to resolve a complaint where the complainant's expectations of the outcome are unrealistic. In these circumstances the relevant Director should consider referring the complaint to the Ombudsman as an independent arbitrator.

Once a complaint has been closed, the Complaints Department will issue the form below for completion by the relevant Service Area to identify any staff members for whom the investigation of the complaint has identified potential concerns (eg regarding their attitude / conduct / behaviour, or in relation to the quality of treatment and care they provided). This information is critical to the Trust's Professional Assurance governance mechanisms and should be returned to the Complaints Department no later than 2 weeks after the closure of the complaint.

Belfast Health and Social Care Trust
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Complaint Closure Form – Identification of Named Staff

Complaint Ref	C/	Division		Specialty		Date Closed		

Staff member Surname	Staff member Forename(s)	Job Title	Specialty	Nature of Concern	Comments
e.g. Smith	*John, Robert*	*Consultant*	*Orthopaedics*	*Quality of Treatment and Care* *Staff attitude / behaviour*	*Concern regarding failure to diagnose patient's cancer and dismissive attitude towards family member*

Please identify any staff for whom the complaint investigation may have highlighted a need for provision of professional support and / or guidance, and return the completed template to [Complaints Administrator] within 2 weeks.

6. Learning from complaints

The Trust is strongly committed to the concept of continuous learning, and to listening to the views of patients/relatives/carers and the public about the care and services we provide. We welcome all form of feedback and recognise that comments, concerns, complaints and compliments provide opportunities for organisational learning and improvement to occur.

All trends and themes that are identified through concerns, complaints and compliments are reported through the Service User Experience Feedback Group, Learning from Experience Group, Assurance Group and to the Trust Board.

For Directorate complaints with a more local focus, the Investigating Officer for the complaint will produce an action plan for the service area in order to bring about improvements and avoid repetitions of the incident(s) giving rise to the complaint.

Complaints often provide learning that will be relevant to a number of wards / departments beyond that in which the complaint originated. Examples of such Trust-wide learning are presented by Directorates for discussion at quarterly Service User Experience Feedback Group meetings and thereafter for consideration by the Learning from Experience Group (see Shared Learning Template below).

Shared Learning dissemination should be actively considered by Service Area in relation to all Northern Ireland Public Services Ombudsman investigation findings where the issues of complaint have been upheld.

Feedback should always be given to the individual involved in the circumstances giving rise to the complaint. The Co-Director will identify the most appropriate means of providing such feedback including consideration of necessary measures in response to the complaint investigation findings (such as further training, disciplinary procedures) or advising that no further action will be required.

Shared Learning Belfast Health and Social Care Trust caring supporting improving together	**Ref. No.**	**Date issued:**

Safety Message:

Summary of Event

Learning Points

Learning applicable to:

Specific Directorate(s) (specify):		Trustwide	
Other (specify):		Regional	

Action Required (*for discussion and agreement at Learning from Experience Steering Group / SAI Group or other appropriate group*)

Approved by:	Designation:	Date approved:

Appendix 2 – Grading of a Complaint

It is the responsibility of the Complaints Manager (in conjunction with the Service Area) to ensure that all complaints are graded using the risk grading process as outlined in the Adverse Incident Reporting Policy and Procedure including Adverse Incident Investigation Procedure. The grading will also be agreed with the Service Directorate Manager. This will determine the level of investigation required and whether any additional actions need to be taken, such as a Serious Adverse Incident Review by Root Cause Analysis, or liaison through the Coroner or involvement of the Trust Safeguarding Team.

All complaints graded as high or extreme risk will be highlighted on the Weekly Governance Teleconference with associated onward notification to the Executive Team and Trust Board.

Where a complaint is received and graded as high or extreme risk, consideration should also be given to ascertain if this will meet the SAI reporting criteria. This should be highlighted by the Complaints Manager to the Senior Manager – Corporate Governance and to the Co-Director and Director of the relevant Service Area, cc'd to the Co-Director for Risk and Governance, the Medical Director, and the relevant Divisional Professional Lead. In cases where the complaint is graded as high risk (red) the Co-Director / Director will agree the level of investigation to be carried out e.g. Root Cause Analysis (RCA). If the complaint is high risk but does not meet SAI criteria, consideration should be given by the Director to undertaking an independent investigation.

Where a complaint falls into the SAI criteria, the complaint investigation can continue if the complaint does not involve the serious adverse incident investigation. It is the responsibility of the appointed Chair of the Serious Adverse Incident Panel to agree a communication plan and ensure the complainant is contacted at the earliest opportunity and provided with information contained in the serious adverse incident leaflet. The final outcome of the investigation will be shared with the complainant.

Complaints can be escalated to Serious Adverse Incident (SAI) status. Where this occurs, the Chief Executive (or designated Director), must advise the complainant in writing that an SAI investigation is under way and that although the complaints process will be suspended for any SAI-related element(s) of the complaint pending completion of appropriate investigation, any aspect of the complaint not covered by the SAI process will continue to be investigated under the HSC Complaints Procedure.

The overall consideration must be to ensure that when the investigation has moved into the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

All other complaints will be investigated accordingly to the degree of the grading, with Clinical Record Reviews undertaken for complaints relating to Quality of Treatment and Care.

Where a complaint is received and the issues are already subject to another investigation (e.g. Professional Body, Ombudsman, Police Inquiry) the complaint cannot be processed until this investigation is completed. The complainant will be advised of this by the Complaints Department. If the complainant wishes they can then re-engage with the HSC Procedure should they remain dissatisfied.

APPENDIX 2 continued- BHSCT Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY and PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION and ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016)

BHSCT RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table				
***Likelihood* Scoring Descriptors**	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

	Consequence Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

- Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.

- Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.

- Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.

- Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Appendix 3 – Complaint Investigation and Resolution

1. The purpose of the complaint investigation process is to establish the facts, to identify areas for improvement, and gain 'resolution' for the complainant. On occasion this process may identify areas of individual concern that will then be investigated separately.

2. The nature and grade of complaints will influence the level of investigation and notification/cascade throughout the Trust. All complaints will be thoroughly investigated in a manner appropriate to resolving the issues in an efficient and effective manner within the agreed timeframes.

3. Higher graded complaints require prompt action and a robust investigation. They may require the involvement of investigating contributors external to the Directorate or even external to the organisation. In complex cases consideration should be given to the use of Independent Persons to help resolve the complaint. Any requests for factual amendments to independent expert reports (including SAIs) must be fully reasoned, explained and recorded. Only an independent expert or SAI panel (as appropriate) can agree and sign off on amendments to their report.

4. On receipt of the complaint from the Complaints Department, the Service Manager will ensure the appropriate person(s) are promptly identified to carry out the investigation. The level of investigation must be proportionate to the grading of the complaint. Complaints made in relation to Inequalities Human Rights or Disabilities should also be forwarded to the Health and Inequalities Manager for information.

5. All investigations should be undertaken by a suitably trained person with appropriate expertise, and conducted in a manner that is supportive to all those involved. The Investigating Officer will oversee the quality and timeliness of the investigation to ensure it has been thorough and addresses all the issues raised by the complainant. The Complaints Manager's role is to continuously monitor progress and escalate any delays or difficulties to the Co-Director if necessary.

6. Where the complaint raises issues in relation to Quality of Treatment and Care, a Clinical Record Review should be conducted by the Service Area in accordance with the process outlined below.

7. The Investigating Manager will assess the complaint, and plan the scope and approach to the investigation. They should contact the complainant to introduce themselves and where appropriate, clarify any issues in the complaint. They should also provide a point of contact should the complainant wish to raise any questions during the course of the investigation.

8. A scoping meeting (organised by the Investigating Manager) should be held **within 48 hours** of receipt of each complaint to identify any immediate actions and support the investigation planning. This includes identifying the key staff who will be required to contribute to the investigation. The Investigating Manager should establish the facts relating to the complaint and assess the quality of the evidence and call upon the services of others if required.

9. Where staff are directly involved in the complaint, statements will be taken at the time of the investigation as an accurate account of events. Individuals should be interviewed by one of the following: -
   - Line manager / Senior Manager with the appropriate level of seniority
   - An independent person with appropriate level of seniority
   - A relevant Medical, Clinical, Nursing or Professional person with the appropriate level of understanding and Seniority.
   - Senior Manager Complaints and Legal Services / Complaints Manager where appropriate.
   - Governance Manager where appropriate

10. In certain circumstances it may be preferable for two persons to interview the individual. Consideration must be taken to ensure that the interviews are carried out in a fair and just manner and that the interview is independent and proportionate to the complaint.

11. The interviewing person should always review any relevant documentation that may have bearing on the complaint. This will include medical, nursing, social work or any other patient /client notes that may be relevant. The interviewer(s) will then formulate their report / response based on the information received and forward to the Investigating Manager. Where it is not possible for an interview to take place the individual named in the complaint will be asked to respond in writing and this response will be considered by their Professional line manager.
12. Issues of complaint relating to named professionals must always be peer reviewed by an appropriate person with appropriate level of skills and understanding of the speciality. Peer reviews must be clearly documented and sent to the Investigating Manager for inclusion in the overall investigation and response process.
13. Where professional issues are identified in a complaint the appropriate Executive Director will be notified and sent a copy of the complaint for information.
    - If the staff member is a Doctor or a Dentist, the Medical Director, Chair of Division and relevant Clinical Directors for the Division will be informed.
    - If the staff member is a Nurse, the Director of Nursing and User Experience and relevant Divisional Nurse will be informed.
    - Information will be provided by the Complaints Department annually regarding all medical and nursing staff named in complaints for inclusion in the appraisal process.
    - If the member of staff is a Social Worker, the Director of Children's Community Services and Adult Social and Primary Care and Divisional Social Worker will be informed.
    - If the member of staff is an Allied Health Professional the Director of Unscheduled and Acute Care and Professional AHP Lead will be informed.
14. Should an individual person be named more than twice within a period of 1 year the Complaints Team will inform the Director/Co-Director and relevant Professional Lead for the Directorate.
15. It is recognised that involvement in both the complaints and investigation processes can be distressing for staff. It is therefore important that staff named in a complaint are appropriately supported throughout, and if necessary following, the investigation process. The Trust's "Buddy" system is available to staff requiring advice and support for example in relation to complaints being investigated by the Norther Ireland Public Services Ombudsman.
16. The Investigating Manager will collate the information and formulate into a response. This response is then ratified or signed off by the Co-director /senior manager and then forwarded to complaints department. Staff must also be kept informed of the investigation and have the opportunity to review the draft response prior to the Director signing off. All investigation correspondence should be uploaded onto DATIX web.
17. It may be appropriate, depending on the complexity or the particular issues raised in the complaint, that a meeting is offered to the family to discuss the outcome of the investigation. This decision will be agreed by the Complaints Manger and Service Directorate Manager. A meeting should be offered as routine in every complaint relating to the death of a patient / service user.
18. On completion of the investigation, the Investigating Manager should prepare a draft response. The response should include and explain how the investigation was carried out and how the conclusions were reached. This draft response must be shared with the relevant staff to ensure factual accuracy and agreement. It should then be ratified by the Co Director / nominated person before being forwarded to the Complaints Department for quality checking and then forwarded to the Director for final signature.
19. Some complaints will take longer than others to resolve because of the complexity, seriousness and the scale of the investigative work required. It is important that the Complaints Manager is informed of any delays to ensure that the Complainant is kept updated.

Clinical Record Review – Process

This process should be followed for all complaints relating to Quality of Treatment and Care

Complaints Department forwards copy of complaint to relevant Service Manager and Clinical Director (CCd to Co-Director / Chair of Division) including blank copy of "Clinical Record Review" template (see below)

↓

Clinical Director identifies relevant Consultant to undertake review, and service manager ensures said consultant receives patient's notes and Clinical Record Review template for completion

↓

Service Manager advises staff involved in the delivery of care associated with the complaint that the review is taking place

↓

Reviewing Consultant carries out review and completes Clinical Record Review template within 2 weeks

↓

Reviewing Consultant submits completed Clinical Record Review to relevant Clinical Director and discusses the findings

↓

Clinical Director signs off completed Clinical Record Review template and provides copy to Service Manager

↓

Service Manager incorporates Clinical Record Review findings into draft complaint response

↓

Clinical Director informs Chair of Division/ co-director of any Clinical Record Review templates with "unsatisfactory" or "needs improved" ratings

↓

Chair of Division/Co-director consider appropriate next steps and communicate to Medical Director's Office as required

Clinical Record Review

Complaint number/patient ID:

	Analysis of Care provided	Rating
(1)	Case Description – summary of clinical case	
(2)	Assessment (includes history taking, examination and diagnoses)	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(3)	Investigation	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(4)	Treatment (decision making, case selection, procedures or operation)	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(5)	Communication (patients, family, GP and consent)	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(6)	Teamworking (communication within hospital including MDT/and handover)	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(7)	Documentation (record keeping, appropriate follow up etc)	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(8)	Overall/Assessment	

Name individual undertaking review:

Doctor GMC number: **Date:**

Name Clinical Director:

Signature: ______________________ **Date:**

Definitions

Satisfactory care:- *Care which complies in all aspects with the standard expected taking into consideration the wider systemic issues.*

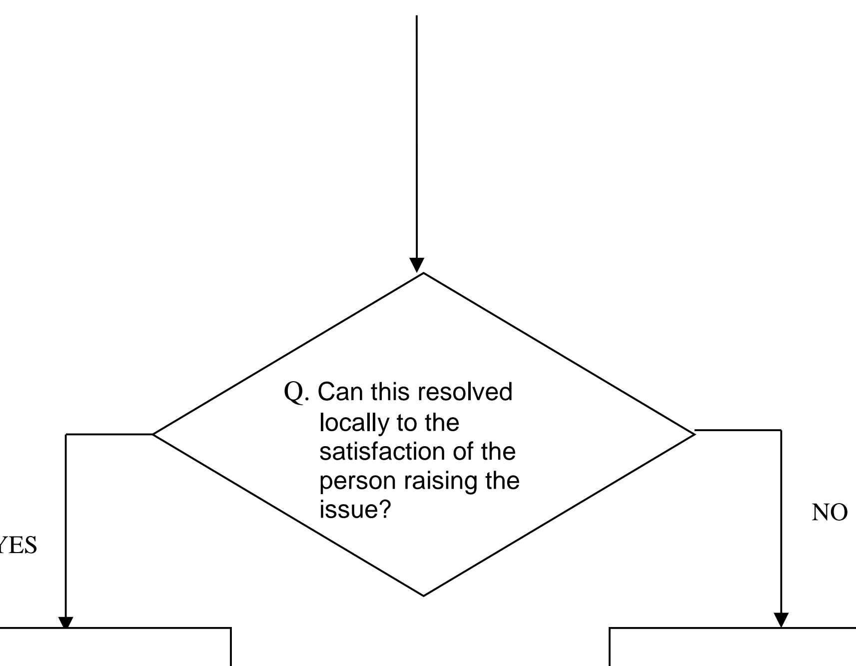
Care which could be improved but not unsatisfactory:- *Care which did not fall significantly below the standard expected but there were areas identified which could be improved.*

Unsatisfactory care:- *Care which falls significantly below the standard expected, having considered wider systemic issues.*

Appendix 4

Complaint Process Flowcharts

Issue /concern/ complaint raised by patient/ client, family, friend etc in a ward / department / service delivery area



YES:

- Actively listen to the Complainant
- Establish outcome sought by complainant
- Record the issues accurately
- Agree a plan of action with the complainant and document
- Inform relevant staff (including Line manager)
- Carry out actions and feedback to complainant and document
- If Complainant is happy with the outcome – record on Complaints record form which can be found on the Intranet site (Copy enclosed)
- Send form to Complaints Manager for your Service Area to log.

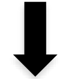
NO:

Advise the Complainant of the Complaints Department or assist the complainant to make a complaint to the Complaint Dept or give complaints leaflet

Offer assistance to Complainant to make a formal complaint by:

- Giving contact details for the Complaints Department
- Contact Complaints Department of their behalf
- Send letter of Compliant direct to the Complaints Department

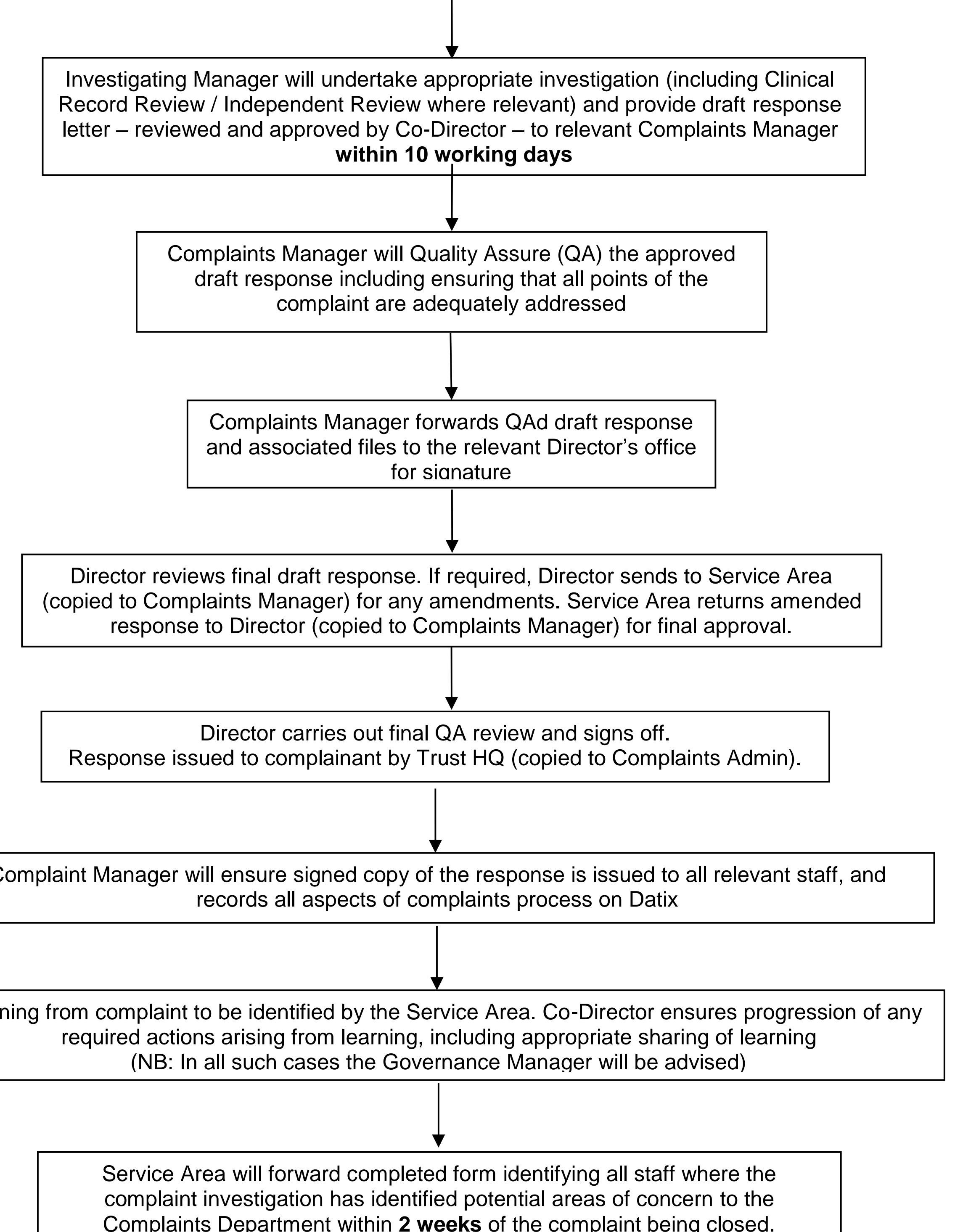
What happens next?



See overleaf

Complaint Department will:

- Log complaint onto Complaints Information System (Datix)
- Issue a letter of acknowledgement to complainant within 2 working days
- Identify all points of complaint which require investigation and response
- Issue all relevant correspondence to the relevant Service Manager (copied to Service Area Co Director/ Director and any other Director, Professional Lead or Clinical Director as relevant) for investigation and provision of draft response by Service Area.



Professional Assurance Process - Complaints

Process to be followed for any complaint received where a professional is named

Complaints Department forwards copy of complaint to relevant Service Area (cc to Relevant Professional Director and Divisional Lead where professional is named in initial complaint details)

Service Area investigates complaint issues

Service Area provides draft response to Complaints Team (inc details of findings from Clinical Record Review as appropriate)

Complaints Team finalise draft and forward to Service Area Director for approval and issue

Upon closure of complaint, Complaints Team requests confirmation from Service Area re any professionals identified regarding the issues of complaint

Complaints Department shares final complaint response letter with relevant Director if professional named, and also shares with relevant named professionals themselves.

Complaints Team enter named professional details into Datix

Complaints Team extract report identifying named professionals on annual basis

Service Area initiates Clinical Record Review process if appropriate

Service Area identifies appropriate next steps and communicates to relevant Professional Assurance Lead as required

Professional Assurance Lead and Service Area progress any required actions, keeping Director / Chair of Division / Divisional Lead informed as necessary

Complaints Department forwards copy of complaint to relevant Professional Assurance Lead

Professional Assurance Lead liaises with Service Area and identifies appropriate next steps

Professional Assurance Lead and Service Area progress any required actions, keeping Director / Chair of Division / Divisional Lead informed as necessary

NB If the issues of complaint become the subject of an SAI investigation or litigation process, the formal complaints process **relating to those issues** will cease (NB the complaints process can continue for other issues not falling within the remit of the SAI / or litigation processes)

However the Clinical Record Review process and associated Professional Assurance mechanisms can continue even if the complaint investigation process stops.

The formal complaint process can subsequently be re-commenced upon confirmation that the SAI / Litigation process has been completed / terminated.

Appendix 5– Vulnerable Adults

Definition of vulnerable adult

For the purposes of 'Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance' the term 'vulnerable adult' is defined as: *a person aged 18 years or over who is, or may be, in need of community care services* ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation.*

Adults who 'may be eligible for community care services' are those who's independence and well being would be at risk if they did not receive appropriate health and social care support.

They include adults with physical, sensory and mental impairments and
learning disabilities, however those impairments have arisen; e.g. whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

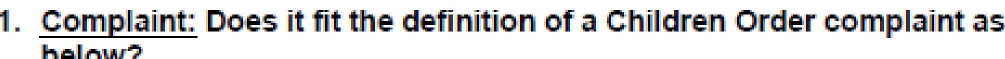
Making a complaint about health and social care can be intimidating, especially for people with mental health problems, learning disabilities or for those who are old or frail. The Trust should have consistent, explicit arrangements in place for advising and supporting vulnerable adults including signposting to independent advice and specialist advocacy services.

Reportable offences and allegations of abuse

Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect then the regional *Safeguarding Vulnerable Adults Policy and Procedural Guidance (Sept 2006)* and the associated *Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults (Dec 2003)* should be activated.

Appendix 6 – Children Order Representations And Complaints Procedure

Children Order Representations and Complaints Procedure

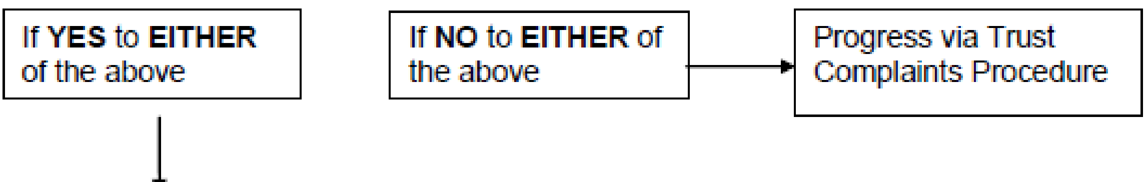


1. **Complaint: Does it fit the definition of a Children Order complaint as below?**

"Any representation (including any complaint) made to the Trust…about the discharge of any of its functions under part IV of the Order or in relation to the child." (Children (NI) Order 1995, Article 45 (3))

OR

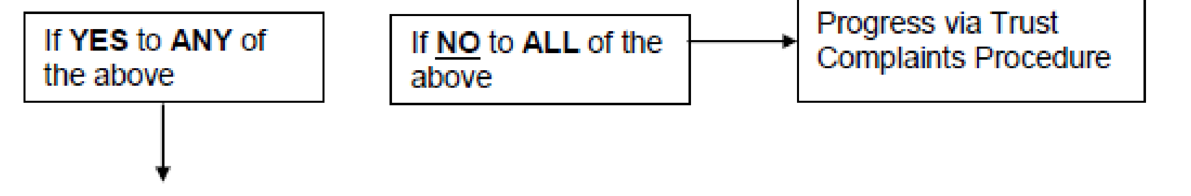
"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and paragraph 6 of Schedule 5 to, the Children Order." (Guidance and Regulations – Vol.4, Para 12.5 – DHSS)



2. **Does it meet the criteria of what may be complained about under Children Order?**

"..about Trust support for families and their children under Part IV of the Order."

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.



3. **Complainant: Does he/she fit the definition of a Children Order complainant?**

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need

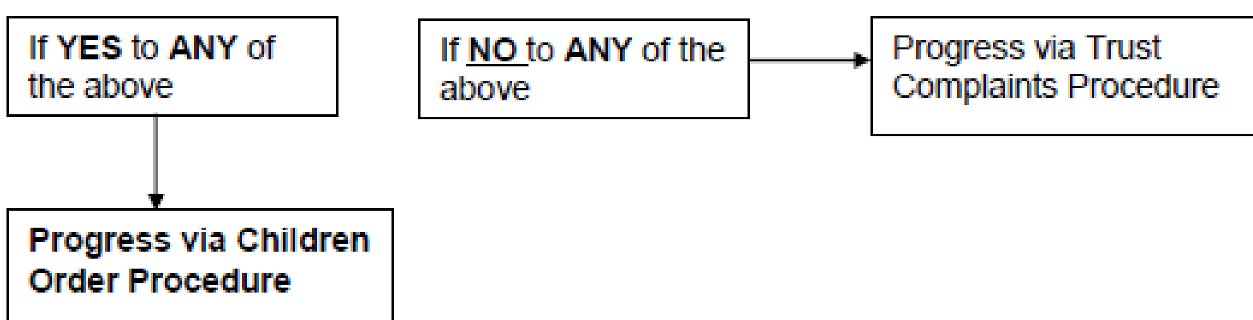
c. A parent **of his/her**

d. Any person who is not a parent of theirs but who has **parental responsibility for them**

e. Any Trust foster parent

f. Such other person as the Trust considers has sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- The person who had the day to day care of the child within the past two years;
- The child's Guardian Litem;
- The person is a relative of the child (as defined by the Children Order, Article 2 (2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- A friend;
- A teacher;
- A general practitioner
  (Children (NI) Order 1995 Article 45 (3))



NB:** For a complaint **to be eligible to be considered under the Children Order Procedure, the answer** to 1 **and** 2 **and** 3 **MUST ALL BE YES.

The Trust should always check with the child (subject to their understanding) that a complaint submitted reflects their views and that they wish the person submitting the complaint to act on their behalf (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Under the Children (NI) Order 1995 (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under part IV of, and paragraph 4 of Schedule 5 to, the Order and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987.

1. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996.
2. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4
3. All staff should familiarise themselves with these requirements

Appendix 7 - Formal Complaints Escalation Process

Every effort should be made to ensure complaints are responded to within 20 working days. Efficient processes for the prioritisation and management of complaints must be established in all Directorates, with every effort being made by staff to promptly identify potential obstacles to provision of responses within 20 days and to take action (escalating to more senior staff as necessary) to ensure the prompt handling of complaint investigation and response writing.

It is recognised however that there may be instances when, for example the complaint is complex and/or involves several Directorates, that it becomes apparent 20 working days will not afford adequate time to fully investigate the concerns raised. It is vitally important to identify likely delays at the earliest opportunity and to immediately notify the relevant Complaints Manager to allow prompt communication with the complainant.

1. Reminders should be sent by the Complaints Department to the relevant **Service Manager/ Investigating Manager 10 working days** following receipt of the complaint.

2. If a response is not received and no information provided when the response is likely to be completed within **12 working days** from receipt of the complaint, the relevant **Co-Director** will be informed.

3. If no response or contact has been made with the complaints team by the **15th working day,** the relevant **Director** will be informed.

4. Complaints which have not been responded to within the 20 working day time frame will be escalated as follows:

    - Complaints outstanding **after 20 working days** (without reasonable explanation provided by Service Area)
      A reminder will be sent to the **Service Manager, Co-Director and Director*** highlighting that the complaint is now outside the 20 working day timeframe.

    - Complaints outstanding **after 30 working days** (without reasonable explanation provided by Service Area)
      A further notice will be sent to the **Co-Director and Director*** advising that the complaint is now well outside of the time frame and urgently requires action. The Medical Director and Co-Director Risk and Governance will be made aware of the delay.

    - Complaints outstanding **after 40 working days** (without reasonable explanation provided by Service Area)
      An escalation notice will be sent to the Chief Executive

* When a complaint covers a number of Service Areas / Directorates all appropriate Directors will be advised.

Appendix 8 - Northern Ireland Public Service Ombudsman Cases

Receiving Correspondence

1. The Chief Executive's Office will scan correspondence from the Northern Ireland Public Services Ombudsman on the day of receipt and email to complaints@belfasttrust.hscni.net with a copy sent to the relevant Complaints Manager.
2. A hard copy of correspondence will be sent to the Complaints Department via post.
3. Complaints Manager will acknowledge receipt of Ombudsman correspondence from the Chief Executive's Office via email, and initiate appropriate action on the day of receipt.
4. Complaints Admin will acknowledge receipt of correspondence to Ombudsman's Office within 1 working day and confirm the name of the designated Complaints Manager. *Correspondence with the Ombudsman's Office is to be password protected at all times*.

Consideration Stage

The Ombudsman reviews details of the case to decide whether to instigate an investigation.

1. Complaints Admin will open a File to hold all documentation in relation to the Ombudsman's correspondence.
2. Senior Complaints Manager and Complaints Manager will discuss and agree an action plan and confirm which Co-Director will take responsibility for overseeing a response.
3. Complaints Admin will forward to the Service Group for action. A copy will also be sent to the relevant Director/Co-Director.
4. Complaints Manager will remove all duplications from the Complaints File and arrange for a copy to be sent to the Ombudsman's Office within 2 working days.
5. Complaints Manager will provide copies of any relevant complaints information required to the Ombudsman throughout the process. *If original notes are requested, ensure that these are requested and tracked in line with Trust procedures.*
6. Complaints Manager will identify actions with the Co-Director and lead Service Group Manager, and confirm a timeframe for responses to be received by the Complaints Department.
7. Service Group Manager will liaise with Health Records staff, within 2 working days, to arrange for copy of medical records to be sent to Complaints Manager.
8. Service Group Manager will prepare a draft response which addresses all of the issues raised within the agreed timeframe.
9. Complaints Manager will quality assure draft response. They will then send the draft response to the relevant Co-Director for approval, before being signed off by the Director.
10. Chief Executive Office will email the signed response to the Ombudsman's Office and send the hard copy, and any other documents requested, to the Ombudsman's Office via secure transport.

11. Complaints Admin staff will keep information on DATIX up-to-date. *An Ombudsman case should not be closed on DATIX until the final decision is made by the Ombudsman.*
12. The Co-Director will ensure any areas of good practice or issues for concern are highlighted with the relevant managers.
13. All staff will adhere to the Ombudsman's timescales. If there is any reason to anticipate delays that cannot be resolved through escalation measures, approval must be sought from the relevant Director to seek an extension from the Ombudsman's office (see process overview and associated templates below).

Investigation Stage

At this second stage, the Ombudsman has made a decision to accept the complaint for Investigation by the NIPSO Investigation Officers.

BHSCT staff will follow the same steps required during the Consideration Stage above plus:

1. Complaints Managers will review all documentation previously sent to the Ombudsman.
2. Complaints Managers will collate and quality assure any additional information requested.
3. Complaints Admin will arrange a meeting with the relevant staff, including Complaints Manager, to approve draft Trust response and associated enclosures.
4. Complaints Managers will highlight any areas of concern and work with Directorates to draft an Action Plan using the agreed Trust template.

Ombudsman's Draft Report

The Ombudsman provides the Trust with a confidential copy of the draft findings, and allows a short review period for the Trust to respond.

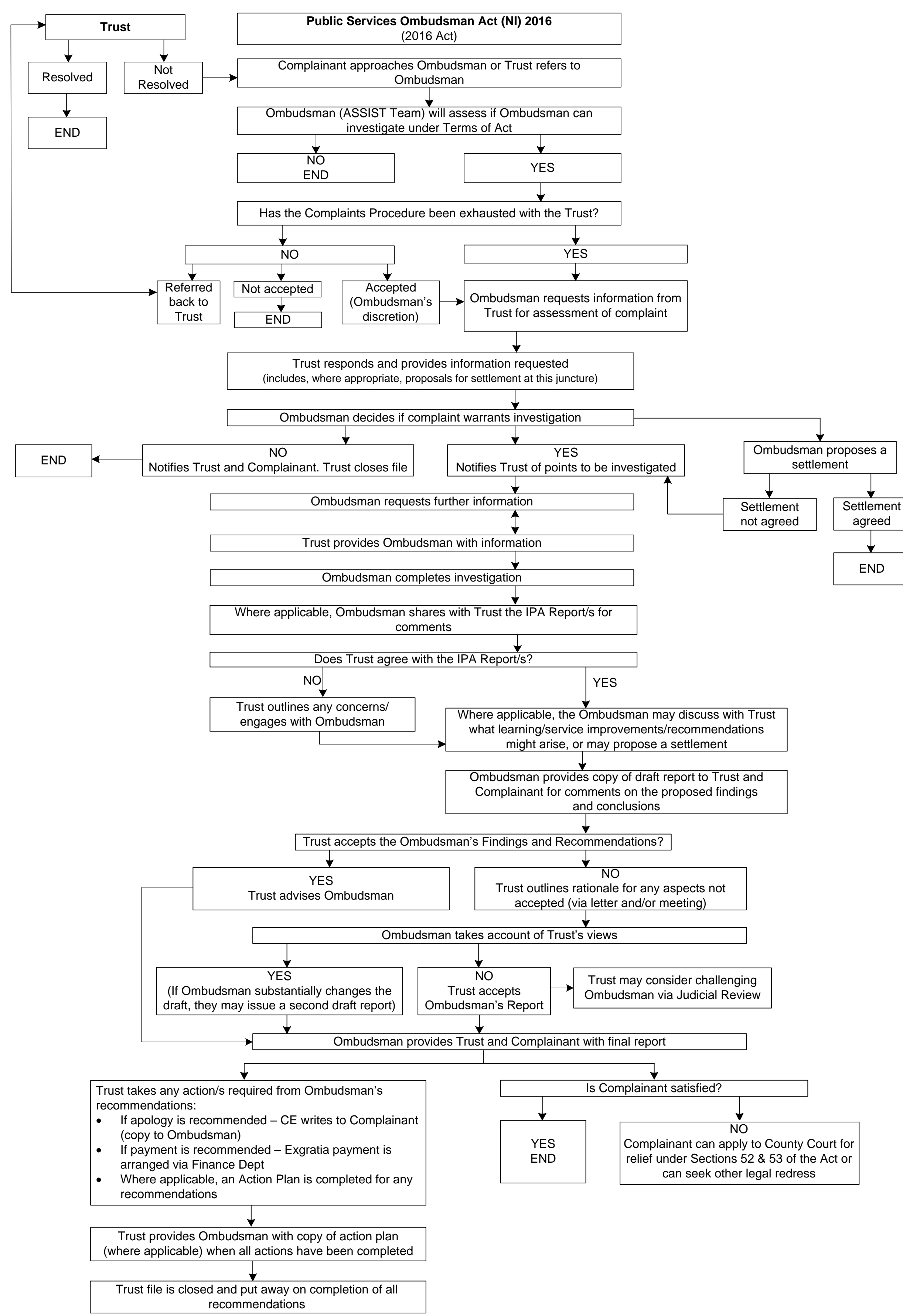
1. On receipt of the Ombudsman's Draft Report, the Complaints Manager will email a copy of the Draft report to all key stakeholders and advise of timescale for response.
2. Complaints Manager may arrange a meeting of all relevant staff to:
   a) Consider and agree the issues raised in the draft findings report
   b) Consider any factual inaccuracies
   c) If appropriate, review all documentation relating to the case
3. Complaints Manager will draft an Action Plan to address any areas of concern highlighted.
4. Service Group Manager will prepare a draft response for the Director's approval.
5. Following the Co-Director's approval of draft response, the relevant Director's Personal Assistant will forward it to the Director/Chief Executive for signature.
6. If appropriate, Complaints staff will prepare for informal meeting with Ombudsman's Office including pre meeting if deemed necessary.

Ombudsman's Final Report

1. The Complaints Manager will acknowledge the final report within 2 working days of receipt.
2. Complaints Manager will draft a letter of apology, to be approved and signed by Director/Chief Executive.
3. Chief Executive Office will issue the letter of apology to the complainant on the Ombudsman's instructions and send a copy to the Ombudsman's office.
4. Complaints Manager will ensure requests for financial redress are processed and appropriately approved and will ensure that the Action Plan is approved and sent to the Ombudsman along with any other documents, if requested.
5. Complaints Manager will record the outcome of the Ombudsman's investigation on the DATIX database investigation screen and close the complaint.
6. Complaints Manager will document Ombudsman cases in the Trust Quarterly and Annual Complaints Reports and other reports as required.
7. Senior Complaints Manager will discuss all Ombudsman cases at Complaints Manager meetings and Complaints Review Group, and will ensure recommendations and learning are shared as required.
8. Action Plans arising from Ombudsman recommendations will be presented by Directorates at Service User Experience Feedback Groupto ensure shared learning and to provide assurance regarding progression of necessary corrective / preventative actions.

Pathway for Complaints being considered by the NI Public Services Ombudsman

(Given the level of discretion available to the Ombudsman, this process may, on occasion, not be strictly followed)



Day	Action	Notes
DAY 1	**NIPSO correspondence received via e-mail**	*1 copy to Trust HQ, 1 copy to Complaints Team*
DAY 1	**Complaints Team extract all points of requested information / documentation into template (see Appendix A below) and e-mail to relevant Service Area(s) along with copy of original NIPSO letter.**	*e-mail will be sent to relevant Co-Director(s) and CCd to relevant Director(s)*
DAY 3	**Service Area(s) return completed template to Complaints Team confirming details of staff responsible for each element of the response (including identifying lead person to co-ordinate overall response), and identifying any anticipated delays**	*Completed template to be CCd to relevant Co-Director(s) and Director(s). Agreement to be reached between relevant Directors to assign lead responsibility for complaints involving multiple Directorates*
DAY 3 - 11	**Service Area(s) gather required information and produce draft response to address all points identified by NIPSO.** **Service Area(s) liaise with Complaints Team to provide updates confirming ability to submit response by required deadline.** **Complaints Team issue reminders / update requests to named contact points in Service Area(s) at 7 and 9 working days after receipt of NIPSO request** **Complaints Team escalate non-response to update requests, or indication of delays from Service Area***	*Non-responses will be escalated to Co-Director after 2 working days; identified delays immediately escalated to Co-Director and Director*
DAY 11	**Service Area(s) submits draft response to Complaints Team – all draft responses to be ratified by relevant Co-Director prior to submission to Complaints Team.**	
DAY 12	**Complaints Team QA draft response for completeness, accuracy of personal details and tone and forward to relevant Director.**	*Completed QA Checklist (Appendix C) to be sent to Director with draft response*
DAY 13 – 15	**Director reviews final draft and liaises with Complaints Team regarding any required amendments.** **Director signs off final response**	
DAY 15	**Complaints Team issue response via secure e-mail to NIPSO**	

**If extension to NIPSO deadline is required, request template (see Appendix B below) must be completed by Service Area and submitted to Director for sign off. Complaints Team will then submit to NIPSO.*

Complaint C/xxxx/xx NIPSO Ref xxxxx RESPONSE DUE – BHSCT HQ Deadline __/__/____ – NIPSO Deadline __/__/____

Lead Contact for final Complaint Response: Directorate ____________________________ Named point of contact____________________________

		NIPSO information / documentation requested	Organisation / Directorate / Service Area	Lead Contact for each query		Any anticipated delays / difficulties in providing the required information by [Insert BHSCT HQ Deadline]?	Any required escalation to ensure provision of required information by [Insert BHSCT HQ Deadline]?
				Name	Contact details		
1	Populated by Complaints Team – to be reviewed by Service Area						
2							
3							
4							
Any additional issues identified by Service Area requiring provision of information as part of NIPSO response:							
5							
6							

Complaint C/xxxx/xx NIPSO Ref xxxxx **DATE REQUESTED BY NIPSO : ____/____/______ DATE RESPONSE DUE – NIPSO Deadline ____/____/______**					
Outstanding information / documentation*		**Reason(s) for delay**	**Details of escalation / measures taken to address delays**	**Current Status / Comments**	**Expected date response available**
1					
2					
3					
4					
5					
Completed by: (Signature) ________________________________ (Printed Name) ________________________________ Role: __________________________ Date:____________					
I confirm that the information / documentation detailed above is unable to be provided to the Ombudsman within the required timeframe and as such request an extension to the indicated deadline. Signed (Director):____ Name :____ Date:_______________________					
Received Complaints Department: Date _________________ Complaints Manager: __________________________ Date submitted to NIPSO: _____________________					

**NB Extension requests should only be made in exceptional circumstances where the requested information remains unavailable despite every reasonable effort having been made by the Service Area to provide a response. Full reasons for delays must be detailed, and the extension request signed off by the relevant Director. Extension requests should be made as promptly as possible once an unavoidable delay has been identified. Where multiple pieces of information / documents have been requested by the Ombudsman, a partial response incorporating all available elements should be submitted by the required deadline, with the extension request only applying to outstanding areas.*

Complaint C/xxxx/xx NIPSO Ref xxxxx NIPSO Request Date __/__/____ Response Due: BHSCT HQ Deadline __/__/____ NIPSO Deadline __/__/____						
		Response element	Y	N	N/A	Comments / Action Taken
1		Is font Arial, size 12 used and are all paragraphs fully justified?	☐	☐	☐	
2		Are reference number, date, address, salutation line and complainant details accurate throughout?	☐	☐	☐	
3		Does the response fully address all the points raised by the Ombudsman's Office?				
	i		☐	☐	☐	
	ii		☐	☐	☐	
	iii		☐	☐	☐	
	iv		☐	☐	☐	
	v		☐	☐	☐	
	vi		☐	☐	☐	
	vii		☐	☐	☐	
	viii		☐	☐	☐	
4		Are there any spelling mistakes	☐	☐	☐	
5		Are there any disparities / conflicting statements	☐	☐	☐	
6		Is the tone of the response appropriate and are apologies included where appropriate?	☐	☐	☐	
8		Does the response include information detailing corrective action taken, or where learning and improvement have been identified if relevant?	☐	☐	☐	
9		Is plain English used, and medical terminology and jargon kept to a minimum and explained fully if necessary?	☐	☐	☐	
10		If policies, procedures or good practice guides are being specifically relied upon, are they clearly identified and enclosed where required?	☐	☐	☐	

Complaints Department

Completed by: ______________________________________ *Role:* ______________________________ *Date:*_____________

Trust HQ

Comments: (about any required amendments or other concerns)

Signed…………………………………………………………………………. (Director) Date……………………………

Appendix 9 - Record Keeping

1. Complaint records and correspondence about complaints will be kept separately from clinical records, subject to the need to record information which is strictly relevant to patient's health in clinical records.

2. A record of a complaint should include:

   - the name of the complainant,
   - DOB
   - address
   - contact details
   - where appropriate Health and Care number, Dept/ Ward/ Facility and GP details
   - clear details of all issues identified in the complaint
     - who or what is being complained about, including the names of staff if known
     - where and when the events of the complaint happened
     - where possible, what remedy is being sought- e.g. an apology or an explanation or changes to services
   - confirmation of advice given on consent when appropriate

3. When the Frontline Resolution Form (see page 17) is completed this should be forwarded to the Complaints Department immediately for acknowledgement and action.

4. A complaint file has the same status as any other record created by a healthcare organisation and is therefore a confidential record.

5. The Trust will ensure that the management and storage of complaint files is consistent with relevant guidance including GDPR, Data Protection, and Good Management Good Records

6. All correspondence regarding the complaint will be marked 'confidential'.

7. The minimum recommended period for retaining a complaint file is *ten years* from the date on which action was completed. For complaint about children and young people the file must be kept until the patient's 25th birthday.

8. Files must be disposed of under confidential conditions (Records Management)

9. Confidential information sent outside the Trust must have the appropriate level of security applied (e.g. encryption, password protection etc).

Appendix 10 – Consent, confidentiality, and third party confidence

Staff should be aware of their legal and ethical duty to protect the confidentiality of service users' information as set out in General Data Protection Regulations, Data Protection Act and the Human Rights Act.

Where a service user is the complainant, it is good practice to explain that information from health and social care records may need to be disclosed to those involved in investigation of the complaint. If the service user objects to this, it should be explained that this could compromise the investigation and potentially result in an unsatisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is a significant public interest in continuing with the matter.

Where the complainant is not the patient it is necessary to obtain the patient's written consent to use personal information prior to investigating a complaint. Third party complaints may be made by a service user's relative, friend, carer, or other representatives (such as their solicitor) provided the service user has given his/her written consent. In such circumstances the Complaints Team will forward a consent form to the relevant person(s) requesting authorisation. The Complaints Manager, in discussion with the Service Director, Data Protection Officer, or other senior person, will determine whether the complainant has sufficient interest to act as a representative.

The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative the Trust will provide information in writing to the person outlining the reasons the decision has been taken. Where Consent has not been received, the complaints response will not be released. A second request letter to the complainant will be sent advising that consent is required. If consent has not been received, a third and final letter will be sent advising that the complaint will be closed within a stated timeframe.

There may, however, be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (e.g. rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the individual is deceased.

Third Party Confidence

The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social service professional. Only that information which is relevant to the complaint should be considered for disclosure, and then only to those within the HSC who have a demonstrable need to know in connection with the complaint investigation.

Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure. Disclosure of information provided by a third party outside the HWSC also requires the express consent of the third party. If the third party objects, then it can only be disclosed where there is an overriding public interest to do so.

Information on consent can be found in the Department of Health Good Practice in Consent guidance. Staff are also directed to the DoH Code of Practice on Protecting the Confidentiality of Service Users.

Use of Anonymised Information

Where anonymised information about a patient/client and/or third parties would suffice, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use information, then it can only be used where there is an overriding public interest in doing so.

Appendix 11 – Internal/ External Support/ Contacts

ADVOCACY AND CONCILIATION

Some people who might wish to complain do not do so because they do not know how to, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their wishes and views known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

Within the Health and Social Care sector, advocacy has been available mainly for vulnerable groups, such as people with learning problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and can be intimidated by professional attitudes that may seem paternalistic and authoritarian.

The Trust should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to gain a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations such as:

- where staff or practitioners feel the relationship with the complainant is difficult
- when trust has broken down between the Trust and both parties feel it would assist in the resolution of the complaint
- where it is important, e.g. because of on-going care issues, to maintain the relationship between the complainant and the Trust
- when there are misunderstandings with the relatives during the treatment of the patient

All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other’s point of view and ask questions.

Complaints raised by unreasonable, vexatious or abusive complainants are NOT suitable for conciliation.

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, e.g. if there is a breakdown in the relationship between a doctor or practitioner and their patient.

Conciliation may be requested by the complainant or the Trust.

COMPLAINTS DEPARTMENT

The BHSCT Complaints Department is located at:

Musgrave Park Hospital
McKinney House
Stockman's Lane
Belfast
BT9 7JB

Tel: 028(95) 048000

LAY PERSONS

A Lay Persons is an independent person that does not act as an advocate, conciliator or investigator. Neither do they act on behalf of the complainant or complained about. Their involvement is to help bring about resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised.

NORTHERN IRELAND PUBLIC SERVICES OMBUDSMAN

The Northern Ireland Public Services Ombudsman (the Ombudsman) can carry out independent investigations into complaints about poor treatment or services or the administrative actions of the Trust. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly- and the Trust or practitioner has not put things right where they could have- the Ombudsman may be able to help.

The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman

Freepost NIPSO
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Tel: 028 90 233821
Freephone: 0800 34 34 24
Text phone: 028 90 897789

email: nipso@nipso.org.uk

PATIENT AND CLIENT COUNCIL

The Patient and Client Council (PCC) is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public
- promoting involvement of the public
- providing assistance to individuals making or intending to make a complaint
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services

If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the Complaints Procedure and advice on how to take a complaint forward
- discussing the complaint and drafting letters
- making telephone calls
- helping prepare for a meeting and accompanying the complainant
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services;
- help on accessing medical / social services records.

All advice, information and assistance with complaints are provided free of charge and are confidential. Further information can be obtained from; **www.patientclientcouncil@hscni.net** or Freephone 0800 917 0222

REGULATION AND QUALITY IMPROVEMENT AUTHORITY - (RQIA)

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. The Regulation and Quality Improvement Authority will monitor how complaints about the regulated services are handled.

Contact Details:

The Regulation and Quality Improvement Authority Headquarters
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Email: info@rqia.org.uk

Telephone number: 028 9051 7500
Fax: 028 9051 7501

Appendix 12 – Unreasonable, vexatious or abusive complaints

All Trust staff should respond to complainants in an appropriate and professional manner. However, there may be times when nothing can reasonably be done to assist a complainant and where further contact with a complainant places inappropriate demands on resources.

In such cases and in consultation with Senior Manager/ Co-Director will establish if the "Unacceptable Actions Policy". Or Guidance for the handling of Habitual or Vexatious complains should be considered.

1. Introduction

The difficulties in handling unreasonable, vexatious or abusive complainants place an unreasonable strain on time and resources and can cause undue stress for staff that may need support in these difficult situations. Staff should respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further which can be reasonably done to assist them or to rectify a real or perceived problem.

In determining arrangements for handling such complainants, the Trust is presented with two key considerations:

a) To ensure that the complaints procedure has been correctly implemented so far as is possible and that no material element of a complaint is overlooked or inadequately addressed, and to appreciate that even habitual or vexatious complaints may have aspects to their complaints which contain some genuine substance. The need to ensure an equitable approach is crucial.

b) To be able to identify the stage at which the complainant has become habitual or vexatious.

2. Purpose of the Guidance

The aim of the guidance is to identify situations where a complainant might be properly considered to be habitual or vexatious and to suggest ways of responding to these situations.

It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken to try and resolve complaints following the Trust's complaints procedure, i.e., through local resolution.
Judgement and discretion must be used in applying the criteria to identify potential or vexatious complainants and in deciding action to be taken in specific cases.

The procedure should only be implemented following careful consideration of the actions and behaviour of a complainant by a Director of the Trust, in conjunction with the relevant Patient/Client Liaison Manager.

3. Definition of an unreasonable, vexatious or abusive complainants

Complainants (and/or anyone acting on their behalf) may be deemed to be unreasonable, vexatious or abusive where previous or current contact with them shows that they meet any one of the following criteria:

Where complainants:

a) persist in pursuing a complaint after the Complaints Procedure has been fully and properly implemented and exhausted (e.g. where investigation has been denied as 'Out of time')

b) change the substance of a complaint or continually raise additional issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response (Not all complainants who raise further concerns or questions on receipt of a response are vexatious. They may be doing so to seek clarification as part of the local resolution process. Care must be taken not to discard new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints)

c) are unwilling to accept documented evidence of treatment given as being factual, e.g. drug records, medical or computer records, or deny receipt of an adequate response in spite of correspondence specifically answering their questions, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed

d) do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of staff to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate

e) focus on a relatively minor matter to an extent, which is out of all proportion to its significance and continue to focus on this point (It is recognised that determining what a '*relatively minor*' matter can be is subjective, therefore careful judgement must be used in applying this criteria)

4. Dealing with unreasonable, vexatious or abusive complainants

A Director of the Trust and/or nominated deputies may decide to deal with complainants in one or more of the following ways:

a) Once it is clear a complainant meets any one of the criteria above, they should be informed in writing that they may be classified as habitual or vexatious complainants. This procedure should be copied to them and they should be advised to take account of the criteria in any further dealings with the Trust.

b) Decline any contact with the complainants either in person, by telephone, by fax, by email, by letter or any other combination of these, or restrict contact to liaison through a third party (If staff are to withdraw from a telephone conversation with a complainant, it may be helpful to have an agreed statement to be used at such times).

c) Notify the complainants in writing that a Director of the Trust has responded fully to the points raised, and have tried to resolve the complaint, that there is nothing more to

add and continuing contact will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

d) Inform the complainants that in extreme circumstances, the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors or to the Police if violence or threats are made against staff.

e) Temporarily suspend all contact with the complainants regarding their complaint whilst seeking legal advice and advise the complainant accordingly. It may still be necessary however to continue providing a healthcare service.

5. Withdrawing 'unreasonable, vexatious or abusive' Status

Once a complainant has been identified as 'habitual or vexatious' there needs to be a mechanism in place for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate.

Staff should use discretion in recommending 'habitual or vexatious' status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate.

Where this appears to be the case, a discussion between key staff and the Chief Executive and/or nominated deputies will take place. Subject to his/her approval, normal contact with the complainants and application of the Trust's complaints procedure will then be resumed.

Even correspondence from complainants who have been classified as habitual or vexatious should be screened to ensure that no new complaint has been raised and to determine if the Trust's discretion should be applied.

Appendix 13 –Unacceptable Actions Policy

1. Introduction

HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complainants, staff need to:

- Ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- Appreciate that even habitual complainants may have grievances which contain some substance;
- Ensure a fair approach;
- Be able to identify the stage at which a complainant has become habitual.

The following Unacceptable Actions Policy should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

This policy sets out the approach to those complainants whose actions or behaviour HSC organisations consider unacceptable. The aims of the policy are to:

- Make it clear to all complainants, both at initial contact and throughout their dealings with the organisation, what the HSC organisation can or cannot do in relation to their complaint. In doing so, the HSC organisation aims to be open and not raise hopes or expectations that cannot be met;
- Deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered unacceptable. All complainants have the right to be heard, understood and respected. HSC staff have the same rights.
- Provide a service that is accessible to all complainants. However, HSC organisations retain the right, where it considers complainants’ actions to be unacceptable, to restrict or change access to the service;
- Ensure that other complainants and HSC staff do not suffer any disadvantage from complainants who act in an unacceptable manner.

2. Defining Unacceptable Actions

People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is assertive or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint.

The actions of complainants who are angry, demanding or persistent may however result in unreasonable demands on the HSC organisation or unacceptable behaviour towards HSC staff. It is such actions that HSC organisations consider unacceptable and aim to manage under this policy.

These unacceptable actions are grouped under the following headings:

a) Aggressive or abusive behaviour

Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance approach must be adopted. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

b) Unreasonable demands

Complainants may make what the HSC consider unreasonable demands through the amount of information they seek, the nature and scale of service they expect or the number of approaches they make. What amounts to unreasonable demands will always depend on the circumstances surrounding the behaviour and the seriousness of the issues raised by the complainant. Examples of actions grouped under this heading include demanding responses within an unreasonable timescale, insisting on seeing or speaking to a particular member of staff, continual phone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

HSC organisations consider these demands as unacceptable and unreasonable if they start to impact substantially on the work of the organisation, such as taking up an excessive amount of staff time to the disadvantage of other complainants or functions.

c) Unreasonable persistence

It is recognised that some complainants will not or cannot accept that the HSC organisation is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the organisation persistently about the same issue. Examples of actions grouped under this heading include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the HSC organisation can or cannot do and continuing to pursue a complaint without presenting any new information.

The way in which these complainants approach the HSC organisation may be entirely reasonable, but it is their persistent behaviour in continuing to do so that is not. HSC organisations consider the actions of persistent complainants to be unacceptable when they take up what the HSC organisation regards as being a disproportionate amount of time and resources.

3. Managing Unacceptable Actions

There are relatively few complainants whose actions a HSC organisation consider unacceptable. How the organisation manages these depends on their nature and extent. If it adversely affects the organisation's ability to do its work and provide a service to others, it may need to restrict complainant contact with the organisation in order to manage the unacceptable action. The HSC organisation will do this in a way, wherever possible, that allows a complaint to progress to completion through the complaints process. The organisation may restrict contact in person, by telephone, fax, letter or electronically or by any combination of these. The organisation will try to maintain at least one form of contact. In extreme situations, the organisation will tell the complainant in writing that their name is on a "no contact" list. This means that they may restrict contact with the organisation to either written communication or through a third party.

The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in the ending of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

HSC organisations do not deal with correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. When this happens the HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful. The HSC organisation will ask them to stop using such language and state that it will not respond to their correspondence if they do not stop. The HSC organisation may require future contact to be through a third party.

HSC staff will end telephone calls if the caller is considered aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that the behaviour is unacceptable and end the call if the behaviour does not stop.

Where a complainant repeatedly phones, visits the organisation, sends irrelevant documents or raises the same issues, the HSC organisation may decide to:

- Only take telephone calls from the complainant at set times on set days or put an arrangement in place for only one member of staff to deal with calls or correspondence from the complainant in the future;
- Require the complainant to make an appointment to see a named member of staff before visiting the organisation or that the complainant contacts the organisation in writing only;
- Return the documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed;
- Take other action that the HSC organisation considers appropriate. The HSC organisation will, however, tell the complainant what action it is taking and why.

Where a complainant continues to correspond on a wide range of issues and the action is considered excessive, then the complainant is told that only a certain number of issues will be considered in a given period and asked to limit or focus their requests accordingly.

Complainant action may be considered unreasonably persistent if all internal review mechanisms have been exhausted and the complainant continues to dispute the HSC organisation's decision relating to their complaint. The complainant is told that no future phone calls will be accepted or interviews granted concerning this complaint. Any future contact by the complainant on this issue must be in writing. Future correspondence is read

and filed, but only acknowledged or responded to if the complainant provides significant new information relating to the complaint.

4. Deciding to restrict contact

HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy.

With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff.

Wherever possible, the HSC organisation will give the complainant the opportunity to modify their behaviour or action before a decision is taken.

Complainants are told in writing why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place.

5. Appealing a decision to restrict contact

A complainant can appeal a decision to restrict contact. A senior member of staff who was not involved in the original decision considers the appeal. They advise the complainant in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

6. Recording and reviewing a decision to restrict contact

The HSC organisation will record all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact may be reconsidered if the complainant demonstrates a more acceptable approach. A senior member of staff will review the status of all complainants with restricted contact arrangements on a regular basis.

GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Updated April 2022

REVISIONS TO HSC COMPLAINTS PROCEDURE

Title	Update/Action	Date Effective
Guidance in relation to the Health and Social Care Complaints Procedure	Updated to reflect the closure of the Health and Social Care (HSC) Board and migration of functions to Strategic Planning and Performance Group (SPPG), DoH.	01 April 2022
Guidance in relation to the Health and Social Care Complaints Procedure	Introduced in place of: Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	01 April 2019
Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	Introduced in place of: (HPSS) Complaints Procedure 1996	01 April 2009
Health and Personal Social Services (HPSS) Complaints Procedure 1996	Revoked and replaced with new Guidance	31 March 2009

AMENDMENTS TO COMPLAINTS DIRECTIONS

Directions	Details	Date Effective
Health and Social Care Complaints Procedure Directions	The Main Directions were amended for the third time at: CURRENTLY WITH DSO	Xx xxxxx 2022
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The HSC Board Directions were revoked. CURRENTLY WITH DSO	Xx xxxxxx 2022
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The PHA Directions were amended for the second time at: CURRENTLY WITH DSO	Xx xxxx 2022

Directions	Details	Date Effective
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The BSO Directions were amended for the second time at: CURRENTLY WITH DSO	Xx xxxx 2022
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	01 April 2019 **2019 No. 4**
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and	01 April 2019 **2019 No. 3**

Directions	Details	Date Effective
	• Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol	
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b)	01 April 2019 **2019 No. 2**

Directions	Details	Date Effective
	substitute(b) The HSC Board Complaints Manager acts impartially as "honest broker" to the complainant and Practice/Practitioner in the resolution of the complaint.	
Health and Social Care Complaints Procedure Directions	The **Main Directions** were amended for the second time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—update to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as "honest broker" to the complainant and Practice/Practitioner in the resolution of the complaint.	01 April 2019 **2019 No. 1**

Directions	Details	Date Effective
	• Paragraph 14 (Response) of the principal Directions omit sub-paragraph (7).	
Complaints about Family Health Services Practitioners and Pilot Scheme Providers **(Amendment)** Directions (Northern Ireland) 2013	The **HSC Board Directions** were amended for the second time in regard to the handling of complaints under paragraph 12(5)(b) at: • Paragraph 18(c) (Response) was amended to include sub-paragraph 18(c)(i) to respond to the complainant within 20 days when the HSC Board has been asked to act as 'honest broker'; and • Sub-paragraph 18(c) (ii) to respond to the complainant within 10 days in all other cases.	02 September 2013 **2013 No. 12**
Health and Social Care Complaints Procedure Directions **(Amendment)** (Northern Ireland) 2009	The **Main Directions** were amended for the first time at: • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	02 September 2013 **2013 No. 11**
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The Directions were introduced. Known as **BSO Directions**	26 July 2010
Directions to the Regional Agency for Public Health	The Directions were introduced. Known as **PHA Directions**	26 July 2010

Directions	Details	Date Effective
and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints		
Amendment Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the first time in respect to monitoring and the requirement by the Family Practitioner Services or pilot scheme provider to obtain consent from the complainant was removed at: Paragraph 21(2)(a) in regards to what the practitioner must send to the HSC Board and the timescale: and Paragraph 21(2) (b) in regards the practitioner sending the HSC Board quarterly complaints.	01 October 2009
Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The Directions were introduced. Known as **HSC Board Directions**	01 April 2009
Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009	The Directions were introduced. Known as **Main Directions**	01 April 2009

BACKGROUND

The HSC Complaints Procedure*, 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning'* was developed and published in 2009. It replaced the former Health and Personal Social Services (HPSS) Complaints Procedure 1996 and provided a streamlined health and social care (HSC) complaints process that applies equally to all HSC organisations. As such it presented a simple, consistent approach and set out complaints handling procedures with clear standards and guidance for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

The HSC Complaints Procedure (published 2009) was developed in conjunction with HSC organisations and publically consulted on before being finalised and published. It reflected the changing culture across HSC services and demonstrated an increased emphasis regarding the promotion of and need for **safety and quality** in service provision as well as the need to be open and transparent; and to learn from complaints and take action in order to reduce the risk of recurrence.

On the 1st April 2019 revised guidance was introduced and incorporated a number of legislative changes. The document was renamed, '*Guidance in relation to the Health and Social Care Complaints Procedure' or 'HSC Complaints Procedure'* for short.

The HSC Complaints Procedure presents HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution and learning;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well-defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as the use of independent experts, lay persons and conciliation;
- resolve complaints quickly and efficiently;
- provide flexibility in relation to target response times;

- provide an appropriate and proportionate response within reasonable and agreed timescales;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the region.

The standards for complaints handling are designed to assist HSC organisations in monitoring the effectiveness of their complaints handling arrangements locally and build public confidence in the process. The eight specific standards of HSC are:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

More details on each of the standards are provided in Annex 1 of this document.

It is recognised that sometimes, and even in despite of the best efforts of all concerned, there will be occasions when local resolution fails. Where this happens the complainant will be advised of their right to refer their complaint to the Ombudsman. The HSC Organisation also reserves the right to refer complaints to the Ombudsman.

Update – 01 April 2022

As a result of the migration of the HSC Board to the Department of Health this guidance has been amended to reflect the transfer of the HSC Board functions in respect of HSC Complaints to the Strategic Planning and Performance Group (SPPG) in the Department.

SPPG will on behalf of the Department of Health assume the roles and responsibilities previously undertaken by the HSC Board. This updated guidance is effective from 01 April 2022.

SECTION 1 – INTRODUCTION 11

What the HSC Complaints Procedure covers 13

What the HSC Complaints Procedure does not cover 14

SECTION 2 – MAKING A COMPLAINT 20

What is a complaint? 20

Promoting access 20

Who can complain? 20

How can be complaints be made? 23

Supporting complainants and staff 30

What are the timescales for making a complaint? 30

SECTION 3 – HANDLING COMPLAINTS 32

Accountability 32

Actions on receipt of a complaint 36

Investigation 38

Responding to a complaint 42

SECTION 4 – LEARNING FROM COMPLAINTS 50

Reporting and Monitoring 50

Learning 53

SECTION 5 – ROLES AND RESPONSIBILITIES 54

Annex 1: Standards for complaints handling 58

Annex 2: Legal Framework 67

Annex 3: Professional regulatory bodies 69

Annex 4: HSC Prison healthcare 70

Annex 5: The NI Public Services Ombudsman 71

Annex 6: The Regulation and Quality Improvement Authority 73

Annex 7: Advocacy 74

Annex 8: Conciliation 75

Annex 9: Independent experts 79

Annex 10: Lay persons 83

Annex 11: Honest broker 86

Annex 12: Adult safeguarding 88

Annex 13: Unreasonable or abusive complainants 90

Annex 14: Children Order representations and complaints procedure 97

SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

1.1 This document is an updated version of the HSC Complaints Procedure which was first published in 2009 and sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces any previous or existing guidance with effect from 01 April 2022 and continues to provide a streamlined complaints process which applies equally to all HSC organisations, including the HSC Trusts, Business Services Organisation (BSO), Public Health Agency (PHA), NI Blood Transfusion Service (NIBTS), Family Practitioner Services (FPS), Out of Hours services, pilot schemes and HSC prison healthcare. As such, it presents a simple, consistent approach for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

1.2 The HSC Complaints Procedure continues to promote an organisational culture in health and social care that fosters openness and transparency for the benefit of all who use it or work in it. It is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The HSC Complaints Procedure provides the opportunity to put things right for service users as well as learning from the experience and improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.

Local resolution

1.3 The purpose of local resolution is to enable the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10 working days within FPS settings). The expectations of service users should be

managed by HSC staff and any difficulties identified in being able to resolve a complaint within 20 days by local resolution should be communicated to the service user immediately.

1.5 Local procedures should be easily accessible, open, fair, flexible and conciliatory and should encourage communication on all sides. They should include a well-defined process for investigating and resolving complaints. Complainants must be advised of their right and be signposted to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the HSC Complaints Procedure.

Principles of an effective Complaints Procedure

1.6 The HSC Complaints Procedure has been developed around four key principles:

- **openness and accessibility** – flexible options for pursuing a complaint and effective support for those wishing to do so;
- **responsiveness** – providing an appropriate and proportionate response;
- **fairness and independence** – emphasising early resolution in order to minimise strain and distress for all; and
- **learning and improvement** – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements. Lessons learned during the complaints resolution process will assist organisations to make changes to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of not just resolving complaints but also learning from them. Furthermore, by highlighting the potential added value of complaints and subsequent quality and safety improvements made within HSC organisations the process becomes more acceptable and amenable to all.

1.8 Complaints are seen as a significant source of learning within health and social care and provide opportunities to improve:

- outcomes for services users;
- the quality of services; and
- service user experiences.

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users and/or their representatives. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and use the lessons learned to improve quality and safety.

What the HSC Complaints Procedure covers

1.10 The HSC Complaints Procedure deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by, for example:

- HSC Trusts
  - hospital and community services
  - registered establishments and agencies where the care is funded by the HSC
  - HSC funded staff or facilities in private pay beds
  - HSC prison healthcare
- Business services organisation (BSO)
  - services provided relevant to health and social care
- Public Health agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- Family practitioner Services (FPS)

1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[1] as an alternative to making an application to the courts.

[1] Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.

What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care[2] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

1.13 Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC organisation should ensure that there are other processes in place which can be referred to in order to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by DoH
- requests for information under Freedom of Information or access to records under the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[3]

1.14 Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately transferred to the Complaints

[2] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/
[3] Public Interest Disclosure (Northern Ireland) Order 1998

Manager for onward transmission to the appropriate department. Where a complaint is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication. If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure

1.16 Disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body (see paragraph 1.20 below). The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

1.17 Where a decision is made to embark upon a disciplinary investigation, action under the HSC Complaints Procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the HSC Complaints Procedure.

1.18 The Chief Executive (or designated senior person[4]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part

[4] A designated Senior Person should be a Director (or Nominee)

in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

1.19 In drafting these letters, the overall consideration must be to ensure that when investigation is required the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body

1.20 A similar approach to that outlined above should be adopted in a case referred to a professional regulatory body (Annex 3). The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation may need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the DoH

1.21 Complaints about commissioning and the purchasing of services can be made generally; or by, or on behalf of, any individual personally affected by a commissioning decision taken by the department, and will be dealt with under the DoH Complaints Procedure.

Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[5] and requests for access to health or social care records under the UK General Data Protection Regulation (GDPR)[6] and Data Protection Act 2018.

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[5] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[6] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

Independent Inquiries and Criminal Investigations

1.23 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints procedure.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 14. The HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[7].

Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[8]) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016[9]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[10]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint

[7] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[8] Adult Safeguarding Operational Procedures: Adult Safeguarding (hscni.net)
[9] Protocol for Joint Investigation of Adult Safeguarding Cases: DRAFT (hscni.net)
[10] Information about and contact details for HSC Trusts can be accessed at the following link - https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect

not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures

1.27 Any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- threshold for registration/deregistration was not met;
- category for registration was not correct.

Coroners Cases

1.28 With the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroner's investigation they will continue to be dealt with under the HSC Complaints Procedure. Once the Coroner's investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner may then be dealt with under the HSC Complaints Procedure.

Legal Action

1.29 Even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

1.31 It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to continue with their complaint via the HSC Complaints Procedure and requests this, the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot also be investigated under the HSC Complaints Procedure.

Serious Adverse Incidents (SAI)

1.32 Complaints may indicate the need for a Serious Adverse Incident (SAI) review. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI review is under way. They must also indicate to all concerned that the HSC Complaints Procedure may still continue during the SAI review. However, only those aspects of the complaint not falling within the scope of the SAI review will continue via the HSC Complaints Procedure.

1.33 The overall consideration must be to ensure that when the review is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

Whistleblowing

1.34 The Department of Health has a framework and model policy in place for HSC organisations on Whistleblowing[11]. All HSC organisations should have their own separate procedures in place.

[11] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-whistleblowing.PDF

SECTION 2 – MAKING A COMPLAINT

What is a complaint?

2.1 A complaint is "**an expression of dissatisfaction that requires a response**". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such.

Promoting access

2.2 Standard 2: *Accessibility* provides the criteria by which organisations should operate (Annex 1 refers). Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursuing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised on the types of help available, for example, through front-line staff, the Complaints Manager and the Patient and Client Council (PCC). HSC organisations should promote and encourage more open and flexible access to the HSC Complaints Procedure and other less formal avenues in an effort to address barriers to access.

Who can complain?

2.3 Any person can complain about any matter connected with the provision of HSC services. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

Consent

2.4 Complaints by a third party should be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as when the:

- individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- individual is incapable (for example, rendered unconscious due to an accident; judgement impaired as a result of a learning disability, mental illness, brain injury or serious communication problems);
- subject of the complaint is deceased; and
- delay in the provision of consent may result in a delay in the resolution of the complaint.

2.5 Where a person is unable to act for him/herself, his/her consent shall not be required.

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance[12].

2.7 Third party complainants who wish to pursue their own concerns can bring these to the HSC organisation without compromising the identity of the patient/client. The HSC organisation must consider the matter then investigate and address the issue and any concerns identified fully. A response will be provided to the third party on any issues which may be addressed without breaching patient/client confidentiality.

[12] https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care

Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the UK General Data Protection Regulations (GDPR) and Data Protection Act 2018 which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. More detailed information can be found in the DoH guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information* [13]published January 2012.

2.9 It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health and/or social care records may need to be disclosed to the complaint investigators, but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that non-disclosure could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

Third Party Confidence

2.10 The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social care professional. Only information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HSC who have a demonstrable 'need to know' in

[13] DoH Code of Practice:
https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

2.11 Disclosure of information provided by a third party outside the HSC also requires express consent. If the third party objects, then information they provided can only be disclosed where there is an overriding public interest in doing so.

Use of Anonymised Information

2.12 Where anonymised information about a patient/client and/or third parties would suffice for investigation of the complaint, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use certain information, then it can only be used where there is an overriding public interest in doing so.

How can complaints be made?

2.13 Complaints may be made in a variety of formats including verbally, written or electronic. Should a verbal complaint be made the complainant should be asked to formalise their complaint in writing. If the complainant is unable to put their complaint in writing then Trust staff or the Patient Client Council can provide assistance. It is helpful to establish at the outset what the complainant wants to achieve in order to avoid confusion or dissatisfaction and subsequent complaints. HSC organisations should be mindful of technological advances specifically in regard to email communications and must adhere to their relevant Information Technology (IT) policies and procedures. Complaints Managers should also consider local arrangements to ensure there is no breach of patient/client confidentiality in the management of information surrounding complaints.

2.14 Complaints may be made to any member of staff, for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint “on the spot” or pass it to the Complaints Manager.

It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery[14]. (See Flowchart page 45)

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, to the Chief Executive. All HSC organisations have named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services;
- Regulated Establishments and Agencies; and
- Independent Sector Providers.

Family Practitioner Services (family doctors, dentists, pharmacists, opticians)

2.16 Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure which forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the SPPG Complaints Team[15], if he/she does not feel able to approach immediate staff (see flowchart page 46).

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[14] Section 75 of the Northern Ireland Act 1998 https://www.legislation.gov.uk/ukpga/1998/47/section/75
[15] SPPG Complaints Team acting on behalf of the DoH.

2.18 Where requested, the SPPG Complaints Team will act impartially as "honest broker" to the complainant and Practice/Practitioner in either the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the SPPG Complaints Team should be, wherever possible, to restore the trust between the patient and the Practice/Practitioner staff. This will involve an element of mediation on the part of the SPPG Complaints Team or the offer of conciliation services where they are appropriate. The SPPG Complaints Team should seek with the complainant's agreement to involve the FPS Complaints Manager as much as possible in resolving the issues. The SPPG Complaints Team is also available to Practice/Practitioner staff for support and advice.

2.19 The SPPG Complaints Team has a responsibility to record and monitor the outcome of complaints lodged with them.

2.20 The SPPG Complaints Team will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint Independent Experts, Lay Persons or Conciliation Services, where appropriate.

2.21 Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies[16] must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

- Effectively publicising the arrangements for dealing with complaints and ensuring service users, clients and families are aware of such arrangements;
- Ensuring that any complaint made under the complaints procedure is investigated;
- Ensuring that time limits for investigations are adhered to;

[16] Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.

- Advising complainants regarding the outcomes of the investigation; and
- Maintaining a record of learning from complaints that is available for inspection.

2.23 Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure. It is for the Ombudsman to determine whether or not a case falls within that office's jurisdiction.

2.24 Complaints may be made by service users or persons acting on their behalf providing they have obtained the service user's consent. Complaints relating to contracted services provided by the registered provider or agency may be received directly by the service provider or by the contracting Trust. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider or agency. The registered provider is required by legislation to ensure the complaint is fully investigated. The general principle in the first instance would be that the registered provider or agency investigates and responds directly to the complainant.

2.25 However, individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that commissioned the care on their behalf (see flowchart on page 47) as the commissioning Trust has a continuing duty of care to the service user and should participate in local resolution as necessary.

2.26 Where complaints are raised with the HSC Trust, the Trust must establish the nature of the complaint and consider how best to proceed. For example, the complaint may be about an aspect of the "care plan" and can, therefore, only be fully dealt with by the Trust. The complaint may also trigger the need for an investigation under child protection or protection of vulnerable adults' procedures or indeed, might highlight non-compliance with statutory requirements. It is not the intention to operate parallel complaints procedures, however, if the RQIA is notified of a breach of regulations or associated standards it will review the matter and take whatever appropriate action is required. It is important, therefore, that Trusts work closely with the registered

providers, other professionals and the RQIA to enable appropriate decisions to be made.

2.27 HSC Trusts must assure themselves that regulated establishments and agencies that deliver care on their behalf are effective and responsive in complaints handling. Service users may approach the Ombudsman if they remain dissatisfied. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the registered provider without HSC Trust participation in local resolution will be referred to the HSC Trust by the Ombudsman for action.

2.28 Copies of all correspondence relating to regulated sector complaints should be retained. The RQIA will use this information to monitor all regulated services including those services commissioned by the HSC Trust.

2.29 Voluntary Adoption Agencies became regulated by the RQIA in 2010 and in due course, these arrangements will extend to Fostering Agencies services which will also be regulated by the RQIA.

Independent Sector Providers

2.30 This section of the guidance has been developed for use in complaints against Independent Service Providers (ISP) in contract with HSC Trusts. Complaints against regulated establishments and agencies, such as, residential and nursing homes should be handled in accordance with paragraphs 2.22 to 2.28 above. On occasions HSC organisations contract with ISPs to provide services for patients/clients. An example where this may be the case is in the maintenance of waiting lists for elective forms of treatment.

2.31 Such contracts are agreed and managed by HSC Trusts and procured in accordance with public procurement law. ISPs may have their own premises or may be permitted to use Trust premises, equipment and facilities.

2.32 Trusts must be assured that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints. This should include the appointment of designated

officers of suitable seniority to take responsibility for the management of the in-house complaints handling procedures, the investigation of complaints and the production of leaflets, or other literature (available and accessible to patients/clients) that outline the provider's complaints procedure.

2.33 Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated (see flowchart on page 48).

2.34 Where complaints are raised directly with the Trust, it must establish the nature of the complaint and consider how best to proceed. The Trust may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where it raises serious concerns or where the Trust deems it in the public interest to do so. This may also be considered preferable should the Trust premises and/or staff have been involved (see flowchart on page 48).

2.35 In all cases, appropriate communication should be made with the complainant to inform them which organisation is leading the investigation into their complaint.

2.36 In complaints investigated by the ISP:

- A written response will be provided by the ISP to the complainant and copied to the Trust;
- Where there is a delay in responding within the target timescales the complainant will be informed and where possible provided with a revised date for conclusion of the investigation; and
- The letter of response must advise the complainant that they may progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and, if so, will confirm who should be responsible for conducting it. The Trust will work closely with the ISP to enable appropriate decisions to be made.

2.37 The complainant must also be informed of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

2.38 It is possible that referrals to the Ombudsman, where complaints are dealt with directly by the ISP without Trust participation in local resolution, will be referred to the Trust by the Ombudsman for action.

2.39 Trusts should have agreed arrangements in place to ensure that ISPs regularly provide information relating to all complaints received and responded to directly by them. This information should be made available to the Trust for monitoring purposes. The ISP must keep a record of complaints, the subsequent investigation and its outcome and any action taken as a result. This record must be submitted to the Trust no longer than 10 working days after the end of each quarter for complaints closed in the period. This should include details of the number, source and type(s) of complaint, action taken and outcome of investigation.

2.40 The ISP should also indicate if the learning from complaints has been disseminated to all relevant staff. The ISP must review their complaints procedure on an annual basis and in this annual review shall include a review of the outcome of any complaints investigations during the preceding year to ensure that where necessary any changes to practice and procedure are implemented. This annual review must be available for inspection by Trust staff on request.

What information should be included in the complaint?

2.41 A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – e.g. an apology or an explanation or changes to services.

Supporting complainants and staff

2.42 Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate (Annex 1 refers). Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (detailed in Section 5 – Roles and responsibilities). Independent advocacy and specialist advocacy services are also available (Annex 7 refers).

What are the timescales for making a complaint?

2.43 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh and the relevant evidence such as records of treatment will be easier to source.

2.44 If a complainant was not aware that there was potential cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

2.45 There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity and impartiality. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

2.46 In any case where a Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to pursue this further.

2.47 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety

and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

SECTION 3 – HANDLING COMPLAINTS

Accountability

3.1 Standard 1: *Accountability* provides the criteria by which organisations should operate (Annex 1 refers). Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation:

- to take responsibility for the local complaints procedure;
- to ensure compliance with the regulations; and
- to ensure that action is taken in light of the outcome of any investigation.

In the case of HSC Trusts, a Director (or a Clinical Governance Lead in FPS setting) should be designated. All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements.

3.2 Where care or treatment is provided by an independent provider, for example residential or nursing home care, the commissioning body must ensure that the contract includes entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Performance Management

3.3 Complaints provide a rich source of information and learning from complaints should be considered a vital part of the HSC organisation's performance management strategy. HSC organisations need to be able to demonstrate that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's governance and risk management arrangements.

3.4 Complaints should be used to inform and improve the standard of service provision. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a

recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

3.5 Local arrangements must ensure that a full and comprehensive response is given to a complainant and that there is the necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DoH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

3.6 This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions[17] and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

3.8 The Complaints Manager or whoever is designated on their behalf must be readily accessible to both the public and members of staff. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;

[17] DoH Complaints Directions: https://www.health-ni.gov.uk/publications/hsc-complaints-directions

- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)[18] to assist staff requiring professional indemnity[19];
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.9 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager should

[18] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).
[19] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

3.10 HSC organisations must ensure that the complaints process is well publicised locally. This means that service users should be made aware of:

- their right to complain;
- all possible options for pursuing a complaint, and the types of help available; and
- the support mechanisms that are in place.

3.11 Ready access to information can make a critical difference to the service user's experience of HSC services. Information about services and what to expect, the various stages involved in the complaints process, response targets and independent support and advice should be available. Clear lines of communication are required to ensure complainants know who to communicate with during the lifetime of their complaint. The provision of information will improve attitudes and communication by staff as well as support and advice for complainants.

3.12 Local information should:

- be visible, accessible and easily understood;
- be available in other formats or languages as appropriate;
- be provided free of charge; and
- outline the arrangements for handling complaints, how to contact complaints staff, the availability of support services, and what to do if the complainant remains dissatisfied with the outcome of the complaints process.

Training

3.13 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. HSC staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function

effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.14 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate (Annex 1 refers).

3.15 All complaints received should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. The first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to the complaint are addressed.

3.16 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation especially if it is likely to exceed the 20 working day target for any reason. Early provision of information and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to accordingly. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.17 Where possible, all complaints should be registered and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that require formal investigation, or those that should be investigated and managed outside of the HSC Complaints Procedure by other means. Front-line staff will often find the information they gain from complaints useful in improving service quality. This

is particularly so for complaints that have been resolved “on the spot” and have not progressed through the formal HSC Complaints procedure. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

3.18 A complaint should be acknowledged in writing within **2 working days** of receipt. FPS complaints should be acknowledged within **3 working days** in line with legislative requirements (see Legal Framework at Annex 2). The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the organisation. A copy of the complaint and its acknowledgement should be sent to any person involved in the complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person’s health or well-being.

3.19 There should be a statement expressing sympathy or concern regarding the issue that led to a complaint being made. This is a statement of common courtesy, not an admission of responsibility.

3.20 It is good practice for the acknowledgement letter to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within **10 working days**. As soon as the HSC organisation becomes aware that the relevant response timescale is not achievable they must provide the complainant with an explanation. The complainant must be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

3.21 The acknowledgement should:

- seek to confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with a member of the complaints staff or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

3.22 Complaints Managers should provide the complainant with further information about the complaints process. This may include locally produced information leaflets or those provided by the Ombudsman's Office or the RQIA. It is also advisable to include information about the disclosure of patient information at this stage.

Joint Complaints

3.23 Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify any other organisations involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

3.24 Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the DoH or HSC Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the Departmental or the HSC Complaints Procedure.

Investigation

3.25 Standard 5: *Investigation* provides the criteria by which organisations must operate (Annex 1 refers). HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only "resolution" but also to:

- ascertain what happened or what was perceived to have happened;
- establish the facts;
- learn lessons;

- detect misconduct or poor practice; and
- improve services and performance.

3.26 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/senior person, wherever necessary, about the conduct or findings of the investigation.

3.27 Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout. Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

Assessment of the complaint

3.28 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence.

Investigation and resolution

3.29 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those

responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

3.30 The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others. There are a number of options available to assist HSC organisations in the resolution of complaints. These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of:

- senior managers/professionals at an early stage;
- honest broker;
- independent experts;
- lay persons; and
- conciliators.

3.31 It is not intended that HSC organisations utilise all the options outlined above as not all these will be appropriate in the resolution of the complaint. Rather HSC organisations should consider which option would assist in providing the desired outcome. The SPPG Complaints Team on behalf of DoH will provide the necessary support and advice to FPS in relation to access and appointment of these options, where appropriate.

Completion of Investigation

3.32 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[20] will assist HSC organisations in ensuring the completeness and readability of such reports.

3.33 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual

[20] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2034-07_0.pdf

accuracy and to ensure clinicians/ professionals agree with and support the draft response.

3.34 All correspondence and evidence relating to the investigation should be retained. The Complaints Manager should ensure that a complete record is kept of the handling and consideration of each complaint. Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

3.35 HSC organisations should regularly review their investigative processes to ensure the effectiveness of these arrangements locally.

Circumstances that might cause delay

3.36 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.14).

Periods of acute mental illness

3.37 If a service user makes a complaint during an acute phase of mental illness, the Complaints Manager should register the complaint and consideration should be given to delaying the complaint until his/her condition has improved. A delay such as this will need either the agreement of the complainant or someone who is able to act on his/her behalf including, where appropriate, consultation with any advocate. The decision about whether a complainant is well enough to proceed with the complaint should be made by a multi-disciplinary team, and the Complaints Manager should refer regularly to this team to establish when this point has been reached.

Physical Injury

3.38 Where a complainant is alleging physical injury, a physical examination should be arranged without delay and with the consent of the injured person. Medical staff undertaking the physical examination should clearly report their findings. If a person refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented.

3.39 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements. The complainant must also be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

Responding to a complaint

3.40 Standard 6: *Responding to complaints* provides the criteria by which organisations must operate (Annex 1 refers). A response must be sent to the complainant within **20 working days of receipt** of the complaint (**10 working days within FPS**) or, where that is not possible, the complainant must be advised of the delay (as per paragraph 3.39 above).

3.41 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC may reply electronically whilst ensuring they adhere to the relevant Information Technology (IT) policies and procedures and maintain appropriate levels of confidentiality according to Trust policies and procedures

3.42 Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

3.43 The Chief Executive (or Clinical Governance Lead) may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task (or the governance lead within FPS settings). In such circumstances, the arrangements for clinical and social care governance must ensure that the Chief Executive (or Clinical Governance Lead) maintains an overview of the issues raised in complaints, the responses given and be assured that appropriate organisational learning has taken place. HSC organisations should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

3.44 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any aspect of the letter;
- advise of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure; and
- advise of the availability of the Patient and Client Council to provide assistance in making a submission to the Ombudsman.

Concluding Local Resolution

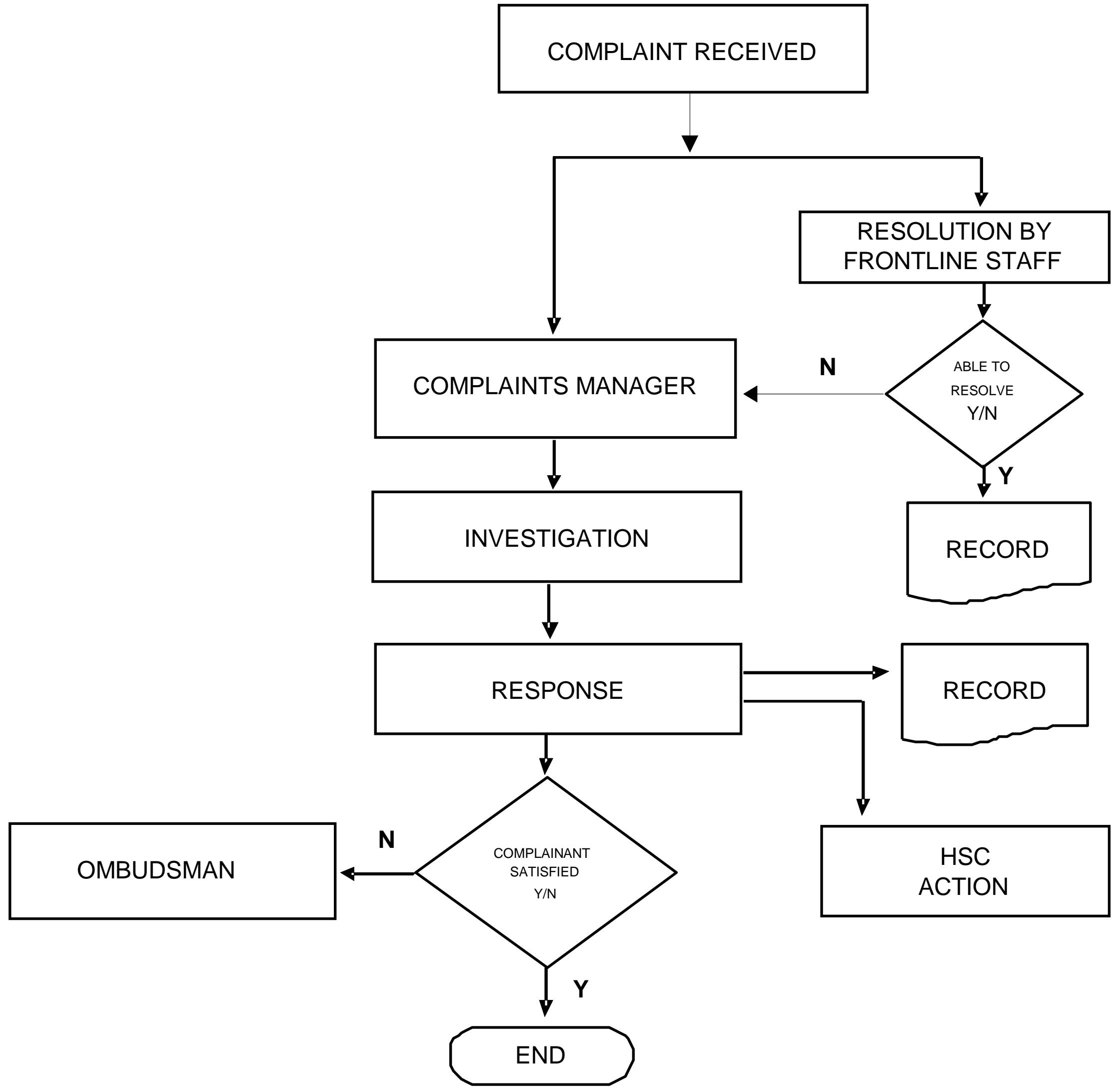
3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants should contact the organisation within one month of the organisation's response if they are dissatisfied with the response or require further clarity[21]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

3.46 Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive/Clinical Governance Lead, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from the investigation into their complaint.

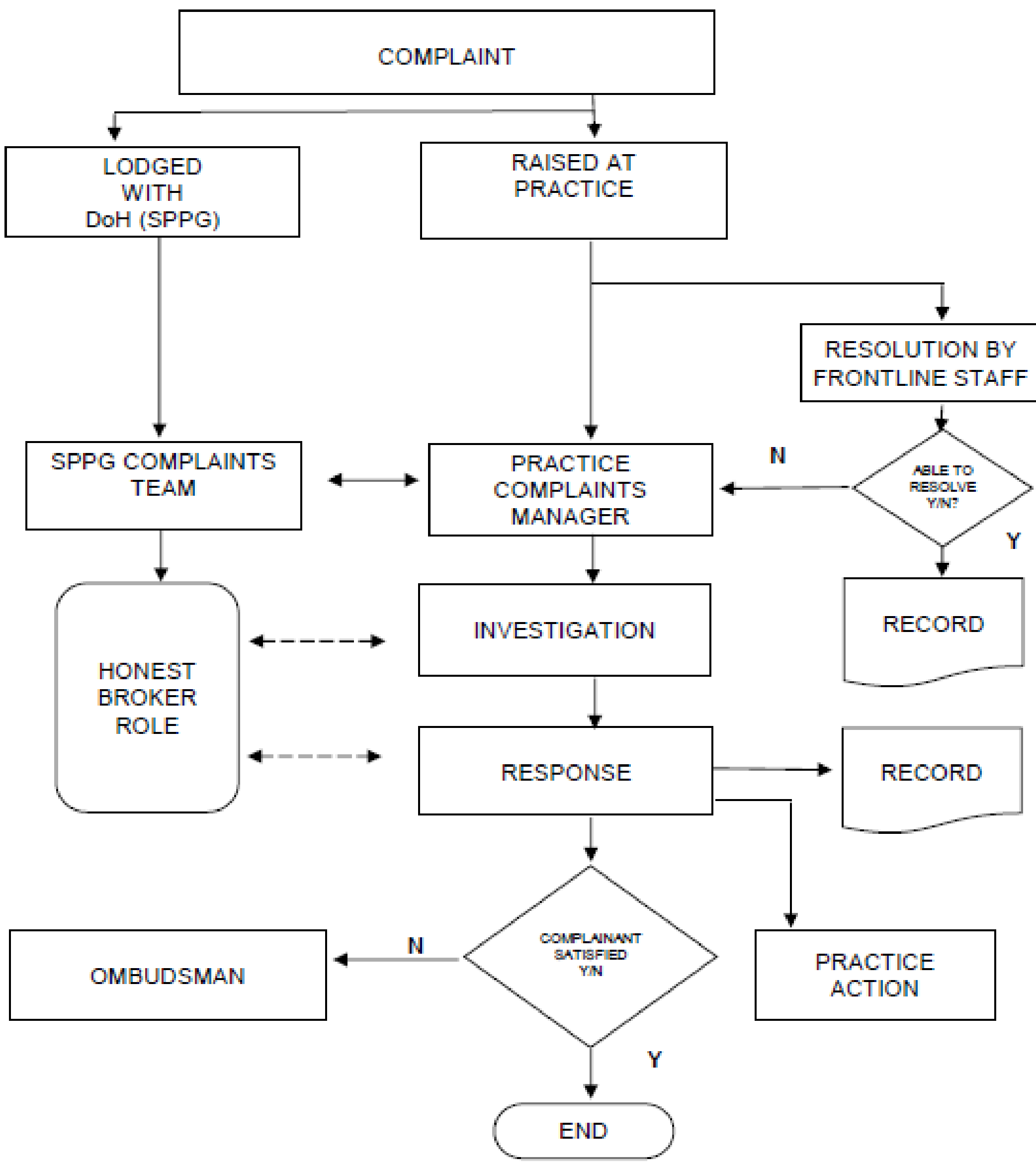
3.47 **This completes the HSC Complaints Procedure.** There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

[21]Inserted 5th June 2013 per letter from Director of Safety, Quality & Standards Directorate

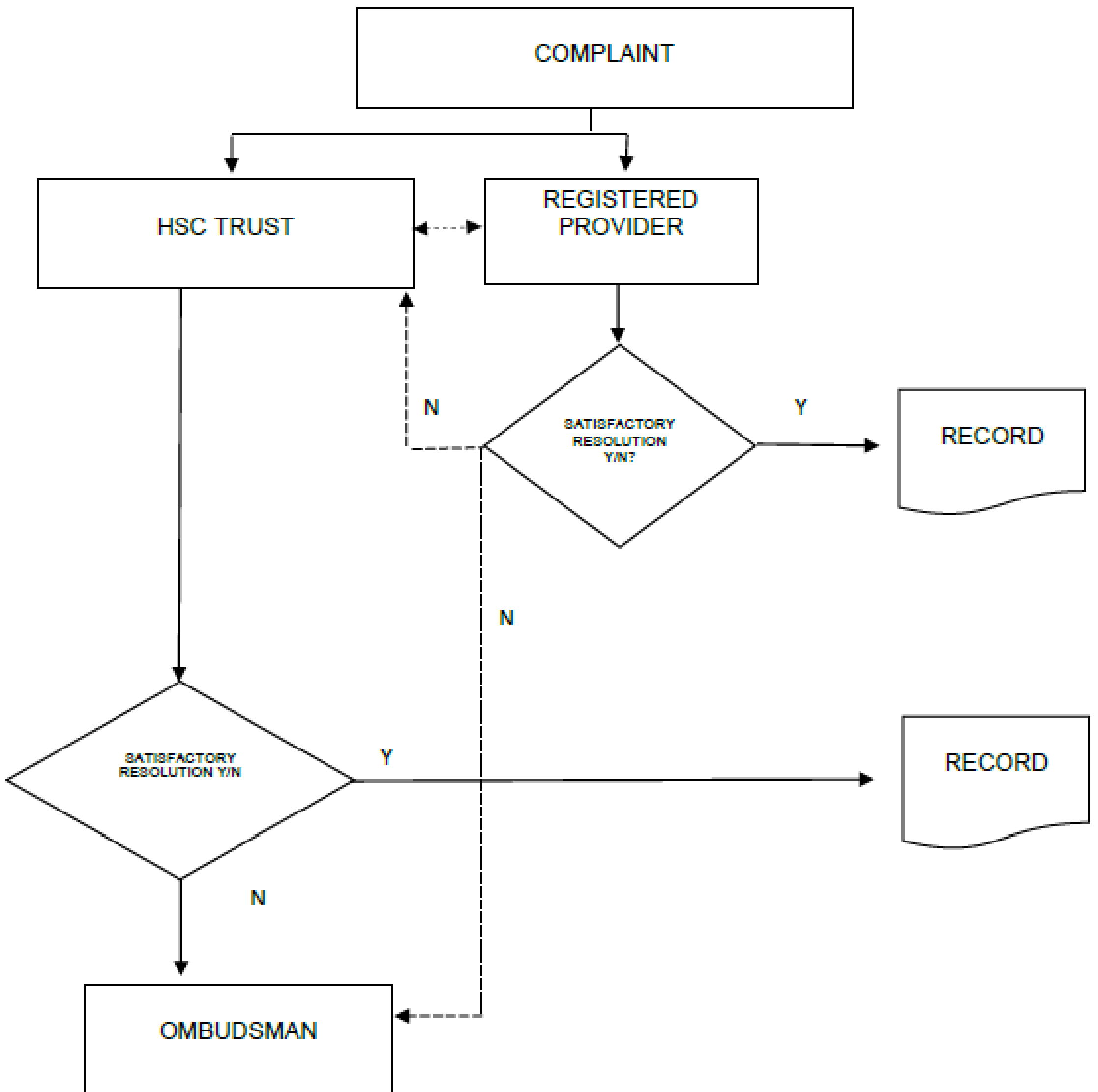
HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



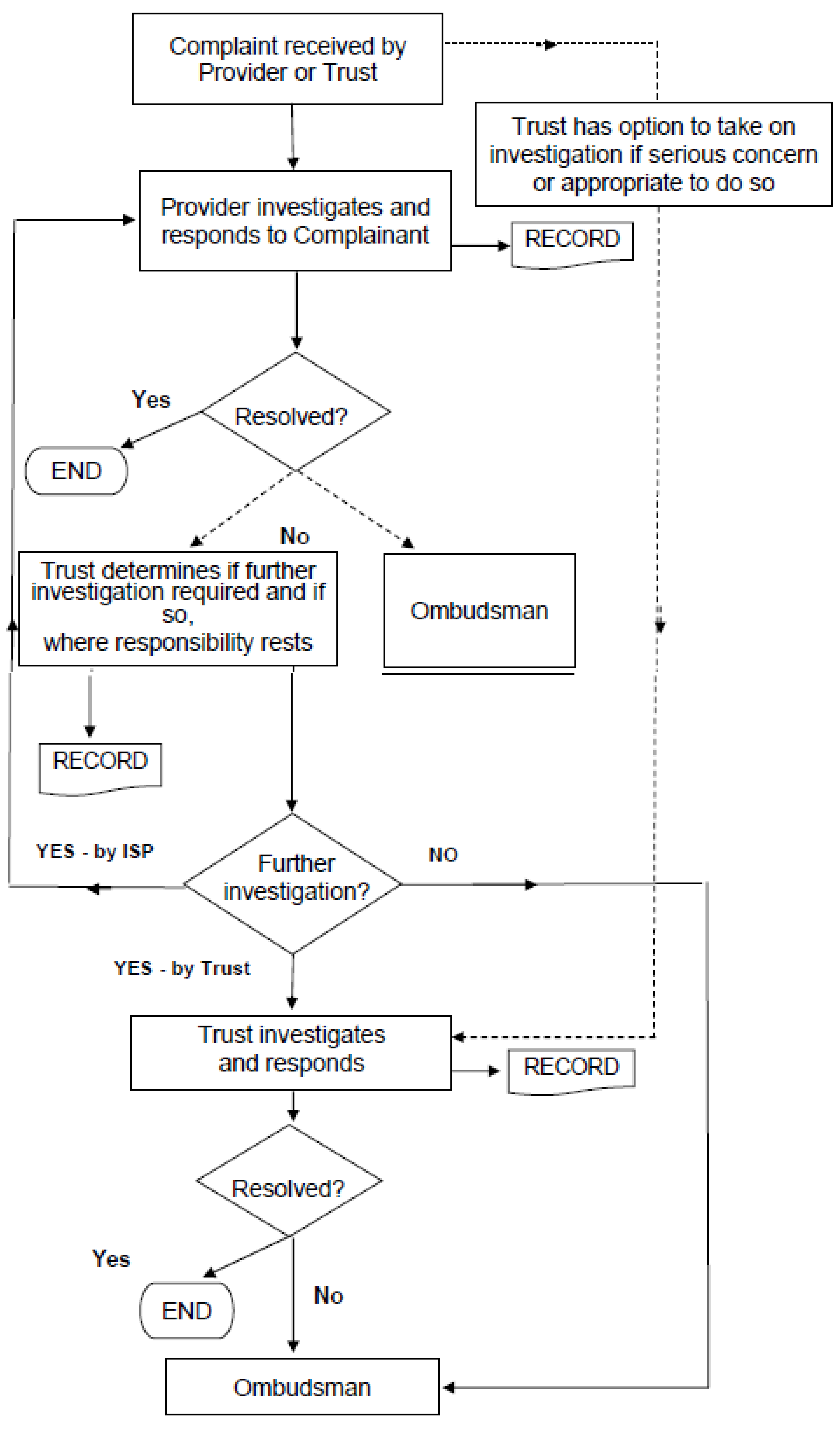
FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



REGULATED ESTABLISHMENTS & AGENCIES FLOWCHART (Services commissioned by HSC - Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.)



INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement Family Practitioner Services	within 2 working days* of receipt within 3 working days
Response Family Practitioner Services	within 20 working days within 10 working days (20 working days if lodged with the SPPG Complaints Team)
Should complainant wish to seek clarity in relation to response or express continued dissatisfaction	within 1 months of the organisation’s response

* **A working day is any weekday (Monday to Friday) which is not a local or public holiday.**

SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

4.1 Each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally. The HSC organisation must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements.

4.3 The *Standards for Complaints Handling* (Annex 1 refers) provide the criteria by which organisations must operate and will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally. HSC organisations should also involve service users and staff to improve the quality of services and effectiveness of complaints handling arrangements locally

4.4 The HSC must ensure they have the necessary technology/information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems as described below.

DoH

4.5 The SPPG Complaints Team on behalf of DoH will maintain an oversight of all FPS and HSC Trust complaints received (including HSC prison healthcare) and be prepared to analyse any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

4.6 The SPPG Complaints Team will produce an annual report on complaints outlining the number of FPS and, where appropriate, out-of-hours services complaints received, the categories to which the complaints relate and the response times. The annual report should also include the number of FPS complaints in which the SPPG Complaints Team acted as "honest broker". Copies should be sent to the PCC, the RQIA and the Ombudsman. Reports must not breach patient/ client confidentiality.

4.7 The DoH will continue to collect statistics on the number, type and response times of complaints made to HSC organisations. A regional breakdown of complaints statistics will be provided via the Departmental website on an annual basis.

HSC Trusts

4.8 All HSC Trusts must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide their Management Boards and the DoH with quarterly complaints reports outlining the number and types of complaints received, the investigation undertaken and actions as a result including those relating to regulated establishments and agencies, and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare. The reports must summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.10 HSC Trusts must also produce an annual complaints report to include the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints. Copies should also be made available to the PCC, RQIA, the Ombudsman and the DoH. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Trusts should receive quarterly reports summarising the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.12 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.13 Family Practitioner Services must provide the SPPG Complaints Team with anonymised copies of all written complaints received and responses provided by the Practice within 3 working days of the response being issued.

4.14 Arrangements should be in place to ensure that the complainant is aware and agrees to his/her complaint being forwarded to the SPPG Complaints Team.

4.15 The SPPG Complaints Team will record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.16 All other HSC organisations must publish an annual report on complaints handling. Copies should be sent to the PCC and the DoH. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.17 All regulated establishments and agencies are required if requested to provide the RQIA with a statement containing a summary of complaints made during the preceding 12 months and the action that was taken in response. The RQIA will record and monitor all outcomes and will report on complaints activity within the regulated sector.

Learning

4.18 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[22].

4.19 Learning is a critical aspect of the HSC Complaints Procedure and provides an opportunity to improve services and contribute to and learn from regional, national and international quality improvement and patient safety initiatives. All HSC organisations, the RQIA and Ombudsman must share the intelligence gained through complaints.

4.20 The SPPG Complaints Team on behalf of the DoH will have in place regional-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints and must ensure they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

[22] The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf

SECTION 5 - ROLES AND RESPONSIBILITIES

DoH

5.1 The SPPG on behalf of DoH is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The S*tandards for Complaints Handling* provides a level against which HSC service performance can be measured (Annex1 refers).

5.2 The SPPG Complaints Team will maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The SPPG Complaints Team must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The SPPG Complaints Team on behalf of the DoH will have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The SPPG Complaints Team will provide a vital role in supporting FPS complaints that includes:

- providing support and advice;
- the role of "honest broker" between the complainant and the service provider;
- providing independent experts, lay persons, conciliation services, where appropriate;
- recording and monitoring the outcome of all complaints;
- addressing breaches of contractual arrangements; and
- sharing complaints intelligence with appropriate authorities e.g. the DoH Medicines Regulatory Group (MRG).

HSC Organisations

5.5 HSC organisations must:

- make arrangements for the handling and consideration of complaints and publicise these arrangements locally;
- appoint a Complaints Manager with responsibility for co-ordinating the local complaints arrangements and managing the process;
- appoint a senior person to take responsibility for delivering the organisation's complaints process and ensuring that all necessary organisational learning takes place;
- ensure that all staff who provide services on their behalf are aware of, and trained in, the procedures to be followed when dealing with complaints;
- ensure that complainants and staff are supported and made aware of the availability of support services;
- ensure that there is full co-operation between organisations/bodies in the handling and consideration of complaints;
- integrate complaints management into the organisation's clinical and social care governance and risk management arrangements;
- monitor the effectiveness of local complaints handling arrangements;
- have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints; and
- where appropriate, publish annually a report on complaints handling.

The Patient and Client Council (PCC)

5.6 The PCC is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance to individuals making or intending to make a complaint; and
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services.

5.7 If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- help in accessing medical/social services records.

5.8 All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from: www.patientclientcouncil@hscni.net or Freephone 0800 917 0222

WHO CAN HELP ME RAISE MY COMPLAINT?

You can get practical help to raise your complaint from the Patient and Client Council (PCC).

You can contact a PCC Officer at:

Phone: 0800 917 0222
Email: complaints.pcc@hscni.net

For more information, visit PCC's website:
www.patientclientcouncil.hscni.net

The PCC Complaints Support Service is there to:

- Give you information on how to complain and who to complain to
- Help you write letters of complaint
- Make telephone calls for you about your complaint
- Go with you to meetings about your complaint and make sure your concerns are responded to
- Work with health and social care organisations to improve services as a result of your complaint

WHAT CAN I DO IF I AM NOT SATISFIED WITH THE TRUST'S RESPONSE?

If you are not happy with the trust's response to your complaint, you can contact the Northern Ireland Public Service Ombudsman (NIPSO) at:

Phone: 0800 343 424

Email: nipso@nipso.org.uk

For more information, visit NIPSO's website:
www.nipso.org.uk

ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

1. The following standards have been developed to address the variations in the standard of complaints handling across HSC organisations. These will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally and will build public confidence in the process by which their complaint will be handled. These are the standards to which HSC organisations are expected to operate for complaints handling:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);
2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;
3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;
4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;
5. Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;
6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;
7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure; and
8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;
2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and
4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;
2. Complaints from a third party must, where possible, have the written consent of the individual concerned;
3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;
4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;
5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered; and
6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements.

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;
2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;
3. HSC organisations will promote the use of independent advice and advocacy services;
4. HSC organisations will facilitate, where appropriate, the use of conciliation;
5. HSC organisations will adopt a consistent approach in the application of DoH guidance on responding to unreasonable or abusive complainants;
6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs; and
7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria:

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;
4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant’s consent;
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;
6. All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;
7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised; and
8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements;

STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;
2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;
3. HSC organisations must consider alternative methods of responding to complaints;
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;
5. The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);
6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint; and
7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;
2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;
3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;
4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;
5. HSC organisations must review the arrangements for complaints handling and responsiveness; and
6. HSC organisations must be assured, that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints.

STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;
2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;
3. Learning will take place at different levels within the HSC (individual, team and organisational);
4. HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;
5. HSC organisations will incorporate learning arising from any review of findings of an investigation;
6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives; and
7. HSC organisations will include learning from complaints within its Annual Report on Complaints.

ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- Health and Personal Social Services General Dental Services (Amendment) Regulations (NI) 2008;
- The General Ophthalmic Services (Amendment) Regulations
- (Northern Ireland) 2014The Pharmaceutical Services Regulations (NI) 1997.

The Children (NI) Order 1995:

- The Representations Procedure (Children) Regulations (NI) 1996.

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
  Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) 2009;
  Amendment Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009);
- Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009) (Honest Broker Timescales) (Amended 2013)
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010).

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003:

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;
- The Adult Placement Agencies Regulations (NI)2007;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007;

ANNEX 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: 020 7713 5155 www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: 020 76377181 www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: 020 71676000 www.gdc-uk.org	**Royal Pharmaceutical Society of Great Britain (RPSGB)** Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 08452572570 https://www.rpharms.com
General Medical Council (GMC) Doctors Phone: 01619236602 www.gmc-uk.org	**Pharmaceutical Society of Northern Ireland** Pharmacists and pharmacy premises in Northern Ireland Phone: 02890 326927 www.psni.org.uk
General Optical Council (GOC) Opticians Phone: 020 7580 3898 www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: 020 7357 6655 www.osteopathy.org.uk	**Professional Standards Authority for Health and Social Care (the Authority)** aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. Phone: 020 73898030 http://www.professionalstandards.org.uk
Health and Care Professions Council (HCPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 03005006184 www.hpc-uk.org	**Northern Ireland Social Care Council (NISCC)** Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: 028 95362600 www.niscc.info

ANNEX 4: HSC PRISON HEALTHCARE

1. HSC prison healthcare is commissioned by the DoH. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

2. Complaints raised about care, treatment or issues relating to the provision of prison healthcare will be dealt with under the HSC Complaints Procedure.

ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman[23] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

All listed authorities within the Ombudsman's jurisdiction have a statutory obligation to signpost complainants to the Ombudsman's office where the listed authority's complaints handling procedure is exhausted.

Section 25 of the Public Services Ombudsman Act (Northern Ireland) 2016 states:

25. (1) This section applies where a listed authority's complaints handling procedure is exhausted.

(2) The authority must, within 2 weeks of the day on which the complaint handling procedure is exhausted give the person aggrieved a written notice stating –

(a) that the complaints handling procedure is exhausted, and

(b) that the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman.

(3) A notice under subsection (2) must –

(a) inform the person aggrieved of the time limit for referring the complaint to the Ombudsman; and

(b) provide details of how to contact the Ombudsman.

[23] With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation.

2. The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Freepost: Freepost NIPSO
Telephone: (028) 9023 3821
Freephone: (0800) 34 34 24
Email: nipso@nipso.org.uk

3. Additional information on the jurisdiction and powers under the Public Services Ombudsman Act (NI) 2016 can be accessed at:
www.nipso.org.uk

ANNEX 6: THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

1. The RQIA is an independent non-departmental public body. The RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.

2. The RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DoH. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

3. The RQIA has a duty to encourage improvement in the delivery of services and to keep the DoH informed on matters concerning the provision, availability and quality of services.

4. The RQIA may be contacted at:

9th Floor, Riverside Tower
Lanyon Place
Belfast
BT1 3BT
Tel: 028 90 517500

http://www.rqia.org.uk/

ANNEX 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

ANNEX 8: CONCILIATION

1. Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the Practice/ Practitioner/HSC organisation/SPPG on behalf of the DoH and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH; or
- when there are misunderstandings with relatives during the treatment of the patient.

2. All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

3. Where a complainant is considered unreasonable or abusive under the *Unacceptable Action Policy* (Annex 13 refers) then conciliation would NOT be an appropriate option.

4. Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, for example, if there is a breakdown in the relationship between a doctor or practitioner and their patient.

5. Conciliation may be requested by the complainant, the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH. In FPS complaints it may be suggested by the SPPG Complaints Team.

FPS arrangements

6. The Practitioner/Practice/Pharmacy Manager (respondent) should approach the SPPG Complaints Team for advice.

7. Where a request for a conciliator is received the SPPG Complaints Team will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the SPPG Complaints Team will advise the FPS Practice/Practitioner. In some cases the SPPG Complaints Team may consider an alternative to conciliation, such as, an honest broker.

Agreement by parties involved

8. The FPS Practice/Practitioner/HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

9. Where it has been agreed that the intervention of a conciliator is appropriate, the HSC organisation or SPPG Complaints Team (on behalf of FPS) should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand what conciliation involves;
- agreeing the timescales;
- agreeing when conciliation has ended; and
- explaining what happens when conciliation ends.

10. The conciliator must advise the Practice/Practitioner/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The Practice/Practitioner must then notify the SPPG Complaints Team of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or the SPPG Complaints Team (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

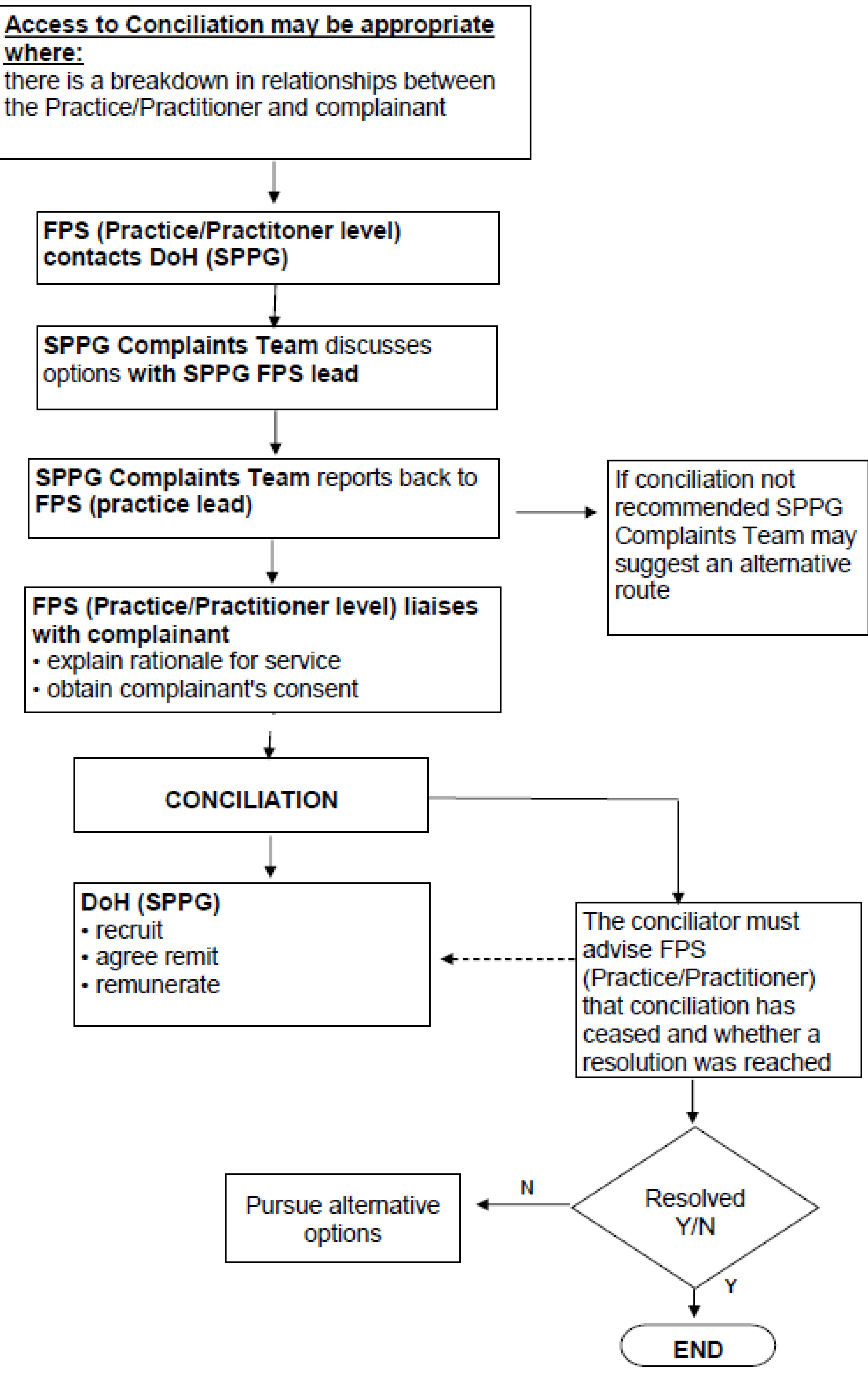
Appointment of conciliators

12. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate conciliation service. In addition it is responsible for all other arrangements, including remuneration.

Monitoring

13. The SPPG Complaints Team will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

Conciliation – FPS



ANNEX 9: INDEPENDENT EXPERTS

1. The use of an Independent Expert in the resolution of a complaint may be requested by the complainant, the Practice/Practitioner/ HSC organisation. In FPS complaints it can also be suggested by the SPPG Complaints Team on behalf of the DoH. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation; and
- to give an independent perspective on clinical issues.

FPS arrangements

2. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

3. Where a request for an Independent Expert is received the SPPG Complaints Team **may** wish to liaise with the relevant FPS lead to consider the best way forward. Where it is considered that independent expert advice would aid resolution then the SPPG Complaints Team will advise the FPS practice. In some cases the SPPG Complaints Team may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice/Practitioner/HSC organisation/SPPG Complaints Team must contact the complainant and discuss the rationale for involving an Independent Expert and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

5. The HSC organisation or SPPG Complaints Team may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding health and social care practice.

6. Where it has been agreed that an Independent Expert will be involved the Practice/Practitioner/HSC organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

7. The Independent Expert's findings/report will be forwarded to the Practice/Practitioner/HSC organisation/SPPG Complaints Team (if acting as contact point). A full report of the findings should be made available by the practice/pharmacy/HSC organisation to:

- the complainant; and
- the SPPG Complaints Team (for FPS only).

8. The letter of response to the complainant is the responsibility of the Practice/Practitioner/ HSC organisation.

Appointment of Independent Experts

9. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

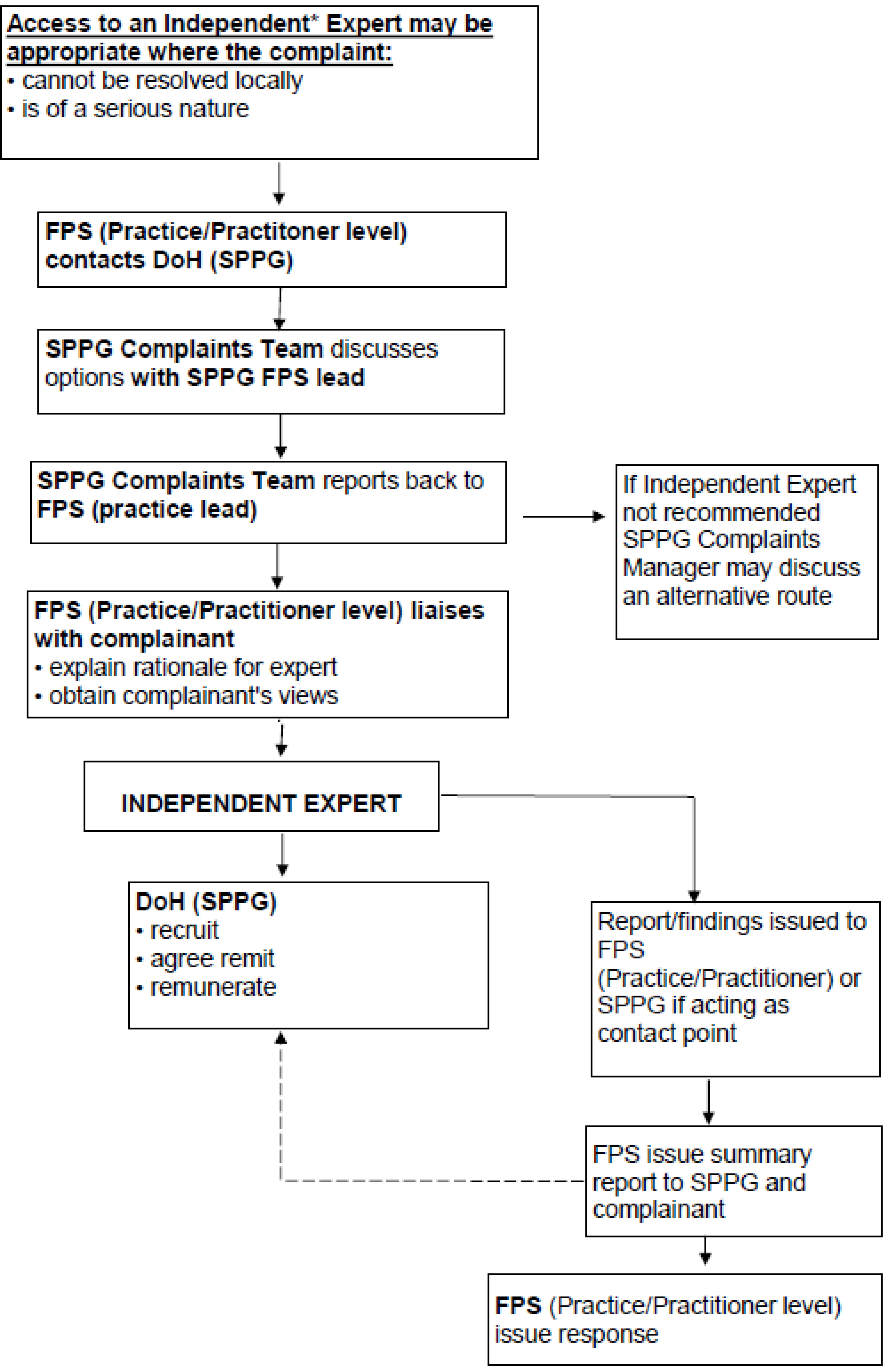
10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

11. The SPPG Complaints Team will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

12. A flowchart outlining the process for FPS is shown overleaf.

Independent Experts – FPS Access



*Definition of "Independent" = an Independent Expert must be recruited from another LCG area (and in certain circumstances outside Northern Ireland) and must have no connection with any of the parties to the complaint to avoid calling into question their objectivity and independence.

ANNEX 10: LAY PERSONS

1. Lay persons may be beneficial in providing an independent perspective of non-clinical/ technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay persons involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the investigator during the investigation process where the complainant is considered unreasonable (Annex 13 refers).

2. Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

- communication issues;
- quality of written documents;
- attitudes and relationships; and
- access arrangements (appointment systems).

3. It is essential that both the provider and the complainant have agreed to the involvement of a lay person.

4. Lay persons should have appropriate training in relation to the HSC complaints procedure and have the necessary independence and communication skills.

FPS arrangements

5. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

6. Where a request for a lay person is received the SPPG Complaints Team **may** liaise with the relevant FPS lead to consider the best way forward. Where it is considered that a lay person's involvement would aid resolution then the SPPG Complaints Team will advise the FPS practice. In some cases the SPPG Complaints Team **may** consider an alternative to a lay person.

Agreement and consent

7. The FPS Practice/ Practitioner/ HSC Organisation/SPPG Complaints Team must contact the complainant and discuss the rationale for involving a lay person and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation/SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

8. Where it has been agreed that a lay person will be involved the Practice/Practitioner/HSC Organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand the focus of the issue(s);
- ensuring all parties understand what lay person involvement means;
- agreeing the timescales;
- agreeing to the provision of a final report, and
- explaining what happens when this process is complete.

9. The layperson's findings/report will be forwarded to the Practice/Practitioner/HSC Organisation/SPPG Complaints Team. The full report will be made available by the Practice/ Practitioner/HSC Organisation/SPPG Complaints Team (for FPS only) and to the complainant.

10. The letter of response to the complainant is the responsibility of the Practice/Practitioner/HSC Organisation/SPPG Complaints Team.

Appointment of lay persons

11. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person. In addition it is responsible for all other arrangements, including training, performance management and remuneration.

Monitoring

12. The SPPG Complaints Team will monitor the effectiveness and usage of lay person arrangements within HSC Trusts and FPS.

ANNEX 11: HONEST BROKER ROLE

1. "Honest broker" is the term used to describe the role of the SPPG Complaints Team in supporting and advising FPS on the handling of complaints. The complainant or the Practice/Practitioner can ask the SPPG Complaints Team to act in this role at any point in the complaints process. It is expected that the SPPG Complaints Team will not carry out the investigation but it is also expected that it will add value to the process by providing support and advice to FPS.

2. It is not an alternative to local resolution. Neither is it an opportunity for the SPPG Complaints Team to take over an investigation. Rather it is about facilitating communications and building relationships between the Practice/Practitioner and the complainant or reaching positions of understanding. The honest broker will act as an intermediary and is available to both, the complainant or Practice/Practitioner staff throughout the complaints process. For example, the honest broker may:

- provide advice to both the complainant and the Practice/Practitioner;
- act as a link between both parties and/ or negotiate with them; and
- facilitate and attend meetings between/with both parties together or separately.

3. Paragraphs 2.16 to 2.21 outline the options available to complainants when pursuing FPS complaints. This includes an option to lodge their complaint directly with the SPPG Complaints Team. Where the complainant contacts the SPPG Complaints Team the options available to resolve the complaint will be explained:

- that the complaint can be copied to the relevant practice/pharmacy for investigation, resolution and response; or
- that the SPPG Complaints Team can act as honest broker between the complainant and the Practice/Practitioner.

4. FPS co-operation in complaints of this type is essential for the role of honest broker to effectively assist in the successful local resolution of complaints. FPS will be asked for their agreement should the complainant prefer the SPPG Complaints Team's involvement.

5. Where the SPPG Complaints Team has been asked to act as honest broker they will:

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate;
- provide advice to the complainant and the Practice/Practitioner on target timescales[24]; and
- where there is a delay, ensure the complainant is advised as set out in paragraph 3.39.

6. Whichever process is used it is important to note that the Practice/Practitioner are responsible for the investigation and the response. The SPPG Complaints Team, however, must ensure that:

- a written response is provided by the Practice/Practitioner to the complainant and any other person subject to the complaint (whether this is direct from the Practice/Practitioner or from the SPPG Complaints Team after receiving a report from the Practice/Practitioner;
- the response is of sufficient quality and addresses the complainant's concerns;
- the written response is provided within target timescales and where this is not possible that the complainant is informed; and
- the response notifies the complainant of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure.

7. The complainant may contact the SPPG Complaints Team for further advice and support.

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[24] For 'honest broker' this is 20 working days from receipt of the complaint: for FPS, this is 10 working days from receipt of the complaint.

ANNEX 12: ADULT SAFEGUARDING

Definition of vulnerable adult

1. The regional policy 'Adult Safeguarding – Prevention and Protection in Partnership' defines the terms 'adult at risk of harm' and 'adult in need of protection[25]'.

2. The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

3. An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**
AND/OR
b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain.

Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

[25] 'Adult Safeguarding – Prevention and Protection in Partnership' (July 2015) (https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents), p10

4. An ‘**adult in need of protection**’ is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

AND

d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

5. In order to meet the definition of an ‘adult in need of protection’ either (a) or (b) must be present, in addition to both elements (c), and (d).

6. The decision as to whether the definition of an ‘adult in need of protection’ is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Reportable offences and allegations of abuse

7. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk then the regional *‘Adult Safeguarding Operational Procedures’ (September 2016)* and the associated *‘Protocol for Joint Investigation of Adult Safeguarding Cases’ (August 2016)* should be activated (see paragraph 1.26).

ANNEX 13: UNREASONABLE OR ABUSIVE COMPLAINANTS

1. HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

2. In determining arrangements for handling such complainants, staff need to:

- ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- appreciate that even habitual complainants may have grievances which contain some substance;
- ensure a fair approach; and
- be able to identify the stage at which a complainant has become habitual.

3. The following *Unacceptable Actions Policy*[26] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Actions Policy

4. People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the HSC organisation or unreasonable behaviour towards HSC staff to be unacceptable. It is these actions that HSC organisations aim to manage under this policy.

[26] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

Aggressive or abusive behaviour

5. HSC organisations understand that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards HSC staff, it will consider that unacceptable. Any violence or abuse towards staff will not be accepted.

6. Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations will judge each situation individually and appreciate individuals who come may be upset. Language which is designed to insult or degrade, is racist, sexist or homophobic or which makes serious allegations that individuals have committed criminal, corrupt or perverse conduct without any evidence is unacceptable. HSC organisations may decide that comments aimed at third parties are unacceptable because of the effect that listening or reading them may have on staff. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

7. HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and staff should refer to the Zero Tolerance campaign launched in 2007 to clarify the HSC position in relation to attacks on the workforce. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

8. HSC organisations consider these demands become unacceptable when they start to (or when complying with the demand would) impact substantially on the work of the organisation.

9. Examples of actions grouped under this heading include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; and
- repeatedly changing the substance of a complaint or raising unrelated concerns.

10. An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

11. Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the organisation or inundates the organisation with copies of information that has been sent already or that is irrelevant to the complaint.

12. The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint, or with other people’s complaints.

Unreasonable use of the complaints process

13. Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about an organisation with which they have a continuing relationship, if subsequent incidents occur.

14. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a complaints system to be important and it will only be in exceptional circumstances that

it would consider such repeated use is unacceptable, however it reserves the right to do so in those exceptional circumstances.

Unreasonable refusal to co-operate

15. When the HSC organisation is looking at a complaint, it will need to ask the individual who has complained to work with them. This can include agreeing with the HSC organisation the complaint it will look at; providing it with further information, evidence or comments on request; or the individual summarising the concerns or completing a form for the HSC organisation.

16. Sometimes, an individual repeatedly refuses to cooperate and this makes it difficult for the HSC organisation to proceed. The HSC organisation will always seek to assist someone if they have a specific, genuine difficulty complying with a request. However, the HSC organisation consider it is unreasonable to bring a complaint to it and then not respond to reasonable requests.

Examples of how the HSC manage aggressive or abusive behaviour

17. The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in a termination of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

18. HSC organisations will not accept any correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. The HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful and ask them to stop using such language. It will state that it will not respond to their correspondence if the action or behaviour continues.

19. HSC staff will end telephone calls if they consider the caller aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that their behaviour is unacceptable and end the call if the behaviour persists. In extreme situations, the HSC organisation will tell the complainant in writing that their name is on a “no personal contact” list. This means that it will limit contact with them to either written communication or through a third party.

Examples of how the HSC deal with other categories of unreasonable behaviour

20. The HSC organisation has to take action when unreasonable behaviour impairs the functioning of its office. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

21. Where a complainant repeatedly phones, visits the organisation, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the HSC organisation may decide to:

- limit contact to telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of staff who will deal with the future calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact from the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; and
- take any other action that the HSC organisation considers appropriate.

22. Where the HSC organisation considers correspondence on a wide range of issues to be excessive, it may tell the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly.

23. In exceptional cases, the HSC organisation will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further.

24. The HSC organisation will always tell the complainant what action it is taking and why.

The process the HSC follows to make decisions about unreasonable behaviour

25. HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to change their behaviour or action before a decision is taken.

How the HSC lets people know it has made this decision

26. When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[28] why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

27. It is important that a decision can be reconsidered. A complainant can appeal a decision to restrict contact. If they do this, the HSC organisation will only consider arguments that relate to the restriction and not to either the complaint made to the organisation or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable, the restrictions were disproportionate; or that they will adversely impact on the individual because of personal circumstances.

28. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They

must advise the complainant in writing[27] that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

29. The HSC organisation records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above, may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complainants with restricted contact arrangements on a regular basis.

[27] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

ANNEX 14: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995[28] (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987[29].

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996[30].

3. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 (a flowchart to aid decision making is attached).

4. The HSC Trusts should familiarise themselves with these requirements.

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[28] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[29] Adoption Order (NI) 1987: http://www.legislation.gov.uk/nisi/1987/2203/contents
[30] Representations Procedure (Children) Regulations (NI) 1996: http://www.legislation.gov.uk/nisr/1996/451/contents/made

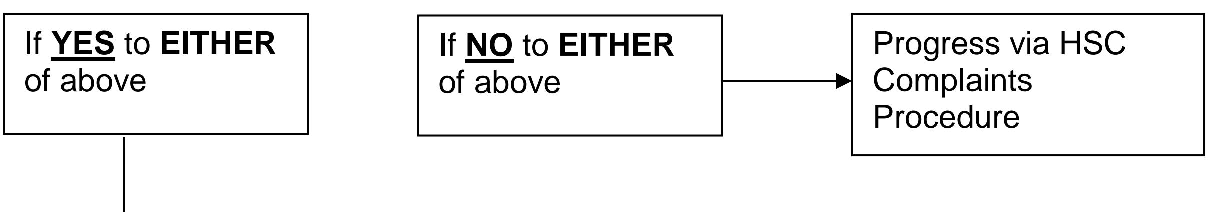
CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Complaint: Does it fit the definition of a Children Order complaint as below?

"…Any representation (including any complaint) made to the Trust … about the discharge of any of its functions under Part IV of the Order in relation to the child."
(Children (NI) Order 1995, Article 45(3))

OR

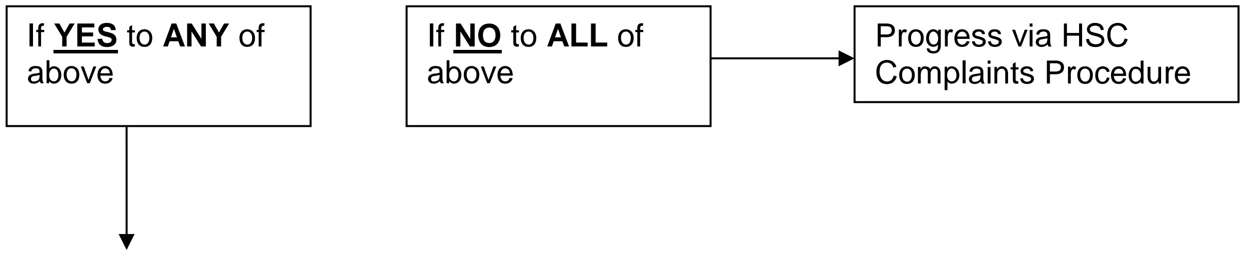
"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and para 6 of Schedule 5 to, the Children Order."
(Guidance & Regulations – Vol. 4, Para 12.5 – DHSS)



2. Does it meet the criteria of what may be complained about under Children Order?

"… about Trust support for families and their children under Part IV of the Order."
(Vol. 4, Para 12.8)

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.



3. <u>Complainant</u>: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need;

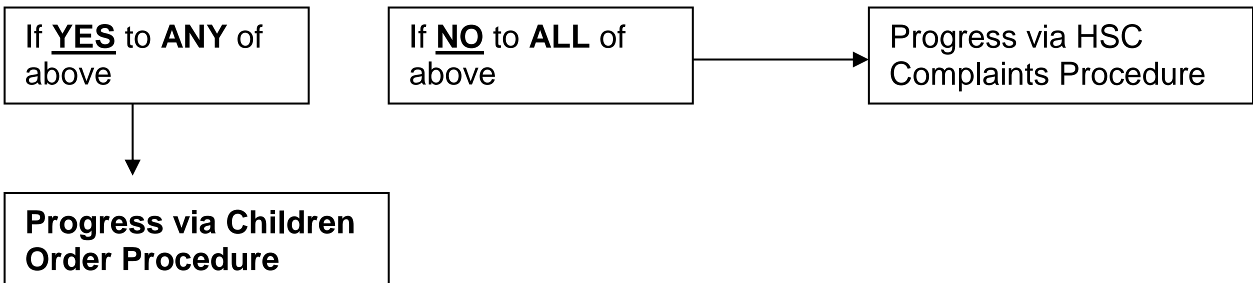
c. A parent **of his**;

d. Any person who is not a parent of his but who has **parental responsibility for him**;

e. Any Trust foster parent;

f. Such other person as the Trust considers has a sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- the person who had the day to day care of the child within the past two years;
- the child's Guardian ad Litem;
- the person is a relative of the child (as defined by Children Order, Article 2(2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- a friend;
- a teacher;
- a general practitioner.
  (Children (NI) Order 1995 Article 45(3))



***NB*: In order for a complaint to be eligible to be considered under the Children Order Procedure, the answer to 1 and 2 and 3 MUST all be YES.**
Consent: *The (Trust) should always check with the child (subject to his understanding) that a complaint submitted reflects his views and that he wishes the person submitting the complaint to act on his behalf.* (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Definitions of Key Terms

Throughout the standards and guidelines the following terms have the meanings set out below:

Term	Meaning
Complaint	"an expression of dissatisfaction that requires a response"
Complainant	an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	the Chief Executive of the HSC organisation
Complaints Manager	the person nominated by an HSC organisation to handle complaints
DoH[31]	Department of Health in Northern Ireland
Family Practitioner Service (FPS)	family doctors, dentists, pharmacists and opticians
Honest Broker	this is the term used to describe the role of the SPPG on behalf of DoH in FPS complaints
HSC Organisation	an organisation which commissions or provides health and social care services and for the purpose of this guidance includes HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the Business Services Organisation (BSO), the Public Health Agency (PHA), Family Practitioner Services (FPS), Out-of-Hours Services, and pilot scheme providers
Local Resolution	the resolution of a complaint by the organisation, working closely with the service user

[31] Formally the Department for Health, Social Services and Public Safety (DHSSPS)

NIBTS	Northern Ireland Blood Transfusion Service
NIPSO	Northern Ireland Public Services Ombudsman (NIPSO, known as 'the Ombudsman')
Out of-Hours services	refers to immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
PCC	Patient and Client Council
Pilot Scheme	a small-scale experiment or set of observations undertaken to decide how and whether to launch a full-scale project (refers to personal dental services provided by an HSC Trust in this case)
Pilot Scheme Complaints Procedure	is a complaints procedure established by the pilot scheme
Practice based complaints procedure	is an FPS complaints procedure established within the terms of the relevant regulations
Registered Provider	person carrying on or managing the establishment or agency
RQIA	Regulation, Quality and Improvement Authority which is the organisation responsible for regulating, inspecting and monitoring the standard and quality of health and social care services provision by independent and statutory bodies in Northern Ireland
Registered Establishments and Agencies	for example, residential care homes, nursing homes, children's homes, nursing agencies, independent clinics/hospitals, etc. registered with
Regulated Sector	and regulated by the RQIA

Senior Person	refers to registered establishments and agencies
Service User	means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC Trust
	means a patient, client, resident, carer, visitor or any other person accessing HSC services
Special Agency	For example the NI Blood Transfusion Service (NIBTS)
SPPG	Strategic Planning and Performance Group, DoH (formerly HSC Board)

Clinical Record Review Implementation Overview – May 2022

Further to work arising in relation to the Independent Neurology Inquiry, a process was agreed and a template pro forma (inc guidance flowchart) devised to trigger and facilitate peer review of clinical records in complaint cases involving medical staff within key complaint subject categories. The process aims to formalise review of complaints by a clinician not involved in the issues of complaint as standard practice.

Within this process, Clinical Directors identify a relevant Consultant* to undertake a review of the issues of complaint.

Clinical Assessment, Investigation, Treatment, Communication, Team-working and Documentation are evaluated by the reviewing Consultant to identify:

Satisfactory care:- Care which complies in all aspects with the standard expected taking into consideration the wider systemic issues.

Care which could be improved but not unsatisfactory:- Care which did not fall significantly below the standard expected but there were areas identified which could be improved.

Unsatisfactory care:- Care which falls significantly below the standard expected, having considered wider systemic issues.

The outcomes of the completed reviews are discussed with the Clinical Director who informs the Chair of Division and Co-Director of any concerns identified. The Chair of Division and Co-Director will subsequently consider appropriate next steps and communicate to the Medical Director's Office as required.

Feedback was sought on the CRR process, and a pilot initiated for identified clinical specialties within the Unscheduled and Acute Care Directorate. Clinical Record Reviews were also undertaken on a retrospective basis for selected Neurology cases.

The Clinical Record Review process was subsequently incorporated into the revised Trust's Complaints Policy as a requirement for all complaints relating to Quality of Treatment and Care, and later expanded to include a further six complaint subjects. Upon review of the process and feedback from Service Areas in April 2022 however, it was agreed that **with effect from May 2022 CRRs would only be required for complaints relating to Quality of Treatment and Care, and Staff Attitude / Behaviour**.

An audit was completed during December 2020 and January 2021 to assess the effectiveness of the implementation of the Clinical Record Review process. The purpose of this audit was to identify potential improvements and required actions to ensure consistent and robust compliance with the process throughout the Trust.

As a result of the audit findings, the following key actions were required from Directorate teams:

1) From 1st June 2021, copies of completed Clinical Record Review templates must be submitted by Service Areas to clinicalrecordreview@belfasttrust.hscni.net for Assurance purposes. Returns will be actively monitored and non-submissions will be escalated within Directorates

2) The original completed templates are to be retained and actioned by Service Areas who will be responsible for liaising with the Medical Director's office as required (eg for any MHPS related measures being implemented)

Where review / investigation of complaint issues confirms that a CRR is not required, the Clinical Director should email clinicalrecordreview@belfasttrust.hscni.net to advise of the reason why this is the case eg:

- complaint does not relate to a member of medical staff
- insufficient details available to identify the medical staff member involved in complaint
- complaint issues being investigated via another process (eg SAI, Royal College Review)

* *Where a clinical specialty comprises a small consultant team, Clinical Record Reviews should be conducted by the Clinical Director in conjunction with the Chair of Division.*

CRRs can be completed by a team of clinicians rather than an individual should this approach be preferred within any area.

Where a case is particularly complex consideration may be given to potentially seeking a Royal College review in place of the CRR.

Clinical Record Review – Process

This process should be followed for all complaints involving medical staff that relate to Quality of Treatment and Care or Staff Attitude / Behaviour.

Complaints Department forwards copy of complaint to relevant **Service Manager** (CCd to **Co-Director** / **Chair of Division**) including blank copy of "Clinical Record Review" template

↓

Service Manager shares complaint with relevant **Clinical Director** to initiate Clinical Record Review

↓

Clinical Director identifies relevant Consultant(s) to undertake review, and **Service Manager** ensures said consultant receives patient's notes and Clinical Record Review template for completion

↓

Service Manager advises staff involved in the delivery of care associated with the complaint that the review is taking place

↓

Reviewing Consultant(s) carries out review and completes Clinical Record Review template within 10 working days

↓

Reviewing Consultant(s) submits completed Clinical Record Review to relevant **Clinical Director** (CCd to clinicalrecordreview@belfasttrust.hscni.net) and discusses the findings

↓

Clinical Director signs off completed Clinical Record Review template and provides copy to **Service Manager**

↓ (left branch)

Service Manager incorporates Clinical Record Review findings into draft complaint response

↓

Director confirms completion of Clinical Record Review before approving and signing complaint response

↓ (right branch)

Clinical Director informs **Chair of Division** / **Co-Director** of any Clinical Record Review templates with "unsatisfactory" or "needs improved" ratings

↓

Chair of Division / **Co-Director** consider appropriate next steps and communicate to **Medical Director's Office** as required

Clinical Record Review

Complaint Ref: ______ **Patient H+C No:** ______

(1)	**Case Description – summary of clinical case**	
	Analysis of Care provided *Include brief explanatory comment for each rating that you have assessed as "Needs Improved" or "Unsatisfactory"*	**Rating**
(2)	**Assessment (includes history taking, examination and diagnoses)**	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(3)	**Investigation**	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(4)	**Treatment (decision making, case selection, procedures or operation)**	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(5)	**Communication (patients, family, GP and consent)**	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(6)	**Teamworking (communication within hospital including MDT / & handover)**	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(7)	**Documentation (record keeping, appropriate follow up etc)**	**Not Applicable** **Satisfactory** **Needs Improved** **Unsatisfactory**
(8)	**Overall/Assessment** – *summarise your findings from reviewing this patient's treatment and care including any areas for improvement*	

Name individual undertaking review: ______

Treating Dr GMC No: ______ **Date:** ______

PLEASE RETURN TO CLINICAL DIRECTOR, CCd TO clinicalrecordreview@belfasttrust.hscni.net

Name Clinical Director: ______

Signature: ______ **Date:** ______

Satisfactory care*:- Care which complies in all aspects with the standard expected taking into consideration the wider systemic issues.*

Care which could be improved but not unsatisfactory*:- Care which did not fall significantly below the standard expected but there were areas identified which could be improved.*

Unsatisfactory care*:- Care which falls significantly below the standard expected, having considered wider systemic issues*

Complaint Investigation Training

Objectives

- To build the confidence, knowledge and skills required to investigate complaints
- To provide clarity about the role of the Investigating Manager in the Complaints process

Why do complaints matter?

To the Organisation:

Identify risks

Learn lessons

Improve services

Reputation

Make case for more resources

To the Service User:

Public accountability

Restore confidence

Address negative feelings

Closure

Improvement

Valued / worthwhile

HSC Complaints Procedure

GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Updated April 2022

Sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services.

Standard 5: **Investigation Of Complaints**

www.health-ni.gov.uk/publications/hsc-complaints-standards-and-guidelines

HSC Complaints Procedure

- All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.
- HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree.
- A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened.
- Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Complaint Investigation Key Principles:

1. Investigations are conducted in line with agreed governance arrangements

2. Investigations are robust and proportionate and the findings are supported by the evidence

3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant

4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent

Complaint Investigation Key Principles:

5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint

6. All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints

7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised

8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements

HSC organisations should establish a clear system to ensure an appropriate level of investigation.

The purpose of investigation is not only "resolution" but also to:

- ascertain what happened or what was perceived to have happened
- establish the facts
- learn lessons
- detect misconduct or poor practice
- improve services and performance

Department of Health | An Roinn Sláinte | Männystrie O Poustie

COMPLAINT RECEIVED

RESOLUTION BY FRONTLINE STAFF

ABLE TO RESOLVE Y/N

N

Y

COMPLAINTS MANAGER

RECORD

INVESTIGATION

RESPONSE

RECORD

HSC ACTION

OMBUDSMAN

N

COMPLAINANT SATISFIED Y/N

Y

END

Questions???

Frontline Resolution

- In the majority of circumstances the quickest and most effective way of resolving a concern or complaint is to deal with the issues when they arise as soon as possible.
- Usually this is best undertaken as close to the point of care/service delivery as possible.
- If the concern or complaint requires further investigation or if the complainant wishes to address their concerns to somebody not involved, the complainant will be referred to the Complaints Department.
- On receipt of a concern or complaint, the first responsibility is to ensure that the patient's immediate health needs are being met.

An **Issue/Concern or Complaint** is raised by a **Patient/ Client/ Family Member or Friend** to a **member of staff** in a **Ward/ Department or Service Area**

Can this be **resolved** in the ward/ department/ service area by a member of staff **through engagement** with the complainant to the satisfaction of the complainant?

YES

- Respond with Empathy
- Actively Listen to the Complainant
- **Establish the outcome sought** by the Complainant
- Record the issues accurately
- **Agree a plan of action** with the Complainant and Document
- **Inform relevant staff** (including line manager)
- **Carry out actions** and **feedback to complainant** and document
- If complainant is happy with the outcome - **record on Front Line Resolution form**
- Send completed form to: complaints@belfasttrust.hscni.net

NO

Offer assistance to Complainant to make a formal complaint by:

- Giving the complainant contact details for the Complaints Department
- Contacting the Complaints Department on behalf of the complainant
- Send a letter of complaint direct to the Complaints Department on behalf of the complainant

caring supporting improving together

A **Frontline Resolution form** should be completed with:

- details of the complaint
- the corrective / remedial actions taken to resolve the complaint
- confirmation that the complainant is content that their issues and concerns have been satisfactorily resolved
- identifying any potential professional assurance concerns indicated by the complaint

Frontline Complaint Record Form

Date:	
Time:	
Details Taken By:	
Location & Service Directorate:	

Details of Patient/Client/Service User:

Name			
Address			
Date of Birth		Hospital Number	
Contact number (if patient is complainant)			
Contact e-mail address (if patient is complainant)			

Complainant Details (if different from Patient/Client/Service User above):

Name	
Address	
Contact number	
Contact e-mail address	

Note of Complaint/Enquiry

Action Taken

Is the complainant happy that their complaint has been satisfactorily resolved? **Yes** ☐ **No** ☐

If "No" Advise complainant, of formal complaints process and that if they are not the patient, that written consent will be required before the complaint investigation can begin

Please identify any staff where the issues identified by this complainant have highlighted potential concerns. This information is critical to the Trust's Professional Assurance governance mechanisms:

Staff member Surname	Staff member Forename(s)	Job Title	Specialty	Nature of Concern	Comments
e.g. Smith	*John, Robert*	*Consultant*	*Orthopaedics*	*Quality of Treatment & Care Staff attitude / behaviour*	*Concern regarding failure to diagnose patient's cancer and dismissive attitude towards family member*

Please return to Complaints Department, 7th Floor, McKinney House, Musgrave Park Hospital, Belfast, BT9 7JB, or email to complaints@belfasttrust.hscni.net

Formal Complaint Process - Telephone Resolution

- Upon receiving and reviewing a complaint, Service Area staff may determine that a conversation with the complainant may be an appropriate means of resolving the concern (ie rather than a formal written response).
- Similar techniques should be used for such calls as per Frontline Resolution
- Where contact is made with a complainant in this way, details of the conversation must be documented on a “Telephone Resolution Form” and returned to the complaints department

HSC Belfast Health and Social Care Trust
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Complaints – Telephone Resolution / Record Form

Patient/Client Affected Details

Complaint ref:	
Patient name:	
Name of person contacted:	
Date and time of call:	
Telephone call made by:	

Note of Telephone call with complainant (add key notes and actions)

Checklist to resolve complaint via telephone (please complete)

Prompt questions/statements:

1. Are you happy that this call has resolved your complaint? **Yes/No**

2. Do you require a written response? **Yes/No**

3. Inform complainant – “If at a later stage you remain dissatisfied, you may contact the Complaints Department”. Have you informed the Complainant of this info? – Yes/No

Please identify any staff where the issues identified by this complainant have highlighted potential concerns or highlighted a need for provision of professional support and/or guidance. This information is critical to the Trust's Professional Assurance governance mechanisms:

Complaint Ref	Directorate / Division			Specialty	
Staff member Surname	Staff member Forename(s)	Staff member BHSCT Staff number*	Job Title	Specialty	Brief description of complaint issues relevant to staff member

**where the staff member is a member of medical staff, please also provide GMC number*

Completed by – Name: **Role:**
Signature: **Date:**

Please return completed form to complaints@belfasttrust.hscni.net

Working together Excellence Openness & Honesty Compassion

Formal Complaint Investigation ...WHO?

On receipt of the complaint from the Complaints Department, the Service Manager ensures the appropriate person(s) are promptly identified to carry out the investigation.

The Investigating Manager

- assesses the complaint, and plans the scope and approach to the investigation
- highlights immediately where an issue of patient / client safety is identified
- contacts the complainant where appropriate, to introduce themselves and clarify any issues in the complaint
- ensures the quality, thoroughness and timeliness of the investigation to confirm it addresses all the issues raised by the complainant.

The Complaints Manager

- continuously monitors progress
- provides advice
- escalates any delays or difficulties to the Co-Director if necessary.

- Complaints are not to be investigated by the person complained about.

  However, a copy of the complaint should be shared with them by the Investigating Manager and their input sought to ensure their views are accounted for and considered in the investigation and response process.

- Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious.

- Investigating Managers should seek advice from the Complaints Manager/ senior person, wherever necessary, about the conduct or findings of the investigation.

Investigation Team Membership

- Chair - independent of the circumstances of the complaint, and experienced in conducting reviews
- Relevant professionals - appropriate and proportionate to the type of incident and professional groups involved
- Experienced representative - to support the team in the application of investigation methodologies where required
- The Investigation Team should be separate from those who provide information / evidence to the investigation

Formal Complaint Investigation...*WHAT?*

- Complaints Managers liaise with Service Area(s) to ensure that all complaints are graded. This will determine the level of investigation required.
- The Investigating Manager will determine whether any additional actions need to be taken, such as liaison through the Coroner or involvement of the Trust Safeguarding Team.
- Where a complaint is received and graded as high or extreme risk, consideration should also be given by the Investigating Manager to ascertain if this will meet the SAI reporting criteria.
- If the complaint is high risk but does not meet SAI criteria, consideration should be given by the Collective Leadership Team to undertaking an independent investigation.
- Where an independent investigation is commissioned, the complainant's consent should be sought.

Formal Complaint Investigation…suspension

- Where issues of complaint match SAI criteria, the investigation of these issues should be suspended within the complaints process, and progressed through the SAI review process instead.

- The complaint investigation can continue for issues of complaint that are not covered by the SAI review.

- Where issues of complaint raise safeguarding concerns, the investigation of these concerns should similarly be suspended within the complaints process until the safeguarding investigation has been completed.

- Where a complaint is received and the issues are already subject to another investigation (e.g. Professional Body, Ombudsman, Police Inquiry) the complaint cannot be processed until this investigation is completed.

Risk assessed approach

- It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level.
- A risk assessment process must be applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified.
- On occasion it may be relevant for a complaint to be investigated by an independent reviewer, in such instances a discussion between the Service Area Collective Leadership Team and Governance Manager will consider the appropriate person/service area to undertake this investigation.
- Higher graded complaints require prompt action and a robust investigation. They may require the involvement of investigating contributors external to the Directorate or even external to the organisation. In complex cases consideration should be given to the use of Independent Persons to help resolve the complaint
- Each complaint investigation should be proportionate to the seriousness of the complaint and the likelihood of recurrence.

Risk Likelihood Scoring Table				
Likelihood **Scoring Descriptors**	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed** **Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

	Consequence Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

- Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the corporate risk register by the relevant Director.
- Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.
- Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.
- Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Complaint Grading Examples

Low
- Delayed or cancelled appointments
- Lack of cleanliness
- Medical records missing
- Transport problems

Moderate
- Event resulting in moderate harm (e.g. fracture)
- Delayed discharge
- Failure to meet care needs
- Miscommunication or misinformation
- Medical errors
- Incorrect treatment
- Staff attitude

High / Extreme
- Events resulting in serious harm or death
- Gross professional misconduct
- Abuse or neglect

Questions???

Formal Complaint Investigation ...HOW?

- Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner.
- The investigation must uphold the principles of fairness and consistency.
- The investigation process is best described as listening, learning and improving.
- Complaint investigation must be approached with an open mind, being fair to all parties.

Key investigation steps

EVIDENCE GATHERING - DOCUMENTATION

Review of patient/service user records and timeline (if relevant) - Medical records and other clinical data - eg, case records, laboratory reports, letters, protocols.

Specific reports requested from and provided by staff

Review of local/regional and national policies and procedures including professional codes of conduct in operation at the time of the incident

Review of documentation e.g. consent form(s); risk assessments, care plans, photographs, diagrams or drawings, training records, service/maintenance records including specific reports requested from and provided by staff etc.

Key investigation steps

EVIDENCE GATHERING – PEOPLE

Personal accounts of the patient, relatives, healthcare staff, and other involved agencies (note that these will reflect thoughts, opinions and impressions).

- Review of staff/witness statements (if available)
- Engagement with patients/service users/carers/ family members/ voluntary organisations/ private providers
- Interview with relevant staff concerned e.g.:
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including primary care)

EVIDENCE GATHERING - PEOPLE

INTERVIEWS

Individuals should be interviewed by one of the following: -

- Line manager / Senior Manager with the appropriate level of seniority
- An independent person with appropriate level of seniority
- A relevant Medical, Clinical, Nursing or Professional person with the appropriate level of understanding and Seniority.
- Complaints Senior Manager or Operational Manager/ Complaints Manager where appropriate.
- Governance Manager where appropriate

Involvement of staff identified in complaint

- The complainant and those identified as the subject of a complaint should be advised of:
    - the process
    - what will and will not be investigated
    - those who will be involved
    - the roles they will play
    - the anticipated timescales

- Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

Care for staff identified in complaint

- Support staff throughout the complaint process
- Keep staff informed on investigation process / timelines
- Provide feedback on the outcome of the investigation / complaint response *(staff often say they do not receive feedback)*
- Where staff are experiencing distress or upset as a result of a complaint made in relation to them, consider referral to the Belfast Support Team (BeST)
  - BeST (Belfast Support Team) (sharepoint.com)

Belfast Support Team

BeST is a peer support service which has been established to provide reassurance and emotional support when unexpected events occur.

The service can also offer practical advice around processes or put you in contact with an expert in this area so you feel more comfortable with the processes.

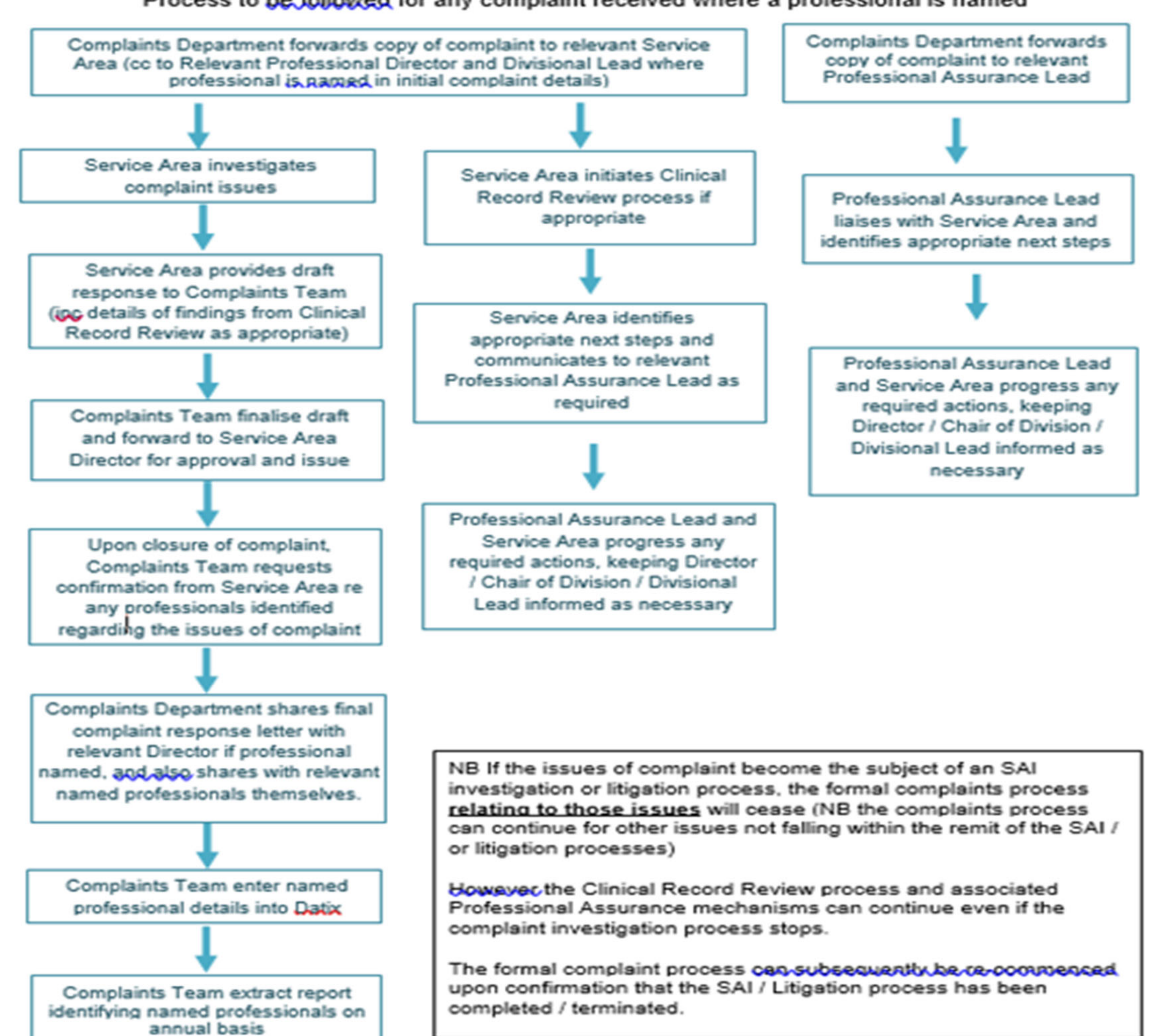
We have volunteers from across different divisions, professions and grades of staff who have committed to being a peer supporter.

The BHSCT is committed to supporting staff and recognises the emotional impact of incidents or unexpected events. We want to support staff in providing safe, effective and compassionate care by making available both practical and emotional support when these events occur.

The Belfast Support team is a 'Buddy' Service which has been set up with a number of buddies available to provide support. Any member of staff who has experienced the emotional impact of an unexpected event can confidentially be put in contact with a buddy. The buddy will provide reassurance and support. They can also offer practical advice on coroner's inquests, complaints and SAI's etc.

Questions???

Investigation Methodology options – Professional Assurance



HSC
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Clinical Record Reviews

A review of complaint processes was undertaken as a result of early learning arising from the Independent Neurology Inquiry.

- It was felt that greater assurance was required in relation to the consideration of clinical issues raised through the Trust's complaints procedure.
- Consequently a process has been implemented to formalise peer clinical review of complaints relating to ***Quality of Treatment & Care*** and ***Staff attitude / behaviour*** where these aspects of the complaint relate to a member of medical staff.
- This "**Clinical Record Review**" process is now incorporated into the Trust Complaints Policy & Procedures
- It is planned that this model will also be progressed for other professional staff groups across the Trust

Clinical Record Review

Complaint Ref: ________ Patient H+C No: ________

(1)	**Case Description – summary of clinical case**	
	Analysis of Care provided *Include brief explanatory comment for each rating that you have assessed as "Needs Improved" or "Unsatisfactory"*	**Rating**
(2)	**Assessment** (includes history taking, examination and diagnoses)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(3)	**Investigation**	Not Applicable Satisfactory Needs Improved Unsatisfactory
(4)	**Treatment** (decision making, case selection, procedures or operation)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(5)	**Communication** (patients, family, GP and consent)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(6)	**Teamworking** (communication within hospital including MDT / & handover)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(7)	**Documentation** (record keeping, appropriate follow up etc)	Not Applicable Satisfactory Needs Improved Unsatisfactory
(8)	**Overall/Assessment** – *summarise your findings from reviewing this patient's treatment and care including any areas for improvement*	

Name individual undertaking review: ________

Treating Dr GMC No: ________ Date: ________

Name Clinical Director: ________

Signature: ________ Date: ________

Satisfactory care:- Care which complies in all aspects with the standard expected taking into consideration the wider systemic issues.

Care which could be improved but not unsatisfactory:- Care which did not fall significantly below the standard expected but there were areas identified which could be improved.

Unsatisfactory care:- Care which falls significantly below the standard expected, having considered wider systemic issues

- Clinical Directors identify a relevant Consultant* to review the medical records associated with the issues of complaint and complete the *pro forma*

  CRRs can be completed by a team of clinicians rather than an individual should this approach be preferred within any area

  Where a clinical specialty comprises a small consultant team, CRRs can be conducted by the Clinical Director in conjunction with the CoD

  Where a case is particularly complex, consideration may be given to potentially seeking a Royal College review in place of the CRR

- The reviewing Consultant(s) assess each area and assign one of the following findings:

  - Satisfactory care:- the care provided complied in all aspects with the standard expected taking into consideration the wider systemic issues.
  - Care which could be improved but not unsatisfactory:- the care provided did not fall significantly below the standard expected but there were areas identified which could be improved.
  - Unsatisfactory care:- the care provided fell significantly below the standard expected, having considered wider systemic issues.

Complaints Department forwards copy of complaint to relevant **Service Manager** (CCd to **Co-Director / Chair of Division**) including blank copy of "Clinical Record Review" template

Service Manager shares complaint with relevant **Clinical Director** to initiate Clinical Record Review

Clinical Director identifies relevant Consultant(s) to undertake review, and **Service Manager** ensures said consultant receives patient's notes and Clinical Record Review template for completion

Service Manager advises staff involved in the delivery of care associated with the complaint that the review is taking place

Reviewing Consultant(s) carry out review and complete Clinical Record Review template within 2 weeks

Reviewing Consultant submits completed Clinical Record Review to relevant **Clinical Director** (CCd to clinicalrecordreview@belfasttrust.hscni.net) and discusses the findings with the Clinical Director

Clinical Director signs off completed Clinical Record Review template and provides copy to **Service Manager**

Service Manager incorporates Clinical Record Review findings into draft complaint response

Director confirms completion of Clinical Record Review before approving & signing complaint response

Clinical Director informs **Chair of Division** / **Co-Director** of any Clinical Record Review templates with "unsatisfactory" or "needs improved" ratings

Chair of Division / **Co-Director** consider appropriate next steps and communicate to **Medical Director's Office** as required

Questions???

Investigation Methodologies

There are a number of options available to assist HSC organisations in the resolution of complaints.

These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include, where relevant, the involvement of:

- Service manager / ASM /professional
- Senior manager/professional
- Trust independent manager/professional
- Lay Person
- Independent Expert
- Conciliation

Investigation Methodology tools

Service Areas should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant.

Some useful investigative tools include:

- Root Cause Analysis
- Significant Event Audit methodology

A range of investigation resources are available on the Corporate Governance Loop page: Serious Adverse Incidents (SAIs) (sharepoint.com)

Those responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

Depending on the subject matter and complexity of the investigation the Investigating Manager may wish to call upon the services of others.

Significant Event Audit (SEA) Review

- assess why and what has happened
- agree follow up actions
- identify learning

Possible outcomes may include:

- no action required
- identification of a learning need and actions
- sharing the learning
- higher level of review required

Significant Event Audit (SEA) Review Template

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1	
1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO *Please select as appropriate*	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY	
8. SUMMARY OF EVENT:	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
11. SERVICE USER DETAILS: *Complete where applicable*	
12. WHAT HAPPENED?	
13. WHY DID IT HAPPEN?	

SECTION 3 - LEARNING SUMMARY
14. WHAT HAS BEEN LEARNED:
15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?
16. RECOMMENDATIONS (please state by whom and timescale)
17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:
18. FURTHER REVIEW REQUIRED? YES / NO Please select as appropriate If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 *Please select as appropriate*	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	24. DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Significant Event Audit (SEA) Review

- What happened?

  Establish a detailed account using all the evidence that had been previously gathered. Also, consider the impact of the event for the patient, professionals involved individually or as a team and for the organisation.

- Why did it happen?

  Critically establish the main and underlying reasons that contributed to the event happening. Try not to focus on superficial causes of events - for example, 'I forgot to pass on an important message' may superficially explain an event, but does not reveal systems and organisational contributory causes such as understaffing, lack of effective message systems, and interruptions.

Significant Event Audit (SEA) Review

- What has been learned?

  Reflection and learning must be demonstrated both at an individual and a team level. Consider educational and training needs, reinforcement/change in systems or protocols, changes in team working and communication.

- What has been changed or actioned?

  Outcomes could include:

  - celebrating excellent care
  - identifying learning needs
  - need for a conventional audit
  - immediate action to rectify problems
  - need for further investigation where there is lack of resolution
  - sharing learning more widely

Root Cause Analysis (RCA)

"Systematic review technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context on which the incident happened"

Root cause analysis (RCA) is designed to explore the contributing factors to adverse clinical events. The process is based on a sequence of questions:

- What happened?
- How did it happen?
- Why did it happen?
- What can be done to prevent it from happening again?

Root Cause Analysis (RCA)

National Patient Safety Agency – Seven Steps to Patient Safety

- Identify which patient safety incidents should be investigated and determine the level of investigation required
- Gather the information and evidence
- Map the chronology of events
- Analyse the information to establish the factors that contributed to the incident and root causes

Key RCA investigative methods include:

- 5 whys analysis (Asking the "why?" question repeatedly)
- Fishbone diagrams **(based on contributory factors)**
- Barrier analysis

Investigating Managers may find other tools useful eg Problem Tree Analysis, the Seven-S Model, Brainstorming / Brainwriting (Anonymised written brainstorming) / Nominal Group Technique (Brainwriting followed by selection to lead to consensus)

These methods can be used separately or in combination to make sense of risks and hazards that are a threat to patient safety.

Root Cause Analysis (RCA) – Fishbone Diagram*

Patient factors:
- Clinical condition
- Social factors
- Physical factors
- Psychological/ mental factors
- Interpersonal relationships

Individual (staff) factors:
- Physical issues
- Psychological
- Personality
- Social or domestic

Task factors:
- Guidelines or procedures or protocols
- Decision aids
- Task design

Communication factors:
- Verbal
- Non-verbal
- Written
- Electronic

Team and social factors:
- Role congruence
- Leadership
- Support and cultural factors

Problem or issue – care delivery or service delivery problem

Education and training factors:
- Competence
- Appropriateness
- Availability
- Accessibility
- Supervision

Equipment and resources:
- Equipment supplies
- Visual display
- Integrity
- Positioning
- Usability

Working condition factors:
- Environment
- Design of physical environment
- Administrative
- Staffing
- Time or workload

Organisational and strategic factors:
- Organisational structure
- Policy, standards, goals
- Externally imported risks
- Safety culture
- Priorities

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** Material developed by the National Patient Safety Agency 2010*

Barrier analysis

Identify barriers that should have been in place and/or failed:

- Physical barriers (an actual physical hindrance) eg:
  - bar coding keypad
  - controlled doors
  - controlled drugs kept in double-locked cabinets that require two keys
- Natural barriers (barriers of distance, time or placement) eg:
  - a system for checking prescriptions in a community pharmacy
  - pre- and post-operative swab counts

- Human action eg:
  - checking the temperature of a bath before immersing an elderly patient
  - checking patients' identification with another staff member
  - checking patients' identification with the patient, carer or relative
  - surgical site marking

- Administrative eg:
  - protocols and procedures
  - Checklists
  - alert notices
  - professional registers

Physical barriers are the most reliable in terms of providing failsafe solutions to safety problems.

Natural barriers, while less effective, generally provide a more robust solution than:

Human action and **Administrative** barriers. These are considered the least reliable barriers because they rely on human action and behaviour, and mistakes can be made.

Communication

It is essential that complainants are kept updated as to how the investigation into their issues of complaint is progressing.

The complaints department maintains regular contact with complainants throughout the complaint process, however they depend on updates from the service area to be able to provide meaningful assurance on progress.

Please make sure to keep your complaints manager/admin informed of developments.

In long-running or complex cases it may be preferable for the Service Area to identify a direct point of contact for the complainant.

Questions???

Documentation

- Once the investigator has reached their conclusion they should prepare a draft report.
- The purpose is to record and explain the conclusions reached after the investigation of the complaint.
- Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual accuracy and to ensure clinicians/ professionals agree with and support the draft response.

Complaint investigation reports should include:

- Concise factual description of the incident/event leading to complaint
- People, equipment and circumstances involved
- Any intervention or immediate action taken to reduce consequences
- Chronology of events leading up to the incident
- Relevant past history
- Relevance of local, regional or national policy guidance including professional codes of conduct in place at the time of the incident
- Outcome/consequences/action taken
- Shared Learning
- Findings including Care delivery problems or service delivery problems identified, and Contributory Factors

Sharing Investigation Outcomes with complainants

- Once the investigation has been completed (including factual accuracy feedback from staff involved) the report findings should be summarised in the draft complaint response letter.

- The Investigating Manager should consider offering to meet with the complainant to discuss the findings and answer any questions.

- It may be helpful to have relevant staff (eg Service Manager / Clinical Director) present at any such meeting, and for those staff to have a pre-meeting to prepare.

- Meetings with complainants may either precede the issuing of the final response letter, or an offer of a meeting may be included in the response.

Professional Assurance

In line with Regional and Trust policy the names of staff connected to the complaint will be retained. Information from Service Areas is essential to ensure accuracy.

This information can inform staff appraisal / revalidation and provides assurance regarding individual practice.

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Complaint Closure Form:
Confirmation of investigation outcome – identification of any substantiated concerns for named staff

The staff members listed below were named in the original complaint. Please confirm whether the complaint investigation has
- *identified any substantiated concerns or highlighted a need for provision of professional support and/or guidance;*
- *confirmed that there are no substantiated concerns; or*
- *confirmed there was a factual error in the initial identification of the named individuals.*

Complaint Ref	C23764	Directorate / Division	SHWH	Specialty	Trauma & Orth	Date Closed	29Oct20	Date closure form issued	30Oct20

Staff member Surname	Staff member Forename(s)	Staff member BHSCT Staff number*	Job Title	Specialty	Complaint Investigation Outcome (concerns substantiated / concerns unsubstantiated / identification of staff member factually incorrect)	Comments
e.g. Watson	*John, Robert*	*xxxxxxxx*	*Consultant*	*Orthopaedics*	*Identification of staff member factually incorrect*	*Complaint identified patient's surgeon as "Mr John Watson". Surgeon was actually "Mr John Wilson"*

Please provide details below of any additional staff members not named named in the original complaint but who were directly involved in the issues of complaint. As above, please confirm the complaint investigation outcome for each person identified.

Staff member Surname	Staff member Forename(s)	Staff member BHSCT Staff number	Job Title	Specialty	Complaint Investigation Outcome (concerns substantiated / concerns unsubstantiated)	Comments

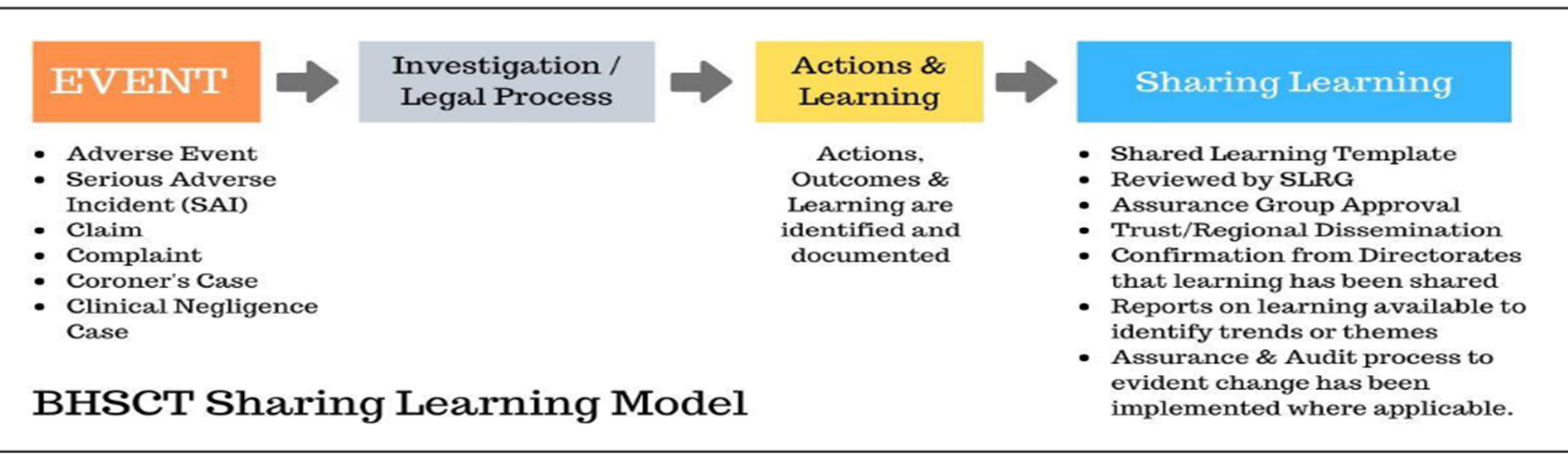
**where the staff member is a member of medical staff, please also provide GMC number*

Completed by – Name: ______________________ **Role:** ______________________ **Signature:** ______________________ **Date:** ________________

PLEASE RETURN COMPLETED TEMPLATE TO [COMPLAINTS ADMINISTRATOR] WITHIN 2 WEEKS OF RECEIPT.

Developing & Maintaining a Learning Culture

- Complaint investigation findings and recommendations should ensure learning takes place as a result of the concerns raised.
- Learning identified from complaints should be shared across the service / the Trust / regionally where appropriate.

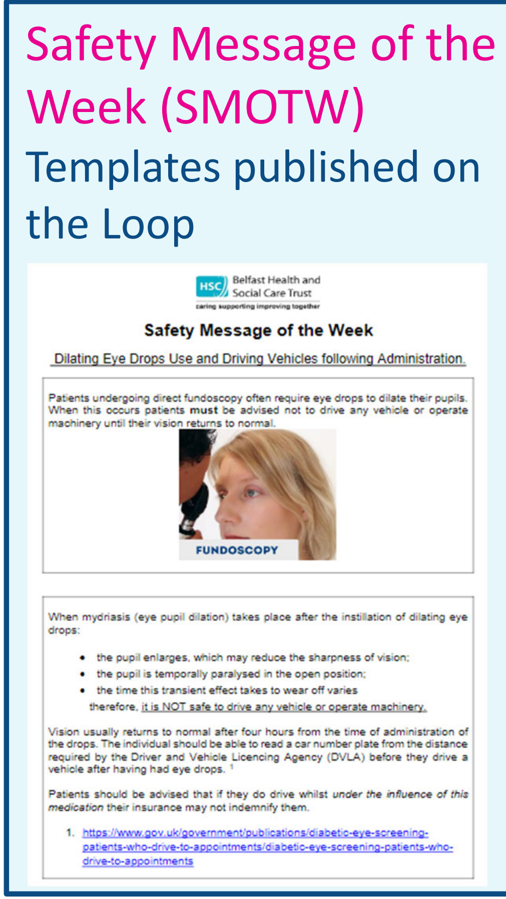


Developing & Maintaining a Learning Culture

Different measures can be taken to disseminate and implement learning eg:

Safety Message of the Week (SMOTW)

Templates published on the Loop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Safety Message of the Week

Dilating Eye Drops Use and Driving Vehicles following Administration.

Patients undergoing direct fundoscopy often require eye drops to dilate their pupils. When this occurs patients **must** be advised not to drive any vehicle or operate machinery until their vision returns to normal.

FUNDOSCOPY

When mydriasis (eye pupil dilation) takes place after the instillation of dilating eye drops:

- the pupil enlarges, which may reduce the sharpness of vision;
- the pupil is temporally paralysed in the open position;
- the time this transient effect takes to wear off varies

therefore, it is NOT safe to drive any vehicle or operate machinery.

Vision usually returns to normal after four hours from the time of administration of the drops. The individual should be able to read a car number plate from the distance required by the Driver and Vehicle Licencing Agency (DVLA) before they drive a vehicle after having had eye drops. [1]

Patients should be advised that if they do drive whilst *under the influence of this medication* their insurance may not indemnify them.

1. https://www.gov.uk/government/publications/diabetic-eye-screening-patients-who-drive-to-appointments/diabetic-eye-screening-patients-who-drive-to-appointments

Safety Matters

BHSCT Newsletter relating to improving the safety and quality of services and sharing learning from incidents and other events.

Safety Matters

Belfast Health and Social Care Trust

March 2022 Vol 2 #1

Welcome to the relaunch of the Safety Matters Newsletter!

This Newsletter aims to cover a wide range of safety related topics, providing important information and sharing learning throughout the Trust. Staff are encouraged to share this Newsletter with colleagues and use it to support communication of key safety issues.

Inside this issue

- March to Safety
- Loop Site
- Raising Concerns
- DSE Free Eyesight Tests
- Oxygen, let it flow....
- Consent
- Know your RCA from your SAI
- In-Patient Falls
- Central Nursing Safety Podcasts

Continue To Follow Covid-19 Guidance

The Trust continues to follow Covid-19 guidance to protect staff, patients, visitors and members of the public. We continue to follow the 2 metre social distancing rule on all Belfast Trust sites. Please continue to wear a mask and observe hands, face, space.

Click on the link to access the Trust Guidance on Covid-19 for staff and Managers- Covid-19 - Home (sharepoint.com)

Have Your Say!

We want to hear from you as we prepare to re-launch of Safety Matters. Just click here https://tinyurl.com/safetymatterssurvey to give us your thoughts and feedback.

Learning can also be implemented via changes to policies / SOPs / guidance / training.

Shared Learning and SMOTW templates should be completed in discussion with the Directorate Governance Manager.

All teams across the Trust can contribute to safety messages for publication.

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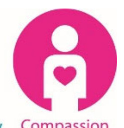
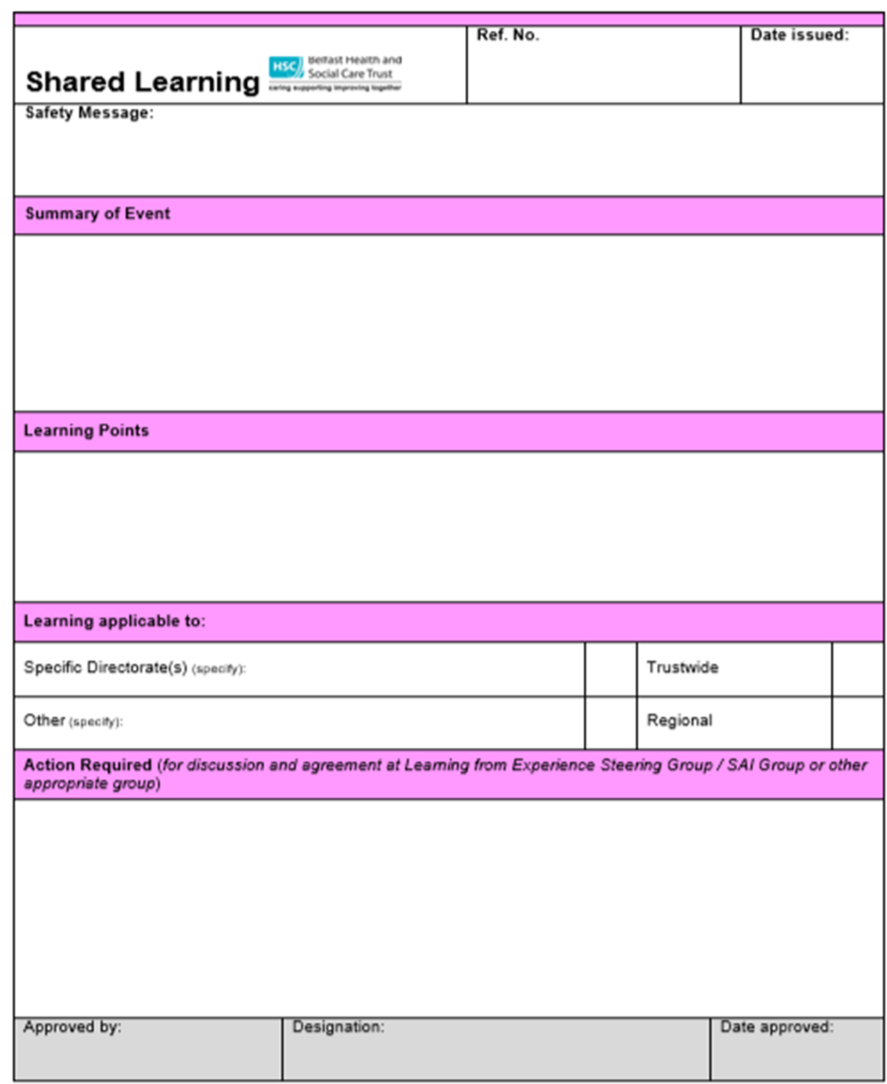


Shared Learning templates

A Shared Learning Template is a communication tool to enable one service to share learning from an Adverse Incident, SAI, Complaint, or other event, with other relevant services.

The Shared Learning Template will usually be a one page document that can be easily read, displayed and filed.

Shared Learning should not name staff or the specific unit where the event occurred.



Shared Learning (HSC Belfast Health and Social Care Trust)	Ref. No.	Date issued:
Safety Message:		
Summary of Event		
Learning Points		
Learning applicable to:		
Specific Directorate(s) (specify):		Trustwide
Other (specify):		Regional
Action Required *(for discussion and agreement at Learning from Experience Steering Group / SAI Group or other appropriate group)*		
Approved by:	Designation:	Date approved:

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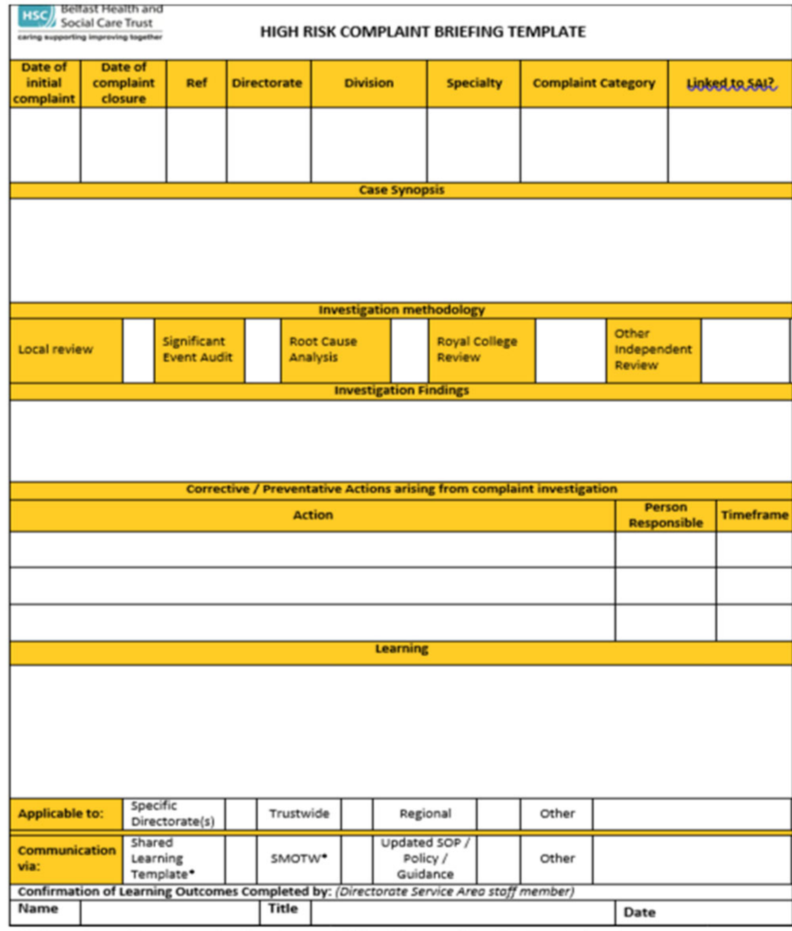
High risk briefing report templates



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HIGH RISK COMPLAINT BRIEFING TEMPLATE

Date of initial complaint	Date of complaint closure	Ref	Directorate	Division	Specialty	Complaint Category	Linked to SAI?

Case Synopsis

Investigation methodology

Local review		Significant Event Audit		Root Cause Analysis		Royal College Review		Other Independent Review	

Investigation Findings

Corrective / Preventative Actions arising from complaint investigation

Action	Person Responsible	Timeframe

Learning

Applicable to:	Specific Directorate(s)		Trustwide		Regional		Other	
Communication via:	Shared Learning Template*		SMOTW*		Updated SOP / Policy / Guidance		Other	

Confirmation of Learning Outcomes Completed by: *(Directorate Service Area staff member)*

Name		Title		Date

**information on Shared Learning Templates and Safety Message of The Week can be found at:*
http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Corporate%20Governance/Shared Learning.aspx

Summary details of investigations undertaken for High Risk complaints should be recorded in a "High Risk Briefing Template"

Investigating Managers should work with their partnered Complaints Manager to complete this template upon closure of the complaint.

Details should be captured re:

- investigation methodology
- investigation findings
- Identified corrective / preventative actions
- learning

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Record-keeping

All correspondence and evidence relating to the complaint investigation should be retained.

Once the investigation has been completed, Service Areas should provide copies of this documentation to the Complaints Department to ensure that a complete record is kept of the handling and consideration of each complaint.

Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

Upon conclusion of the investigation, all documentation referred to in the template should be completed and submitted to the Complaints Department ie:

Reports

All related notes

Timeline

Learning points

Action plans

Recommendations

The Investigating Manager may find it useful to complete a "Complaint Investigation Overview Template" as the investigation progresses.

Complaint Investigation Overview Template

Complaint Title: «COM_NAME»
Complaint Ref: «COM_OURREF»

Complaints Investigation Overview Report

**If more than one service involved, service managers to liaise and agree lead Investigating Officer*

Complainant Name (person making complaint)	<<DATIX>>	**Complainant's Contact Details** (e.g. phone, email)	<<DATIX>>
Service User Name (If different from above)	<<DATIX>>	**Service User's Details** (Address, DOB, Record No.)	<<DATIX>>
Draft Response due (to Complaints from Directorate)	«COM_DRECEIVED»	**Service User Consent Received?**	<<DATIX>>
Complaints Office Initial Grading	Potential Risk to Trust: <<DATIX>> Impact to Service User: <<DATIX>>	**Service Area's Initial Triage** (issues to consider before proceeding with formal complaints process)	1. Confirm Grading: ____________ 2. Can this be resolved informally by immediate contact with complainant? ☐YES ☐NO ____________ 3. Who will Investigating Officer/s be? ____________ 4. Does it meet criteria for SAI? ☐YES ☐NO
Any delay in draft response? (from Directorate to Complaints)	☐YES ☐NO If yes, give reason: (inform Complaints Department asap of delay & reason)		

Key Issues of Complaint for Investigation (list below or reference other document where you have these as applicable)
Where appropriate, you should contact complainant (phone / meet) to clarify issues / nature of complaint / their expectations / outcome they would like, before commencing investigation – *getting your investigation right first time*

Complainant's expectations for outcome?

Investigation Methodology Details of how you carried out your investigation (list not exhaustive) (tick box as applicable)
Attach all documentation to support your investigation, e.g. service user records (inc. electronic), staff rotas, policy/procedure/guidance, reports, interviews, record of phone calls, emails, timeline, etc – *you need to evidence a thorough, robust & proportionate investigation*

- ☐ Records reviewed (inc. electronic records)? Details:
- ☐ Reports received? Details:
- ☐ Trust policy/procedure/protocol/standard etc? Details:
- ☐ Regional or National policy/procedure/guidelines/guidance etc? Details:
- ☐ Staff/witnesses interviewed? Details:
- ☐ Complainant/other external witnesses interviewed? Details:
- ☐ Chronology or timeline of events? Details:
- ☐ Independent advice internal? Details:
- ☐ Independent expert advice external? Details:
- ☐ Use of Lay Person? Details:
- ☐ Root Cause Analysis? Details:
- ☐ Other? Details:

Investigation Details / Analysis / Findings – Review each key issue identified above (detail below or reference other document where you have recorded these, as applicable) (see tools on iconnect)
Example: What happened? What should have happened? If something went wrong, what? Why, when & how did it happen? Facts v disputed events? What is the root cause? Any contributory factors? Mitigating circumstances? Any good practice?

Conclusion/s

Remedy for Complainant / Put Things Right
See Ombudsman's 'Principles for Remedy' i.e. if possible, returning the person to the position they would have been in if the poor service had not occurred, e.g. apology, reviewing/changing a decision, remedial action, reimbursement for costs incurred, etc.

Action Plan to Prevent Recurrence / Lessons Learnt (SMART Objectives)
NB: If no action has been identified, please indicate this below

	Issue Identified	Action Taken / Planned	Person Responsible	Completion Date	
				Target	Completed
1					
2					
3					
4					

Sharing the Learning

What has been learned?

How will you share the Learning?	☐ Directorate(s) (specify)		☐ Trustwide	
	☐ Other (specify)		☐ Regional	

Providing Outcome of Investigation to Complainant – How will you provide the outcome of your investigation?

Meeting? – ☐YES ☐NO
(arrangements can be made via the Complaints Department; a minute/note of the meeting will be required)

Written Response? – ☐YES ☐NO
(to draft a Trust response to the complainant, please ensure you address all their issues, and send the draft via email to the Complaints Department >email address< – see checklist for draft response at Appendix 1)

Checklist	☑ ☒ N/A	Comments
1. At the outset, did you contact the complainant to establish the nature of their complaint and what their expectations are for outcome?		
2. Have you identified all issues of complaint?		
3. Have you separated facts from disputed events?		
4. Have you interviewed any staff / witnesses involved?		
5. Have you reviewed all relevant records/documentation?		
6. Was a visit to the relevant site / facility / clinical area required?		
7. Have you liaised with any other service areas involved to ensure one coordinated investigation and response?		
8. If the complaint relates to clinical / professional issues, have you included review by clinician / professional with appropriate seniority?		
9. Have you obtained all evidence to support your findings?		
10. Have you attached all investigative documentation?		
11. Has your draft response received all relevant Directorate approval (e.g. Assistant Director; Associate / Clinical Director, etc)		
12. Have you shared the outcome with any staff complained about?		

Investigating Officer Completing this Complaints Investigation Report

Name: ____________ Designation: ____________ Date: ________

Send this form and attachments to Complaints Office for retention on central complaints file

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Support / Resources

Guidance, advice and support available from the complaints team

The Trust Complaints Policy, and further guidance on the Clinical Record Review process be found on the Loop via the following links:

Complaints Policy Medical - Comments, Concerns, Complaints and Compliments -Policy and Procedure for the Management of - May2020.pdf - All Documents (sharepoint.com)

Medical - Clinical Record Review - All Documents (sharepoint.com)

Specific questions regarding the Clinical Record Review process can be e-mailed to clinicalrecordreview@belfasttrust.hscni.net

Support / Resources

Complaints team contacts:

Rachel Maxwell – Service Manager

Richard Dixon – Operational Manager

We are the leading independent authority on whistleblowing in the UK. We offer free advice to people concerned about crime, danger or wrongdoing at work.

We also provide expert support and consultancy services to organisations wishing to implement effective whistleblowing procedures. Our clients include Ofsted, the Serious Fraud Office, the NHS, the Home Retail Group and Lloyds Banking Group. Information on our tailored assistance packages is available on our website or you can contact a member of our Services Team.

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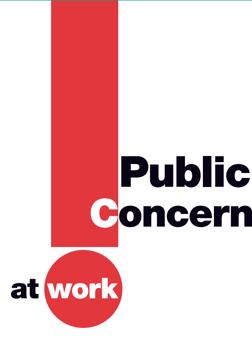


Where's whistleblowing now?

10 years of legal protection for whistleblowers

Foreword

Michael Smyth CBE Chairman

Welcome to Public Concern at Work's 2010 review of the legal protection available to whistleblowers in the UK.

The tenth anniversary of the Public Interest Disclosure Act ("PIDA") offered an excellent opportunity to take stock of the impact of this ground-breaking legislation. This report sets out the results of our findings.

Since our last review in 2007, there have been an extraordinary number of high-profile whistleblowing stories in the public domain. These have highlighted wrongdoing in sectors as diverse as central government[1], financial services[2], health[3] and social care[4]. Controversies over the use of secret filming[5] and anonymous leaking have kept whistleblowing high on the public agenda.

As a result we have experienced a record number of calls to our helpline but, as will be seen from the survey results on page 15 of this review, there is still much work to be done to publicise the help for individuals provided on our helpline and the availability of legal protection under PIDA.

We continue our efforts to persuade leaders of public and private bodies that effective internal whistleblowing arrangements, including support for those who, in good faith, report danger, malpractice or wrongdoing, are not only good for the public interest, but also in the best interests of employers. It was with this aim in mind that we jointly published in July 2008 the BSI Code of Practice on Whistleblowing Arrangements (PAS 1998:2008) which is available for free download from our website (www.pcaw.co.uk/bsi).

None of the work we have undertaken would have been possible without the foresight, enthusiasm and commitment of our founding Director, Guy Dehn, who left the charity in robust shape when he moved on in July 2008. Guy and our long-standing Deputy Director, Anna Myers were instrumental in securing the successes the charity has enjoyed over the past decade and we wish them much luck in their future endeavours.

We are delighted to welcome Catherine Wolthuizen as our new Director at a time when we continue to influence policy and practice in governance and accountability both at home and on the international stage.

I lead a strong board of committed individuals from a range of relevant backgrounds and I thank them and my Deputy, Maurice Frankel, for their contribution. We are always interested to hear from those who feel they could contribute as trustees or as members of our Council, so ably led by Michael Brindle QC.

We do hope you will continue to support us in this valuable work.

Michael Smyth

Contents

Contents

Foreword	**01**
10 years of the Public Interest Disclosure Act	**03**
Whistleblowing law beyond the UK	**08**
How we help individuals	**09**
Case studies from the helpline	**13**
Public perception: What our surveys say...	**15**
The media representation of whistleblowers	**17**
Whistleblowing best practice guide	**20**
People	**22**
Where next for whistleblowing?	**23**
30 PIDA cases	**25**

Helpline case headlines: Dangerous amusement park ride • Employer using gagging clause to prevent ex-employee speaking to SFO • Misselling of regulated insurance and financial products • Deliveries made in vehicles without

1. Damian Green and Chris Galley – news.bbc.co.uk/1/hi/uk_politics/7754099.stm 2. Paul Moore – news.bbc.co.uk/1/hi/uk_politics/7882581.stm 3. Mid Staffs – www.midstaffsinquiry.com 4. Baby P – news.bbc.co.uk/1/hi/england/london/7729045.stm 5. Haywood – www.rcn.org.uk/newsevents/press_releases/uk/joint_nmc_and_rcn_statement_on_margaret_haywood_high_court_verdict

10 years of the Public Interest Disclosure Act

'An Act to protect individuals who make certain disclosures of information in the public interest; to allow such individuals to bring action in respect of victimisation; and for connected purposes.'

Where do the judgments come from?

The need for a law protecting whistleblowers became clear after a series of disasters and tragedies in the 1980s and early 1990s, such as the Zeebrugge ferry disaster, the Clapham rail crash and the Piper Alpha explosion. The time was right for legislation to protect those speaking up in the public interest and we were delighted to have been in a position to influence the nature and scope of this important move forward in public policy. PIDA received wide support from all sides of politics, unions and the business lobby. It was a rare example of a Private Member's Bill becoming law and rarer still that it was put forward by a Conservative MP (Richard Shepherd) under the (then) new Labour Government.

PIDA came into force on 2 July 1999. The preamble describes it as:

'An Act to protect individuals who make certain disclosures of information in the public interest; to allow such individuals to bring action in respect of victimisation; and for connected purposes.'

This protection results in the right to take a claim for unfair dismissal or detriment to the Employment Tribunal (ET).

At the time, Lord Nolan (former Chair of the Committee on Standards in Public Life) praised PIDA for 'so skillfully achieving the essential but delicate balance between the public interest and the interest of employers.' Since its introduction, PIDA has been hailed as a best practice model for whistleblower protection and its approach has been adopted around the world. In the UK, attitudes towards whistleblowers have changed. PIDA is a cornerstone of the whistleblowing framework, in the principles it crystallises, the protection it provides, and the incentive it gives employers to get matters right or pay up. Employers are now more aware than ever of the need to develop robust whistleblowing arrangements, knowing that these may help identify problems at an early stage. As public and regulatory knowledge of the framework that supports whistleblowing increases, the deterrence and the detection of wrongdoing will inevitably rise.

Despite these achievements, our view remains that much more needs to be done to promote PIDA and the good practice principles it encourages.

Open justice and the referral of PIDA claims to regulators

Since the cross-party initiative that brought PIDA into force, there has been considerable ongoing debate and discussion around its operation and effect. This has not always been informed by reference to analysis of cases, in part because they have not been readily accessible. Claims made to the Employment Tribunal including those made under PIDA are not made public, unlike in civil courts. We say this is inconsistent with the principle of open justice.

This means that given the proportion of PIDA claims which are settled, it is entirely probable that a public concern may lie unaddressed, buried in a claim shielded from view. In response to our campaign for greater transparency of PIDA claims, the Government has laid regulations that enable the Employment Tribunal Service to forward claims to the appropriate regulator where the claimant consents. Whilst not ideal, this should raise awareness of the importance of informing a regulator about a serious matter and improve the flow of information to regulators. While we hope genuine whistleblowers will provide their consent for information to be passed to a regulator, our fear remains that whistleblowers will find themselves under pressure to withhold consent, or will use their consent as a bargaining chip in settlement negotiations. Where consent is withheld, the Government has not said who will scrutinise the underlying concern, or whether anyone will look at it at all. Moreover, we do consider it strange that a law which is all about promoting transparency and accountability in the workplace should have its use shrouded in secrecy.

Gagging clauses

Over the past year the media has highlighted the fact that one part of PIDA may need closer observance in that there has been some concern that whistleblowers are being gagged in compromise and severance agreements. While the law is clear that clauses that attempt to gag an individual from making a PIDA-protected disclosure are void, what happens in practice may be different. Entering into a potentially void contract makes little sense on any view. We hope a better knowledge of the law might deter lawyers and employers from this approach.

PIDA Judgments

For this review, we have analysed PIDA judgments, as sent to us by the Employment Tribunal Service.[6] However, of over 3,000 judgments (7,000 claims), only 532 had enough information to enable us to identify the nature of the concern or the issue in dispute. Those judgments reveal the serious concerns that can lie at the heart of a PIDA claim. There is no information on the underlying concern in the remaining 2,500 judgments (6,500 claims). This means the public can only see information about the concern in 8% of claims.

Despite the sparsity of available information, PIDA has generated thought-provoking and challenging cases that reveal the human dimension of whistleblowing. We have selected 30 of the most pertinent examples in the last section of this review (see page 25).

On their facts, the cases provide a telling insight into the modern workplace, labour relations and employment law. The whistleblowing concerns range from serious crimes and cover-ups to the inconsequential; the victimisation complained of covers both the outrageous and the trivial. Above all, the cases show that the Act is helping to tackle serious wrongdoing at work by providing a framework for responsible whistleblowing.

The summaries also provide an accurate picture of how the Act's legal principles are applied by tribunals and the higher courts. In this regard they:

- Confirm that whistleblowers do not lose statutory protection simply because they are mistaken;
- Show the risks to individuals and others of raising a concern anonymously;
- Show the good faith test applied in a handful of cases to bar what, on the facts, appear to be unmeritorious claimants;
- Show how and when it is appropriate to engage a regulator;
- Provide examples of disclosures to the media being protected; and
- Demonstrate that causation is ultimately a matter of fact, not law.

Facts and figures to 2009:

- The number of PIDA related claims has increased from 157 in 1999/2000 to 1761 in 2009;
- Employees lodged over 9000 claims alleging victimisation for whistleblowing;
- Over 70% of these claims were settled or withdrawn without any public hearing;
- Of the remainder 78% were lost and 22% were won.

Statistics supplied by Department of Business, Innovation and Skills.

insurance or MOT • Dentist using old and non-sterile equipment • Charity Director forging cheques • Private nursing home owner sexually abusing residents • Car sales company submitting bogus sales figures to get bonus

6. This covers all judgments received by us from the Employment Tribunal Service from PIDA's inception up to December 2008. We have yet to receive all judgments for 2009.

10 years of the Public Interest Disclosure Act

PCaW breakdown of types of wrongdoing in PIDA judgments

The tiered disclosure framework

PIDA in practice

We set out below the key PIDA principles that have emerged from the tribunals and courts. The cases show that the law will protect the reasonable and honest whistleblower who has raised an issue of genuine public interest.

What does the Act say?

PIDA has a tiered disclosure regime giving virtually automatic protection to those who raise a concern internally with their employer. Protection is also readily available for disclosures to prescribed regulators (such as the Financial Services Authority, the Health and Safety Executive or the Care Quality Commission). In certain circumstances, wider disclosures (for example to an MP or the media) may also be protected.

Who is protected?

The Act covers all workers across all sectors, including temporary agency staff and all NHS staff including General Practitioners. Its broad application includes UK workers based overseas although it does not cover the genuinely self-employed or volunteers. At present non-executive directors are not covered by PIDA – see Where next? on page 23.

What is wrongdoing?

PIDA covers disclosures about a wide range of what might constitute wrongdoing, including danger to health and safety or the environment, crime, miscarriages of justice, and a breach of a legal obligation, or attempts to conceal any of these matters.[7]

What is the public interest?

There has been considerable debate over whether there should be a 'public interest' test in PIDA. This was first illustrated in the case of Parkins v Sodhexo in 2001 in which the ET stated during an interim application that in PIDA reference to a breach of a legal obligation was to be interpreted widely. The case included a complaint by an individual of a breach of his employment contract. While this means that the scope of the Act is wider than was envisaged during the passage of PIDA in Parliament, its application can support individuals with limited employment rights. In Grierson v Meta Management Services Limited in 2008 two individuals were protected under PIDA after they were victimised for raising a grievance that the company had lured them from good jobs promising higher wages that they never received.

Does motive matter?

A requirement of PIDA is that concerns should be raised in good faith. In the early years, decisions had assumed that this had the ordinary legal meaning of 'honestly'. The Government stated in the Bristol Royal Infirmary Inquiry that it had intended good faith to mean 'honestly and not maliciously'. However in Street v Derbyshire Unemployed Workers Centre (2004) the Court of Appeal rejected our submission that the phrase meant 'honestly'. It was however persuaded by our argument that PIDA protection cannot be lost unless there is a predominant ulterior motive that is unrelated to the purposes of the Act. Concern about this decision led Dame Janet Smith to state in the Shipman Inquiry that the good faith test should be removed altogether from PIDA as this would "avoid the possibility that concerns will not come to light because an individual might lose protection if [his or her] motives can be impugned." As yet this recommendation has not been implemented.

What proof is required?

An individual does not have to be right about the substance of his concern, provided he is reasonable (Babula v Waltham Forest College (2006)). However the case of Bolton v Evans (2006) also makes it clear that an individual should be careful to avoid acting like a private detective and step over the line of what is considered to be appropriate conduct in attempting to prove he is right.

Who can you tell?

As outlined above, individuals are protected if they raise a concern with their employer or a prescribed regulator. PIDA will also protect those who go straight to the media if appropriate, as was confirmed in Collins v National Trust (2005). In this case, the ET ruled that, in exceptionally serious circumstances, a disclosure to a local newspaper of a confidential report about dangers on a public beach was protected. This can be contrasted with the case of Holbrook v Queen Mary's Sidcup NHS Trust (2008) in which a radiographer was concerned that a police officer who had been brought in as a patient was drunk. Holbrook's action in anonymously calling 999 without consulting senior staff was found to be unreasonable, and 'a serious error of judgment' by the tribunal. Although clearly a serious breach of confidentiality the decision appears to suggest that all disclosures should first be raised internally – an interpretation which in our view may be wrong in law.[8]

Ten years after PIDA came into force, the Employment Appeal Tribunal (EAT) confirmed in Hibbins v Hesters Way Neighbourhood Project (2008) that whistleblowers are protected even when the information they disclose to their current employer involves wrongdoing by a third party. In Elstone v BP plc in 2009 the ET held a worker could be protected if his current employer victimises him for a disclosure made to a previous employer. The ET said: "what must be borne in mind is the purpose of the legislation – which is to protect employees and workers whoever they work for".

Is PIDA like discrimination law?

While there are significant differences between PIDA and discrimination law, the Court of Appeal has previously ruled that PIDA cases should, where possible, be approached by the courts like discrimination cases (see for example, Melia and Ezias v N. Glamorgan NHS Trust, Court of Appeal, (2007)). The Court of Appeal ruled In Virgo v Fidelis (2004) that awards for injury to feelings in PIDA claims are to be assessed in the same way as for other forms of discrimination (see Vento v Chief Constable of West Yorkshire Police (2002) which indentified three bands of compensation, ranging up to £25,000 for the highest and that the upper band should only be exceeded in exceptionally serious cases).

The Court of Appeal in Kuzel v Roche (2008) held that even if a tribunal did not accept an employer's reason for dismissing a claimant, it did not need to accept the reason put forward by the claimant. The Court of Appeal rejected the contention that the legal burden was on the claimant to prove that the protected disclosure was the reason for the dismissal: they merely had to advance evidence of it. The Court agreed with the EAT that to transplant the operation of the burden of proof from discrimination law would complicate rather than clarify the issue, as discrimination law and unfair dismissal law are different causes of action.

Where do people go?

8 out of 10 claimants first raised their concern internally with their employer. This is good news for employers who want to know about their risks and underscores the value of robust whistleblowing arrangements to risk management and good governance. As employees are giving their employer an opportunity to address the concern first, more needs to be done to make whistleblowers feel supported, avoiding the necessity of a PIDA claim.

Where next?

8% of claimants raised their concern with a regulator. This highlights the need to raise awareness of the role of regulators in public interest matters. We are only aware of one claimant who took his concern to the media direct (see Collins v National Trust, above). This dispels the myth that whistleblowing automatically involves public revelations. Only 1% of individuals initially raised their concern either internally or with a regulator and subsequently went to the media.

• Charity chief executive claiming for building work on his home • Company chairman making loans to himself prior to takeover • Care assistant physically abusing elderly patients in residential home • Waste disposal firm stealing

7. These legal definitions cover a wide range of issues. For a more detailed and illustrative breakdown of the types of concerns raised in the workplace in the PIDA judgments, see page 9.

8. ERA 1996 section 43H – does not require that a concern be raised internally if it is exceptionally serious.

10 years of the Public Interest Disclosure Act

Damages under PIDA are uncapped. Overall £9.5 million has been awarded to successful PIDA claimants.

The law will protect the reasonable and honest whistleblower who has raised an issue of genuine public interest.

What's the damage?
Damages under PIDA are uncapped. From the tribunal awards that we have seen, over £9.5 million has been awarded to successful PIDA claimants. The highest award was over £3.8 million, the lowest £1,000. The average award is £113,677.

The early years of PIDA saw some high awards for aggravated damages and injury to feelings, reflecting the seriousness of the wrongdoing at the heart of some PIDA claims. The case of Bhadresa v Strategic Rail Authority (2002) was about a barrister who witnessed her line manager destroying prosecution case files and reported the matter to the appropriate authority. Her consequent victimisation led to an award of £274,504 which included £10,000 for aggravated damages and £50,000 for injury to feelings. In Howie v HM Prison Service (2008) the tribunal awarded £22,500 and an additional £10,000 for aggravated damages due to the conduct of the employer. Howie was a witness in Lingard v HM Prison Service (2004) in which the tribunal awarded £477,602 – the highest compensatory award in the public sector under PIDA.

Post employment
In a landmark decision, the Court of Appeal ruled in Woodward v Abbey National (2006) that PIDA protection applies to post-employment victimisation. This is intended to discourage employers from trying to make things difficult for a whistleblower after they have left (such as by denying them a reference).

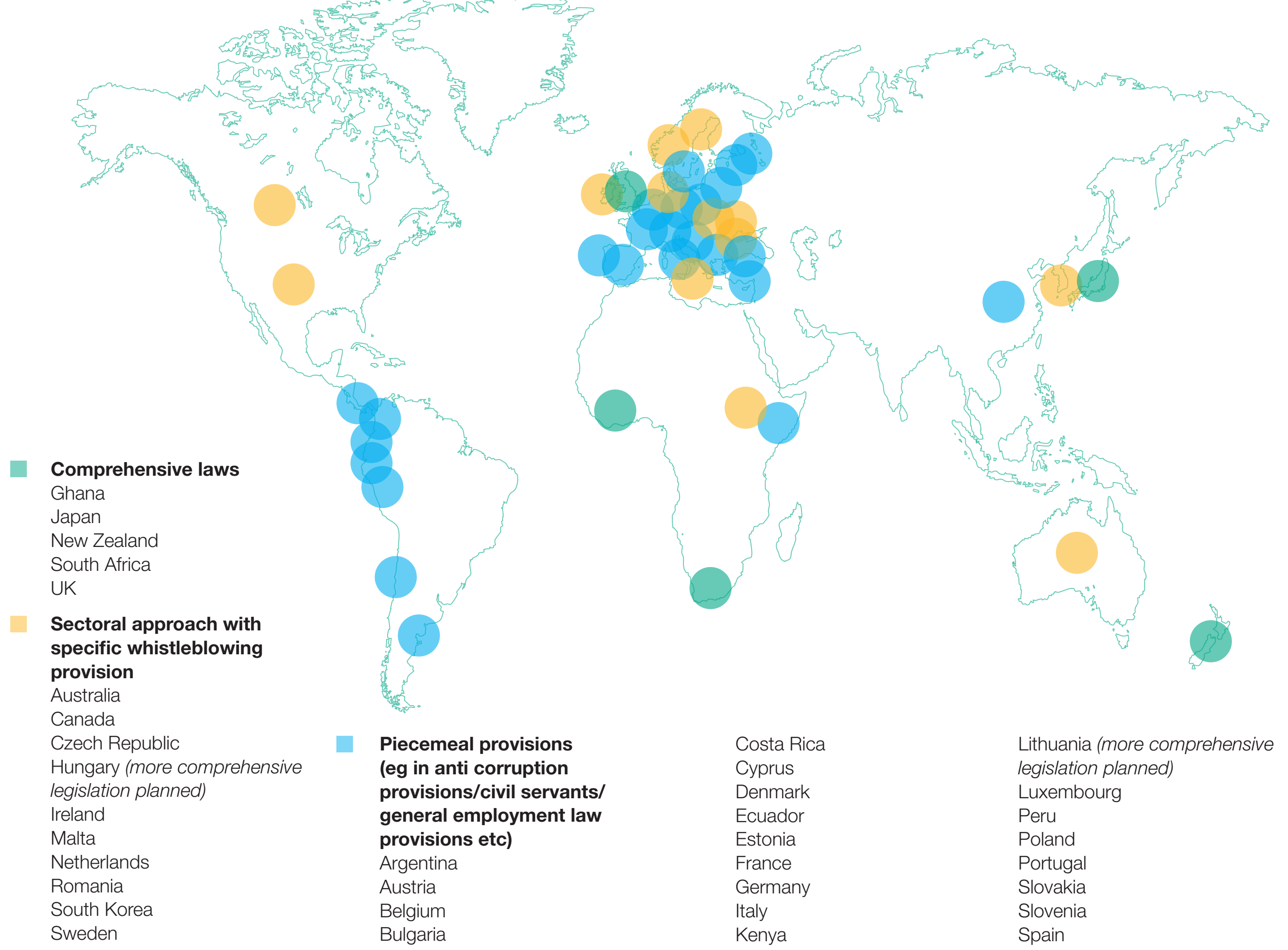
PIDA beyond the employment tribunals
In Cream Holdings v Banarjee (2004) PIDA provided a useful framework for commercial cases about breach of confidence, showing that, where its principles are followed, PIDA will assist in defending against injunctions seeking to restrain publication of matters of serious public interest. This emphasises the core common law principle echoed in PIDA that there is no confidence in iniquity. In other words, courts will not permit attempts to cover up illegality or wrongdoing.

More recently the PIDA framework was considered in April 2009 in the controversial decision of the Nursing and Midwifery Council to remove Margaret Haywood from the nursing register for secretly filming the neglect of elderly patients for the BBC Panorama programme. While the fitness to practice panel looked at the principles of PIDA and confirmed that this was an exceptionally serious concern, they did not apply those principles to establish whether it was reasonable for her to breach patient confidentiality as PIDA itself would have required. This raises the question whether PIDA should be extended to apply to proceedings before a professional body when an individual may be at risk of losing not just their job, but their career – for our recommendations on this see Where next? on page 23.

Whistleblowing law beyond the UK

As can be seen from the graphic below*, PIDA is one of the few comprehensive whistleblowing protection laws, covering all sectors and a wide range of malpractice and wrongdoing. Even in countries where there is some protection it is often piecemeal in approach.

This research has been helped by the recent work undertaken by Transparency International in which preliminary guiding principles for legal protection were developed after an expert roundtable in the summer of 2009. We were delighted to participate in this work. We hope that further progress in formulating international guidance is forthcoming, adding to the existing international conventions in the UN Convention against Corruption and the Council of Europe draft resolution.[9]



top grade paper from paper mill and selling it on • Education centre claiming government funds for bogus student places • Manager of old people's home pocketing resident's money • Pharmacist making false claims for NHS

9. http://assembly.coe.int/Documents/WorkingDocs/Doc09/EDOC12006.pdf

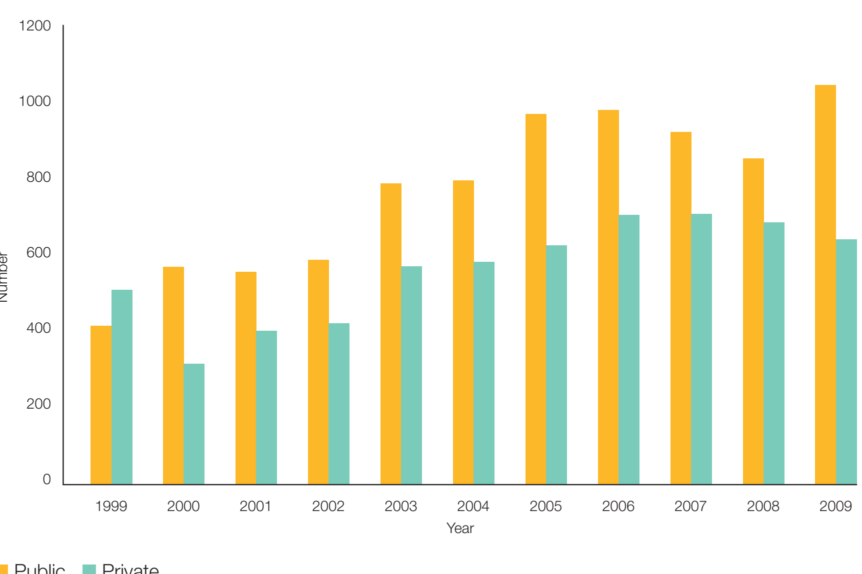
How we help individuals

Overall types of concern recorded on the helpline

- Financial malpractice - 26%
- Work safety - 17%
- Public safety - 12%
- Abuse - 12%
- Consumer/Competition and Regulation - 2%
- Discrimination - 2%
- Ethical - 13%
- Multiple - 8%
- Other - 5%
- Unknown - 3%

Since we launched in 1993 we have taken over 17,000 calls from individuals seeking assistance. Our helpline provides free confidential advice to those who witness wrongdoing or malpractice at work and are unsure whether or how to raise their concern. The advice aims to help callers to speak up at the earliest opportunity, protecting the public interest by preventing damage while minimising the risk to the individual's own position. What follows is our summary of some of the trends that we have seen on our helpline since the introduction of PIDA.

Number of calls to the helpline



What types of concern do we deal with?
We classify all calls involving a whistleblowing issue as public, and those that involve employment rights issues, including bullying and harassment, as private. Overall 56% of our calls have been public. In 2009 this rose to 65%, possibly due to the increased media focus on whistleblowing which may have indirectly drawn attention to our helpline.

We advise on a wide spectrum of issues. Over the last decade the top five types of concern reported to the helpline have consistently been the same: financial malpractice, work safety, public safety (including patient safety in healthcare), abuse (of vulnerable adults or children for example) and calls we classify as ethical namely issues such as nepotism, conflicts of interest or what to do when colleagues have drug and/or alcohol problems.

When do people call?
The great majority of calls to our helpline take place after a concern has been raised. In 1999 82% of individuals had already raised their concern. This has fallen to 66% in 2009. Our advice is of most assistance when an individual is first considering how best to raise a concern. So while we believe it is good news that more people are calling us at this stage, we hope to do more by increasing awareness of the support we can provide and raise the proportion of callers coming to us earlier, when we can be of most help.

Who do individuals tell?
Our files show that, where people have already raised their concern before contacting us, most (69%) have raised the matter internally with their immediate manager. Over the years there seems to be an increasing propensity to go to senior management in the first instance.

Openness, confidentiality and anonymity
Openness makes it easier for the organisation to assess the issue, work out how to investigate the matter, get more information, understand any hidden agenda, and avoid witch-hunts. A worker raises a concern confidentially if he gives his name on the condition that it is not revealed without his consent. A worker raises a concern anonymously if he does not give his name at all. If this happens, it is best for the organisation to assess the anonymous information as best it can to establish whether there is substance to the concern and whether it can be addressed. If no-one knows who provided the information, it is not possible for an organisation to reassure or protect him.

How do individuals raise their concern?
75% of those callers with public concerns who had already raised their concern said they did so openly, 10% confidentially and 2% anonymously. The trend away from anonymous reporting is welcome.

Comments from helpline callers
"Thank you again for all your help and support, without it I would probably have put up a fight but just allowed myself to be sacked, which would have done no good for my CV or self esteem! You do a wonderful job and I hope the next person you help is as satisfied with the outcome as I am."

"The advice Anna gave to me at what was a very difficult time proved invaluable. The direct but kind approach must also be a difficult one to master and yet it is so important for the role you all play."

"I feel much calmer and more in control of my future now and wanted to let you know."

"I am very thankful for you and your colleagues' advice and support through a lifetime experience and once again I do appreciate all you and your organisation have done for me."

prescription rebates • Unreliable data for key government project on energy efficiency • Former director and deputy of a charity falsely claiming holiday pay • Unsafe meat delivered to London schools • Training company billing NHS

How we help individuals

Public calls: industry type

- Care - 16%
- Health - 13%
- Local Gov - 8%
- Central Gov and NDPB - 2%
- Education - 7%
- Manufacturing - 5%
- Retail - 4%
- Transport - 3%
- Financial Services - 6%
- Food/Bev - 2%
- Science/Tech - 2%
- Charitable - 7%
- Armed Forces, Police & Security - 1%
- Other - 10%
- Unknown - 9%
- Construction & Mining - 2%
- Leisure - 2%
- Utilities - 1%

Where do the calls come from?

By sector

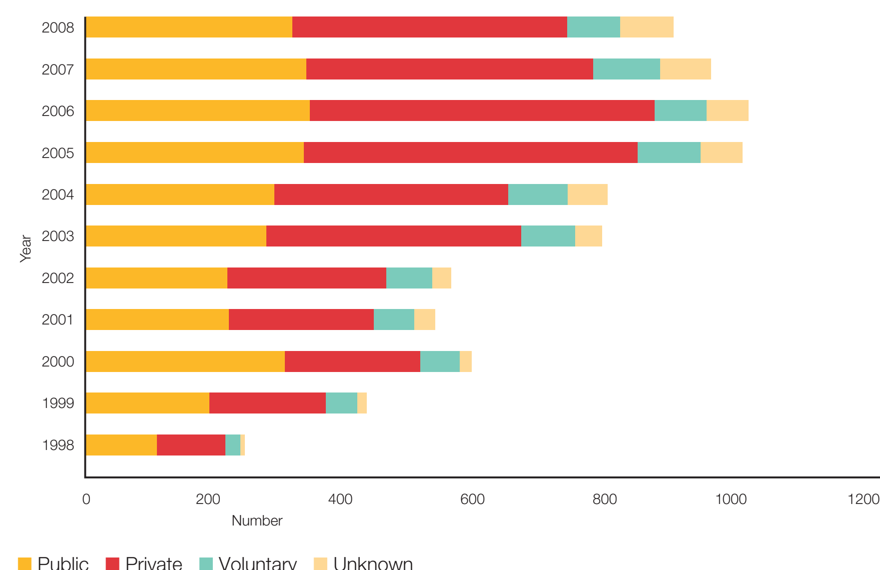
In 2001 there was an equal spread of calls from the private and public sectors at 41% each, though prior to this the majority of calls had come from the public sector. After 2001 the majority of the calls have come from those working in the private sector. Overall 35% of our calls have been public sector, 44% from the private sector with the remainder from the voluntary sector.

By industry

On average 29% of our calls have been from the health and social care sector (16% care, 13% health). 8% were from local government, 7% education, 7% charitable and 6% financial sector.

The number of calls from both the financial and education sectors has increased year on year – rising to 8% and 9% respectively in 2009.

Public calls: sectoral breakdown



What has happened to the concern?

We ask individuals if they know whether any action has been taken in response to their concern when they first call us. Since 2001 we have captured this information on our database. A large majority say that their concern had been ignored. This reflects our own surveys: time and time again people don't speak up because they do not think it will make a difference. We often advise individuals to seek feedback as action may have been taken without the organisation letting them know.

What has happened to the individual when they call?

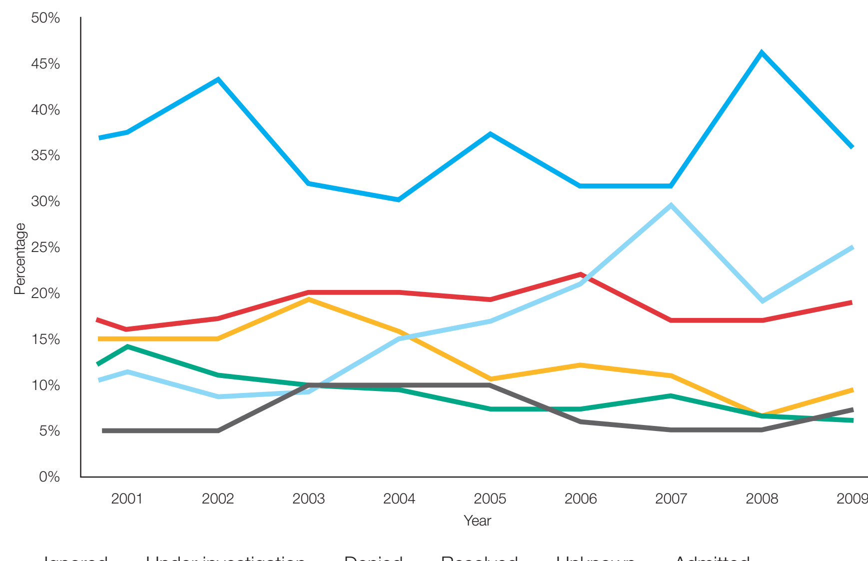
35% of callers with public concerns came to us after they had suffered reprisals (e.g. they were victimised, disciplined or bullied). 2% had already resigned. 15% had been dismissed. 34% of callers said there had been no consequence and only a small proportion received thanks. This may suggest there is still much work to be done by employers to protect workers from reprisals and to demonstrate approval of their actions.

Feedback

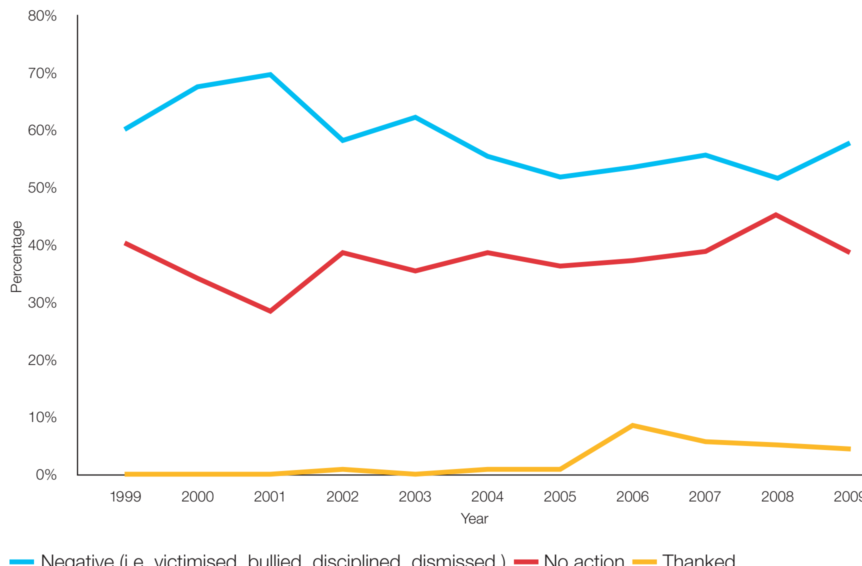
We periodically undertake surveys of those clients who provide telephone details, seeking feedback on our service. We have aggregated these results over an 8-year period. Of those we successfully contacted:

- 95% said the advice was clear and easy to understand;
- 77% said the advice was helpful;
- 71% said they had followed the advice;
- 80% said they would recommend the service to someone with a public concern.

What has happened to the concern?



What has happened to the individual when they call?



for bogus courses • A potentially corrupt immigration officer • Uncontrolled spending on an NHS IT project • Unreliable testing equipment in a nuclear plant • Untrained carers inserting catheters in patients • Bribing a compliance

Case studies from the helpline

Explosive problem

Greg, a chemical engineer, explained that he worked for a short time at a factory located near a primary school. At a meeting, another engineer had reported that the circuits had failed tests (required by regulation) to ensure that in an explosive atmosphere when certain chemical vapours were present there could not be any sparks. This engineer admitted privately to Greg that, if there was an inspection the HSE would close the plant. Greg feared an accident, given that the works engineer (to whom his line manager reports) said that the issue might be looked into in a couple of months and had said before that he 'couldn't give an f... about health and safety'.

We advised Greg to speak to the health and safety manager as soon as possible about his concerns. Greg rang back to say that he had done so, his concerns had been taken seriously and the H&S manager was going to speak to the engineer who had done the original testing.

The wrong ticket

Mary worked for a subcontractor for a parking enforcement agency and said tickets were being sent out by the computer incorrectly with the wrong fine attached. Mary said her manager had told staff to enforce the tickets unless someone complained and that she had been 'told off' for being too helpful to members of the public about ways to appeal. Mary said she had raised this with the agency direct but had been ignored. She admitted she did not get on well with her manager because she was 'too vocal'. She said staff had been sacked recently for no reason and now wanted to go to the papers.

We advised that going to the press was an option but not necessarily the best for her or for addressing the problem. As Mary had not talked to anyone senior at the agency, we suggested she might try this route first. She said she wanted to leave and found it helpful to talk through her options with us. Mary called back to say she had raised the issue at a higher level and that a note had been sent to all staff to ensure that individuals who had received the wrong ticket were told how to appeal. Mary was pleased and thought this was because she had raised it with the agency.

Working at height

Harry works for a company which processes nuts. He said that in the past, cleaning of a storage silo had been outsourced until the system changed and two staff were trained to do it. Harry said the training was inadequate because staff had never been shown how to use the harnesses necessary to complete the task – the silo can only be accessed some 30 feet above ground level. Harry refused to allow his staff to clean the silo. His manager disagreed with his decision saying he had risk-assessed the task as being safe. Harry was facing disciplinary action.

We suggested that Harry make it clear to the manager that he was genuinely worried about staff safety and state his willingness to find a solution. We suggested he contact the trainer to see how staff could be trained with a harness as soon as possible. Harry realised that he had engaged in an argument about his decision not to let staff clean the silo rather than finding a safe way to get the job done.

Numbers for sale?

Vince works in a small restaurant and became worried when his boss asked him to jot down the security number from the back of customers' bank and credit cards, out of sight of the customer. This was to be done even though the customer was present and had given the PIN number or signed the account.

We agreed with Vince that this practice was worrying and suggested Vince check with the bank whether this is an acceptable or normal security measure and come back to us. Vince later called back and said he had called the bank and they had taken a statement from him.

Damned if you do, damned if you don't

Sanjay recently began to patrol his local area as a new member of his local community warden team. He rang for advice after reporting a colleague for lying on an incident form. The incident involved youths misbehaving on a housing estate. Sanjay's colleague had included names of a few known troublemakers who were not present at the time. Sanjay refused to countersign the report and then discovered that his colleague had filed it and appeared to have signed it in Sanjay's name. After reporting it to his manager, Sanjay was warned by a team supervisor that he was not likely to "get on" if he carried on reporting to managers rather than coming to the supervisors first.

We reassured Sanjay that he had done the right thing and how important it was to lead by example. We advised Sanjay that if he did suffer any reprisals from colleagues, he should raise this with his manager immediately and could ring us for advice. Sanjay said he was confident the manager was taking the matter seriously.

A private dilemma

Jane works as a medical secretary in an NHS trust and told her employer that the vast majority of a colleague's work was for a consultant's private practice rather than the NHS. Jane was asked to attend an interview, as part of an overall investigation, to discuss the colleague's working practices and Jane was now worried her colleague was going to find out she was the one who blew the whistle.

We persuaded Jane the hospital was clearly taking the matter seriously and wanted to investigate it. We reminded Jane that it would be odd if all staff were interviewed and Jane wasn't. If Jane was really worried about her own position, we suggested that she explain this to the manager with whom she first raised the matter and seek some reassurance.

Clinical trials

George said he and a number of consultants were worried about a colleague, Helen, who was taking excessive liver samples from patients during a clinical trial. Helen was going outside the terms approved by the hospital ethics committee and taking larger samples for an unapproved purpose. Though the hospital was in the process of investigating the matter and Helen was on gardening leave, George wanted to inform a relevant health regulator.

We suggested George wait for the outcome of the investigation as it was clear the Trust was taking the matter seriously. Helen was not working at the moment so the practice had stopped. George agreed this seemed sensible and that once he knew the outcome he may ring back.

Flushing it out

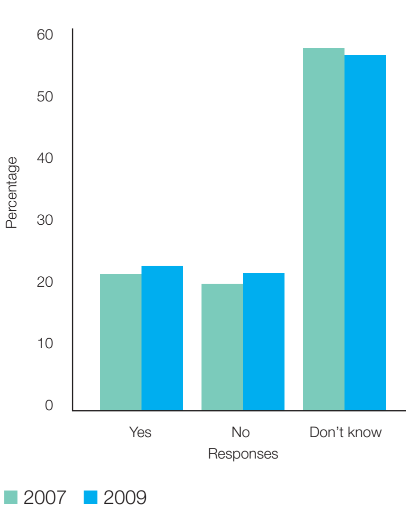
Derek was a senior care co-ordinator in a care home for the elderly. He was on duty one day when he found that the carers had forgotten to give some residents their medication which included tablets for water retention, blood pressure and some heart conditions. Derek immediately told the home's manager who took the unused medication and flushed it down the toilet. Derek came across another incident where medication was missed and was unsure what to do. He decided to contact head office to tell them what he had witnessed. The matter was investigated and the home's manager was taken through a disciplinary process. Derek then contacted PCaW because he was worried about being revealed as the whistleblower.

We worked through the situation with Derek. As he was the sole witness of the manager's actions, it was more than likely the manager would work out that Derek was the source of the concern. We advised him to be open with head office and explain his anxieties to them, particularly as they were taking the concern seriously. We reassured Derek that he could ring back if he had any questions or concerns. A couple of months later Derek advised us that the concern had been resolved. He had followed the advice and when he spoke to head office, they had taken his worries about confidentiality seriously and found another way to deal with the situation. Derek was still at the same home. He was relieved that no-one had been fired, the manager was still in post and there had been a change in the medicine protocols and in the culture at the home.

auditor about factories overseas • Charity contractor fiddling the books and charging double • Subversion by officials of a minister's pledge to Parliament • Care home staff using residents' money to buy their weekly groceries

Public perception:
What our surveys say...

To your knowledge, is there a law that protects workers who 'blow the whistle?'

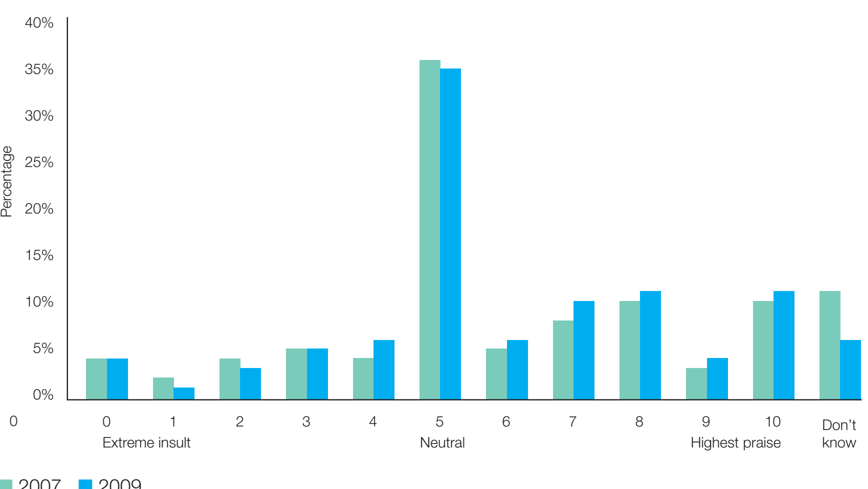


In 2007 and 2009[10] we commissioned YouGov to survey people across the country about their attitudes to and knowledge of whistleblowing. Those surveyed who were in work (1,451 in 2007 and 1,314 in 2009) were also asked whether they would be prepared to blow the whistle if necessary and to whom.

The online surveys show that individuals are willing to raise their concerns and that whistleblowing is viewed as a positive term, though many still do not know about PIDA and the protection that it offers. Only 23% of respondents in 2009 (and 22% in 2007) said they know that there is a law that protects whistleblowers.

How do people feel about the term 'whistleblower'?
'Whistleblowing' is increasingly being seen in a positive frame: on a scale of 1-10, 5% more in 2009 (41%) viewed the word positively than in 2007 (36%); roughly the same (35% in 2009 and 36% in 2007) viewed the word as neutral and 19% in both 2007 and 2009 viewed the word negatively.

How would you rate the word 'Whistleblower'?



This is consistent with the analysis of media coverage of whistleblowing (see page 17) and suggests the former perjorative connotations of the word are disappearing.

Knowledge of the whistleblowing law
In 2009 23% (22% in 2007) of the respondents said that to their knowledge there is a law that protects whistleblowers, 22% (20% in 2007) said there is not and 56% (57% in 2007) said they do not know either way.

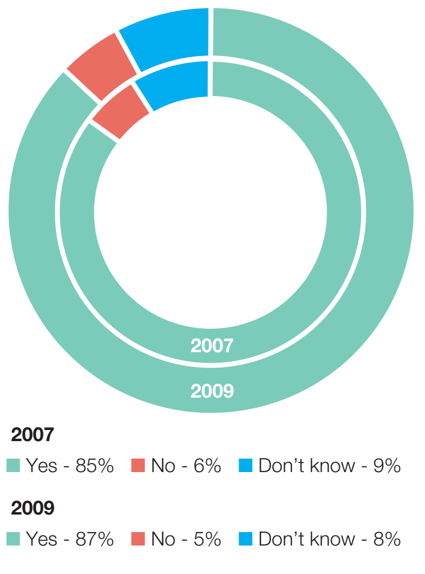
Would you blow the whistle to your employer?
Most individuals would raise a concern with their employer. 87% in the 2009 survey (85% in 2007) said they would raise a concern about possible corruption, danger or serious malpractice with 5% saying they would not raise it with their employer and 8% not knowing what they would do.

Externally?
When asked what they would do if they did not feel confident about telling their employer their concern, the majority of respondents said they would raise their concern with the regulator or police. In both surveys a large number (28% in 2009, 32% in 2007) did not know where they could raise their concern externally.

Does your employer have a policy?
In the 2009, 38% said their employer has a whistleblowing policy, an increase of 9% from 2007. There was also a sectoral split with 33% of private sector employees saying that their employer has a whistleblowing policy compared with 47% from the public sector in 2009.

By way of comparison, in March 2007 Ernst & Young asked 1,300 senior executives in European countries who worked for multinationals that had promoted whistleblowing if they felt free to report a case of suspected fraud, bribery or corruption: across mainland Europe 54% said yes. By contrast in the UK, the figure was 86%. We found the same to be true in our 2008 survey with Nursing Standard magazine: where a trust promotes whistleblowing well, 81% of nurses said they suffered no reprisal and 67% said the concern was handled well. In trusts where whistleblowing is not promoted, this latter figure collapses to 16%.

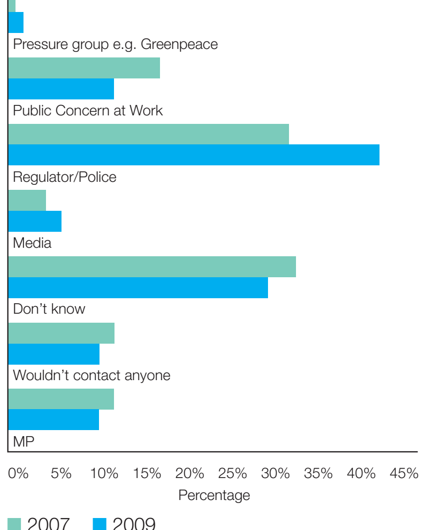
Would you raise a concern about possible corruption, danger or serious malpractice at work with your employer?



2007
Yes - 85% No - 6% Don't know - 9%

2009
Yes - 87% No - 5% Don't know - 8%

If you didn't feel confident telling your employer your concern, which one of the following would you be most likely to contact?



• Staff sewing 'Made in UK' labels on clothes imported from overseas • Financial adviser churning an elderly client's investments to generate commission • A company forging documents to make bogus foreign VAT refund claims

10. A full breakdown of the surveys can be found at www.pcaw.co.uk. All figures, unless otherwise stated, are from YouGov Plc. Total sample size was 2,083 adults. Fieldwork was undertaken between 3rd - 5th June 2009. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+).

In 2007 a total sample size was 2,256 adults. Fieldwork was undertaken between 25th - 29th May 2007. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+).

The media representation of whistleblowers

Over the past decade whistleblowing has been reported almost entirely within a neutral to positive frame.

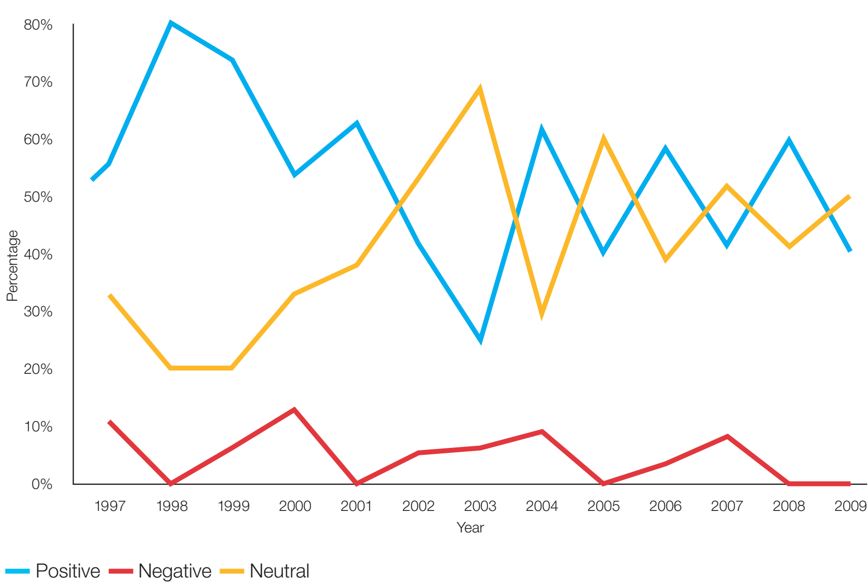
Blowing the whistle on corruption and malpractice is increasingly seen as a brave act in the public interest, according to a study we commissioned from Cardiff University.[11] The research project examined national newspaper reporting on whistleblowing and whistleblowers over the past 12 years, covering the period from 1st January 1997 to 31st December 2009. This includes the period immediately before the introduction of PIDA and tracks how the culture has changed since then.[12]

The study found that whistleblowers are overwhelmingly represented in a positive light in the media. As the graphic below shows, whistleblowing is rarely reported as a negative act. Over half (54%) of the newspaper stories represented whistleblowers in a positive light, whilst only 5% of stories were negative. The remainder (41%) were neutral.

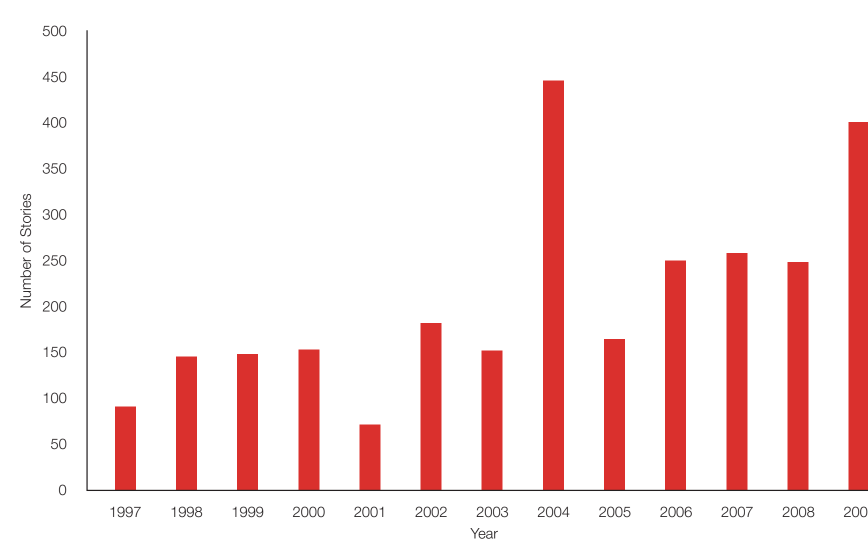
The graph demonstrates that negative coverage of whistleblowing was relatively high (10%) in 1997, before the passage of PIDA. Some of this negative coverage appeared as a consequence of concern over the upcoming legislation. For example, a Sunday Times feature suggested that, with the emergence of legal protection for whistleblowers, our "new community heroes are the people who snitch." In 1998, negative coverage of whistleblowing was completely absent, which the researchers considered indicated that a cultural change was in process. Over the past decade whistleblowing has been reported almost entirely within a neutral to positive frame.

Whistleblowers have received ample media attention: the research found a total of 2,454 stories on the topic from 1997 to early 2009, with a gradual increase in the number of stories year on year.

Portrayal of whistleblowers by year



Stories per year



The number of stories was anomalously high in 2004 due to the high-profile and widely reported story of Harold Shipman, the Yorkshire GP believed to have murdered at least 218 of his patients. Similarly, in 2009, the high number of stories on whistleblowing can be in part attributed to coverage of the credit crunch and patient care problems at Mid Staffordshire NHS Foundation Trust.

In many cases (33.7%) the reports do not reflect on the outcome for the whistleblower. Where outcomes were reported, they were generally presented in a negative light, describing the whistleblower being dismissed (18.7%) or jailed (13%). However, a large number of stories about jailed whistleblowers focused on two prominent cases: those of Mordechai Vanunu in Israel and MI6 employee David Shayler, demonstrating how the media's attention to more dramatic stories may skew overall representations. Other prominent categories included whistleblowers who had been disciplined or suspended (8.1%), or who had resigned from their jobs (4.9%). In 6.5% of stories, there were no consequences of the action taken, whilst the whistleblower was reported as being thanked in just 3.3% of cases.

The research showed that the most frequently reported type of malpractice was financial, accounting for 27% of the newspaper articles. Reporting of financial malpractice was most frequent in 2009 (79%). The intense focus upon financial malpractice during 2009 follows a series of high-profile whistleblowing cases, including that of Paul Moore at HBOS, who was sacked after warning about the bank's excessive risk-taking. The reporting of financial malpractice also follows the news media's established frame of reporting which is currently heavily focused on the economy, finance and the activities of banks during the global economic downturn.

The research showed that the most frequently reported type of malpractice was financial, accounting for 27% of the newspaper articles.

• Catering butchers fiddling the weighing scales to overcharge customers • A contractor lying about the cause of a gas leak to safeguard bonuses • Untrained care assistants performing medical tasks risking infection • A private nursery

11. Karin Wahl-Jorgensen and Joanne Hunt, Cardiff School of Journalism, Media and Cultural Studies.
12. The reports findings are based upon the analysis of 246 articles; a 10% sample of the total. 2,454 newspaper articles returned in the Nexis UK search. Nexis UK search terms 'whistleblower' OR 'whistleblowing' OR 'Public Interest Disclosure Act' as major mention.

Whilst the study took note of the number of stories for all of 2009, only stories up until 20th March 2009 are included in the sample for our content analysis.

The media representation of whistleblowers

The acts of whistleblowing which receive the most media attention are those that fit the existing news agenda and prevailing social and economic trends.

The media do, of course, have a role to play in the shaping the consequences of whistleblowing insofar as they publicise the whistleblowers' claims. The whistleblower is named in a majority (64%) of articles, and remains anonymous in 23%.

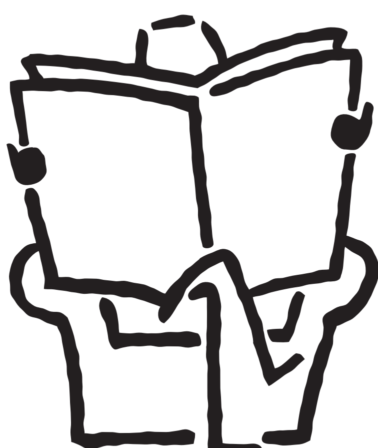
Types of malpractice

Malpractice which jeopardises public safety accounted for 20% of the articles in the sample, peaking during 2000 and 2001. Public safety became a prominent theme following publicity around a number of public safety issues, including the creation of a confidential hotline for railway workers to improve safety on the rail network, and NHS employees alleging that the public were at risk due to unfair treatment of patients, incompetent surgeons and poor hospital conditions.

Media coverage of whistleblowing generally focuses more upon malpractice or wrongdoing in the public sector (63%) than in the private sector (31%). It would appear that malpractice within the NHS, social services, the army and civil service is reported more often than exposing fraud within a private corporation. The focus on whistleblowing within the public sector became most intense in 2004 after a series of high-profile stories about alleged malpractice within government.

These revelations included Clare Short's allegations of the government's illegal surveillance procedures at the UN, Katherine Gun's[13] suggestions of a "dirty tricks" campaign against UN Security Council members in the run-up to the Iraq War, and Steve Moxon's[14] claims of government immigration failings.

Media coverage suggests a growing acceptance of whistleblowing over time following the introduction of PIDA, but also demonstrates that the acts of whistleblowing which receive the most media attention are those that fit the existing news agenda and prevailing social and economic trends.



Whistleblowing best practice guide

One of PCaW's key messages is that when properly designed and implemented, good whistleblowing arrangements should foster a more open and safe workplace culture.

Since the introduction of PIDA, many organisations have considered what arrangements they should have in place to encourage staff to speak up about wrongdoing or malpractice. Recognising that having robust whistleblowing arrangements can be in their own best interests, good organisations will regularly review and audit their arrangements to check that they are working. In addition, as the case studies at the end of this report illustrate, the existence of a whistleblowing policy can help avoid unnecessary disclosures to the media (see Smith v Ministry of Defence (2004) page 29).

It is worth noting that PIDA does not require an organisation to do anything or mandate that a policy should be in place. Best practice in this area is built upon the recommendations made by the Tenth report of the Committee on Standards in Public Life in 2005. The Committee accepted our recommendations on good practice and in particular that there should be a clear route for by-passing line management.

The Committee identified the following key elements for good practice in organisations:

(i) Ensure that staff are aware of and trust the whistleblowing avenues;
(ii) Make provision for realistic advice about what the whistleblowing policy means for openness, confidentiality and anonymity;
(iii) Continually review how the procedures work in practice; and
(iv) Regularly communicate to staff about the avenues open to them.

Having a good policy is only part of developing good whistleblowing arrangements. For a policy to be more than a tick-box exercise, it is vital that those at the top of the organisation take the lead on the arrangements and conduct a periodic review. Strong leadership promoting an open and accountable culture will set the tone for how an organisation deals with whistleblowing. Particularly if it is made clear that whistleblowing concerns will be taken seriously, this will help to embed a better culture where risks to the organisation, their employees and the public will be tackled early. It is worth remembering that, although the whistleblowing policy at Enron was held up as best practice, the culture created by those in charge was so poor that no-one spoke up about the very serious problems in the company.

fiddling the books to receive government funds • Well-known football club fixing the results of a fans' prize draw • An official wilfully misleading councillors about a development • A solicitor knowingly submitting a false personal injury claim

13. Katherine Gun: news.bbc.co.uk/1/hi/uk_politics/3659310.stm
14. Steve Moxon: news.bbc.co.uk/1/hi/uk_politics/3589261.stm

People

Going beyond a tick-box exercise is important. Organisations need to check whether their arrangements are working. In 2003 the Institute of Chartered Accountants in England & Wales produced a useful framework for assessing the efficacy of whistleblowing arrangements for companies subject to the Combined Code on Corporate Governance. They suggest reviewing the following:

- Are there issues or incidents which have otherwise come to the Board's attention which they would expect to have been raised earlier under the company's whistleblowing procedures?
- Are there adequate procedures to track the actions taken in relation to concerns raised and to ensure appropriate follow-up action has been taken to investigate and, if necessary, resolve problems indicated by whistleblowing?
- Have confidentiality issues been handled effectively?
- Is there evidence of timely and constructive feedback?
- Have any events come to the Committee's or the board's attention that might indicate that a staff member has not been fairly treated as a result of their raising concerns?
- Is a review of staff awareness of the procedures needed?

Comprehensive guidance for organisations can be found in the PAS: Code of Practice on Whistleblowing Arrangements which we produced in partnership with the British Standards Institution. The Code of Practice builds on and provides further detail about how to meet the standards set out by the Committee on Standards in Public Life. It sets out what organisations need to consider when devising, implementing and reviewing their whistleblowing arrangements. It can be downloaded for free from our website at www.pcaw.co.uk/bsi. Recently, the Civil Service Commissioners developed their guidance for appeals based on the BSI Code of Practice. We hope it will continue to be a useful document and reference tool for any organisation looking to get whistleblowing right.

In 2008 we said goodbye to our founding Director, Guy Dehn, who set us up and established us as a sustainable organisation. We also said goodbye to four other longstanding members of our team – Anna Myers (Deputy Director), Evelyn Oakley (Company Secretary), Sohrab Goya and Gemma Amran (Helpline Advisers). We thank them for all their excellent work over the years.

We have also had several new additions to our team. Our Director Catherine Wolthuizen was appointed in September 2008 and returned to us in November 2009 after her maternity leave. We are delighted that Shonali Routray has rejoined us after completing her pupillage in 2008. Additionally, four new helpline advisers have been appointed: Andrew Parsons, Ashley Savage, James Hurst and Katie Greer. Finally Martina Lewis-Stasakova joined us in December 2008 as our new Office Manager.

Our Board members are:
Michael Smyth CBE (Chair), Maurice Frankel OBE (Deputy Chair), Peter Connor, Derek Elliott, Chidi King, Martin Le Jeune, Carol Sergeant CBE, James Tickell, Joy Julien, Mandy Pursey and Rachael Tiffen.

Our Patrons are:
Lord Borrie QC and Sir John Banham.

Our Advisory Council members are:
Michael Brindle QC (Chair), Roger Bolton, Steve Burkeman, Gerald Bowden, James Clarke, Tony Close CBE, Ross Cranston QC, Dr Yvonne Cripps, Baroness Dean, Zerbanoo Gifford, Edwin Glasgow QC, Roger Jefferies, Rosalie Langley Judd, David Owen, Mike Sibbald, Dr Elaine Sternberg, Dr Marie Stewart, Stephen Whittle and Marlene Winfield OBE.

At 24 March 2010 our staff were:

Director
Catherine Wolthuizen

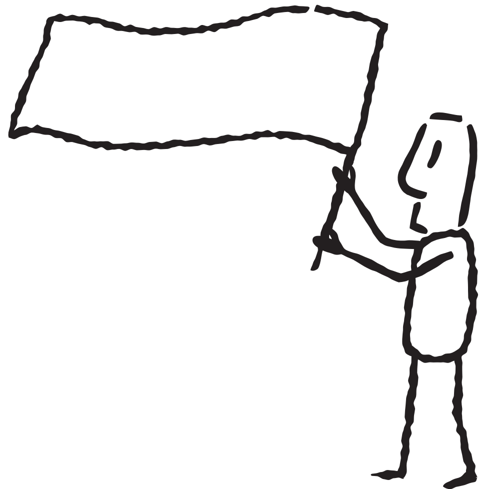
Deputy Director
Cathy James

Company Secretary & Senior Policy Officer
Francesca West

Client Services Manager
Shonali Routray

Helpline Advisers
Olabisi Porteous
Andrew Parsons
Ashley Savage
James Hurst
Katie Greer

Office Manager
Martina Lewis-Stasakova



• A convicted fraudster appointed to a bank's IT department • Skewed selection of winners for radio show competition • Mental health patients being made to sleep on the floor • Care home re-using disposable needles to save costs

Where next for whistleblowing?

The law
PIDA continues to provide a framework for policing how, when and with whom information about wrongdoing should be raised. This requires a delicate balancing act. From our examination of the cases and the development of the principles of PIDA we believe that the law is effective in striking the right balance between employers' interests and the public interest. By and large, the cases reveal that, if you are honest and reasonable, the law will protect you. But the law is a remedy and plays only one part in making whistleblowing work.

That is not to say we think the law is perfect. There are concerns that the requirement of good faith can place too much emphasis on motive. Employment relationships are complicated and a focus on why someone acted in the way they did rather than the wrongdoing raised may muddy already murky waters. This, coupled with concerns that PIDA is being used to complain about an individual's own employment rights, creates a compelling argument in our view for replacing the good faith test with a public interest test. This is an argument put forward by Dame Janet Smith in her report on the Shipman inquiry and one with which we agree.

Further, we would suggest the following small but necessary amendments to the law:

- Professional bodies should be required to apply the principles of PIDA, when considering fitness to practice issues, when appropriate;
- Non-executive directors should be specifically covered by PIDA to encourage effective boardroom whistleblowing;
- Individuals should be protected from victimisation if, on making a claim, the claim form is automatically forwarded to the relevant regulator *without* requiring consent (as the law stands consent is required). This would go some way to restoring much needed oversight in PIDA claims.

The secrecy surrounding PIDA claims is such that we have no ability to monitor the kinds of claims that are settled, any outstanding public risk that the Act was designed to bring to light or any abuse of the Act. The fact that all of this is hidden from view is bad for workers, businesses and the public interest. We shall continue to lobby the government on this point and hope business sees the advantage of our bid for open justice.

To aid a more informed consideration of how PIDA is working, we are looking at whether we can publish all decisions on our website.

Knowledge of the law
Awareness of PIDA is low and needs to be addressed. Workers need to know their rights and we hope to work with Government, unions and businesses to ensure enough is done to promote the law so it is an effective right.

PCaW
This year, PCaW concluded its Strategic Plan for 2010-2013. Recognising the vital importance, unique nature and continued relevance of our work, it re-emphasised the charity's focus on working to protect the public interest by ensuring that whistleblowers are able to raise a matter of genuine public concern without fear of reprisal in the workplace.

The Plan identifies four key strategic objectives:

Protection: Campaigning for a framework of appropriate and effective legislative and regulatory safeguards to provide protection to individuals in the workplace who raise a matter of public concern.

Acceptance: Fostering a culture which respects and appreciates the important role workplace whistleblowers play in bringing impropriety to light, safeguarding the public interest and promoting accountability.

Support: Providing expert advice and assistance to those who wish to raise a matter of public concern in the workplace and to organisations wishing to implement good whistleblowing practice.

Awareness: Raising awareness of the availability of support and protection for whistleblowers, particularly across high-risk sectors.

The Plan identifies a new area of work for us. In recent years, PCaW has worked closely with the Department of Health and the NHS to provide support to the NHS to improve access to whistleblowing support. While there is much work yet to be done in this area and it remains a high priority for the charity, we intend to apply a similar sector-wide approach to social care. This decision reflects the need to support whistleblowers and assist organisations providing social care services, and the importance of ensuring vulnerable users of social care services receive the best possible protection.

We will continue to maintain the momentum in other significant sectors, such as financial services and central and local government.

It is an exciting time for the charity and we look forward to working with existing and new partners to promote best practice in whistleblowing across British workplaces.

As the leading authority on whistleblowing in the UK, we also provide expert support and consultancy services to organisations wishing to implement effective whistleblowing procedures. Our clients include Ofsted, the Serious Fraud Office, the NHS, the Home Retail Group and Lloyds Banking Group. Information on our tailored assistance packages is available on our website or you can contact a member of our Services Team on 020 7404 6609.

"We have got to make it easier for people to say that something is wrong; something needs change without fearing of their jobs, without fear of intimidation at the point of work.

The Department of Health subscribes to the charity Public Concern at Work which runs an advice line for anyone concerned about any issue in the workplace. That's one way of doing it and they're advertised throughout the National Health Service.

If a member of staff does not feel comfortable about raising concerns with their employer, there are a number of other options. I know this is difficult, I know this puts pressure on the individual but we will do everything to support you if you raise the matter with a legal advisor, union official, the RCN, your MP or the independent regulator the Care Quality Commission. I believe the culture of the NHS must change and it's not about hiding things under the table, this does no one any good. If there's a problem we have to deal with it together."

Gordon Brown[15]

• Concealing a bribe paid to a Russian businessman • Airport worker sleeping when supposedly checking baggage • Funeral director stealing jewellery and valuables from deceased • Unregistered gas fitter doing corgi registered

15. Speaking at the 2009 Royal College of Nurses Annual Conference.

30 PIDA cases

Boughton v National Tyres (2000)
Detriment: Failure to investigate and cold-shouldering by colleagues were detriments justifying resignation.

After a break-in at the branch where Boughton worked, he overheard colleagues suggesting that losses at another branch should be written down against the break-in. Boughton taped subsequent conversations to this effect and supplied the tape to his regional manager. Rather than investigate the matter, the regional manager returned the tape to Boughton's manager. Boughton was cold-shouldered at work and then resigned. He brought a PIDA claim. The tribunal found for him, as the regional director had failed to 1) properly investigate the disclosure and 2) show Boughton the "objective support" he deserved. It stressed employers must make it clear to staff that there are no adverse repercussions for *bona fide* whistleblowing. Award not known.

Fernandes v Netcom (2000)
Causation: Complaints about whistleblower were a smokescreen.

Fernandes was finance officer for a subsidiary of a US telecoms company. In 1997 when Fernandes told a contact in the US about large and suspect expense claims made by his CEO, he was told to turn a blind eye. In late 1999 when the CEO's expenses had exceeded £300,000, Fernandes raised his concerns with the US Board. He immediately found himself under pressure to leave and when he refused to resign, he was disciplined and dismissed for authorising the CEO's expenses. Fernandes brought a PIDA claim. The CEO remained in-post until Fernandes had won his claim for interim relief. At the full hearing the ET decided that the complaints about Fernandes were a smokescreen and that he had been sacked for whistleblowing. As Fernandes was 58 and unable to secure similar work, the award was £293,000.

Azzaoui v APCOA Parking (2001)
Disclosure by contractor's staff to Council: Obligations of whistleblower to assist with investigation considered.

Azzaoui was a parking attendant for APCOA in Westminster. In late 2000 he raised a concern that pressure to meet targets meant false penalty notices were issued. In January 2001, when nothing had been done, Azzaoui wrote to Westminster Council setting out 'very serious allegations'. He was suspended and pressed to name implicated colleagues. He declined, claiming APCOA already had enough information to investigate. APCOA dismissed Azzaoui for gross misconduct. The ET held his concerns were raised in good faith with Westminster Council as it had a legal responsibility for the matter in question. Further it found that APCOA had sufficient information to investigate and it was not a breach of trust for Azzaoui not to name names. Award not known.

Bhatia v Sterlite Industries (2001)
Constructive dismissal; detriment.

Bhatia, the new vice-president at Sterlite Industries responsible for mergers and acquisitions, raised concerns with his Chairman and Sterlite's investment bank that a prospectus for listing on the New York Stock Exchange would mislead investors. Although his concern was heeded, when Bhatia later queried the legality of a transaction in Australia, the Chairman threw a digital diary at him and threatened to destroy his career. This led Bhatia to resign. He sued under PIDA and was awarded over £800,000 in compensation.

Eastelow v Taylor (2001)
Causation: No inference that employer knew of anonymous disclosures.

Shortly after starting work at a care home, Eastelow made complaints about her pay and conditions. She made anonymous calls to local social services inspectors about quality of care and fire risks. When a resident died and Eastelow's own conduct came under scrutiny, she was asked to an interview. At the interview Eastelow got angry and then took time off sick. The owner then dismissed Eastelow for unreliability, disruptive conduct, sleeping on duty and taking time off without notice. Eastelow claimed the reason was her disclosure to the social services inspectors. The ET found no evidence that her employer knew Eastelow had made the disclosures and, as they were anonymous, it was unable to infer that the employer knew. PIDA claim lost.

Kay v Northumberland Healthcare NHS Trust (2001)
Public disclosure: Reasonable to go to media with serious public concern, Human Rights Act.

Kay managed a ward for the elderly and raised concerns about bed shortages internally but was told there were no resources. The problem worsened and some elderly patients were to be moved to a gynaecological ward. Kay wrote a satirical open letter to the Prime Minister for his local paper. With the Trust's agreement, Kay was photographed for the local press. When the letter was published, the Trust gave him a final written warning for unprofessional and unacceptable conduct. Kay succeeded in his PIDA claim as the disclosure was protected because 1) section 43G PIDA must be interpreted in a manner consistent with the Human Rights Act; 2) there was no reasonable expectation the Trust would act if his concern had been raised internally; and 3) it was a serious public concern.

Mustapha v ProTX (2001)
Causation less than 1 year: accountant not protected where disclosures were part and parcel of his job.

Mustapha, an accountant, was dismissed after being employed for just over a month. She claimed her dismissal was because she had raised concerns about tax irregularities. On the facts, the ET found that (a) Mustapha had been content with the draft accounts that went to the external auditors, (b) there was no evidence that she had made any disclosure of concern about tax irregularities, and (c) the evidence was inconsistent with the view that her employer was trying to cook the books. The ET held Mustapha had made no disclosure other than routine differences of view that were part and parcel of her job. The ET said that, as an accountant, if there were genuine concerns, she would and should have raised them specifically.

ALM v Bladon (2002)
External disclosure protected.

Within months of starting a new job at a care home Bladon, an experienced nurse, had genuine concerns about standards of care. When he tried

work • Label removed from toxic waste before being taken to local dump • Dangerous dogs in kennel • Irregularities in mosque accounts • Nurse sedating elderly patients when on night duty • Hospital cutting corners to meet

30 PIDA cases

to raise them with the Managing Director's PA, he was asked to put them in writing and told they would be dealt with on the CEO's return from holiday. As the problems continued, Bladon rang the Social Services Inspectorate (SSI) 9 days later. They inspected the home and found most of his concerns substantiated. Bladon was disciplined and sacked for breach of his professional duties. He brought a PIDA claim. The tribunal held that his internal and external whistleblowing were both protected. Even though a short time had elapsed before he contacted SSI, his actions were reasonable because of the nature of the concerns and as the home had no whistleblowing policy. Bladon, who had found another job, was awarded £23,000.

Miss A Balmer v Church View Ltd (2002)
Dismissal: award for injury to feelings.

Balmer was a young, junior member of staff in a care home who witnessed three co-workers repeatedly hit an elderly resident and refuse to feed him when he complained. Shortly after reporting this incident, Balmer met her manager who pressured her to state she was mistaken regarding the abuse. Balmer refused and was then dismissed for 'gross misconduct' in making a false report. The ET found an obvious inference in the dismissal letter that her release was 'inextricably linked' to her having made the protected disclosure. The employer failed to show that there was any investigation into the incident, and that the appeal hearing it conducted took no notice of Balmer's grounds for appeal. The ET awarded Balmer £4,871 which included an award for injury to feelings because 'the sense of injustice [Balmer] must have felt was a damaging blow to her self esteem and confidence and understandably caused her to be injured, not just irritated.'

Bhadresa v SRA (British Transport Police) (2002)
Damages: aggravated damages and injury to feelings – Detriment: unfairly rejected for permanent post after whistleblowing.

Bhadresa was a senior barrister. British Transport Police (BTP) wanted her to run its legal department but, due to a recruitment freeze, this initially had to be done through an agency. Bhadresa was assured of a permanent post, her contract was renewed and she was given a 25% pay rise. BTP then advised Bhadresa that it had to advertise the post under its rules but assured Bhadresa the position was hers. Before the interviews, Bhadresa discovered her line manager disposing of prosecution files. Bhadresa reported this to the appropriate internal authority and was assured of confidentiality. Bhadresa's manager was suspended and the files were recovered from the rubbish bins. Bhadresa was cold-shouldered by colleagues and allies of her manager. BTP appointed a less qualified lawyer and Bhadresa claimed under PIDA. The ET held that Bhadresa was a worker subjected to a detriment and awarded her £274,500, including £10,000 for aggravated damages and £50,000 for injury to feelings.

Holden v Connex SE (2002)
Disclosure to prescribed regulator. Aggravated damages and injury to feelings.

Holden, a train driver, was made a health & safety representative from 1993. Holden took his duties seriously and raised concerns about public and workplace safety. Denied sight of the risk assessment of a new rota for drivers in 1999, Holden sent two reports to the Heath & Safety Executive (HSE), believing there was an increased risk that signals would be passed at red. A copy of each report was made available to colleagues and, following the Ladbroke Grove crash, someone – but not Holden – told the media about them. Holden was charged with sending an emotive and inaccurate report to the HSE. After he was given a final written warning, Holden resigned. The ET held that it was not necessary under PIDA that all the allegations in the report to HSE had to be accurate. It also found that Connex paid lip-service to safety concerns and had embarked on a campaign against Holden to deter him from speaking out and to force him to resign. An award of £55,000 was made, of which £13,000 represented injury to feelings and £5,000 was for aggravated damages.

Backs and List v Chesterton Plc (2004)
Damages.

Backs and List were appointed as senior executive and chief operating officer of Chestertons. A take-over bid was made for the firm and several other expressions of interest were received. The Board decided to put a firm offer to shareholders and Backs and List argued that other expressions of interest should be flagged as these could generate a higher price. The Chairman of the Board disagreed. With lawyers involved on both sides, Backs and List said that they would contact the Takeover Panel and the Stock Exchange because not citing the other interests was likely to breach City rules. After the Chairman had sought to dissuade them, they went ahead anyway and then were dismissed. Backs and List brought and won a PIDA claim, the tribunal finding their disclosures to the Takeover Panel and the Stock Exchange were reasonable and protected as wider disclosures. Out of court settlement – in excess of £5 million.

Herron v Wintercomfort for the Homeless (2004)
External Disclosure to police protected.

Herron worked in a hostel helping the homeless. One day an agitated client arrived and said her partner had threatened to set her on fire. Not long after, the client was admitted to hospital with serious burns, but died before she could give any information to the police. Although Herron's boss told her not to contact the police but to wait and see if they contacted her, Herron told the police what the client had said. Asked by the police and, with her boss away, Herron gave the police the client's file. By then working out her notice, she was charged with gross misconduct, transferred to a distant office and made to work under tight supervision. An ET held Herron's disclosures to the police were reasonable under PIDA and awarded her £2,500 for the distress she had suffered.

A&E targets • Jewellery manufacturer distributing products which had failed safety tests • Accountant asked to falsify balance sheet to inflate profit • Factory workers handling toxic substance without correct safety equipment

30 PIDA cases

Lingard v HM Prison Service (2004)
Detriment: Claimant's identity revealed.

Lingard, a prison officer at Wakefield Prison, raised concerns with senior managers that a fellow officer had arranged a bogus assault charge to be filed against a prisoner and had heard colleagues say he had asked them to plant pornography in the cell of a convicted paedophile. Without telling her, Lingard's managers identified her to staff as the source. She was ostracised by colleagues and offered no support by the Prison Service, even when the situation was clearly causing her stress. An enquiry by outside officers seemed indifferent when key documents went missing and a senior manager argued Lingard's whistleblowing showed she was disloyal. She was forced out. When she took and won a PIDA case, the ET found that the governor of the prison was 'dripping with hostility' to Lingard and that his claim that he was not aware that whistleblowers in the prison service were victimised was 'simply not credible'. She was awarded £477,602. The Director General of the Prison Service told the BBC the case was indefensible and that lessons needed to be learned from it.

Lucas v Chichester Diocesan Housing Society (2004)
Good faith, cogent evidence required, EAT.

Lucas worked for a housing association on a major urban renewal project in Brighton and Hove. After she raised concerns with the funder about financial irregularities, her manager became 'extremely angry' and reduced her hours. Their working relationship deteriorated so rapidly that Lucas was dismissed within a month. When she claimed under PIDA, the tribunal found she was right to raise her concerns and said it was so dismayed by the lack of controls over such substantial amounts of public money, it exceptionally recommended that the local council 'look very seriously at the whole question of accountability in this kind of undertaking', so prompting a public inquiry. However, citing a recent Court of Appeal ruling on good faith, the tribunal then decided Lucas's claim failed as she was motivated by spite about her reduction in hours. Lucas challenged this decision and her appeal succeeded as it was clear that her disclosure preceded her anger and so could not have been motivated by it. The Employment Appeal Tribunal said any question about good faith requires cogent evidence and should be raised squarely in advance.

Smith and others v MoD (2004)
Disclosure to the media not protected, whistleblowing policy available but not used.

T, who worked at an MoD site as a security guard, was convicted of kissing a child 13 years earlier and sentenced to 90 hours community service. When the MoD said he could return to work, seven out of his seventy five colleagues objected. They said that as the site was 50 yards from a nursery, T could be needed to evacuate children if there was a fire. The MoD stood by its decision that T was not a risk. After the seven gave an interview to the media about their concern, they were dismissed for gross misconduct. Their PIDA claim failed as the tribunal held that (a) there was no rational basis for their belief and (b) it was unreasonable to go to the media. On this point, the Tribunal said it was relevant that the seven had failed to follow the MoD's whistleblowing policy.

Collins v The National Trust (2005)
Disclosure to the media protected.

Collins was a National Trust (NT) warden in charge of a stretch of north east coastline, which included the site of a former quarry. Coastal erosion had created a real risk that chemicals and waste from the quarry would leak on to the beach. The NT and the local council had long been in dispute about what should be done and by whom. Collins was shown in confidence by the NT a report the council had obtained which highlighted the risks of further erosion. As the report was already a year old, Collins thought the site should be closed. Two weeks later he passed the report to the local media, who wrote it up and quoted Collins. As a result, he was dismissed. He made a successful PIDA claim. The tribunal found that the disclosure was protected as an 'exceptionally serious' concern because children played on the beach and the public, relying on the NT's reputation, would think it safe. Award not known.

Crangle v Chubb Security Personnel Ltd (2006)
Wider disclosure protected.

Crangle worked as a security guard and told his manager about CCTV footage that showed a cleaner stealing from a Sainsbury's store. His manager chose to ignore this. A month or so later two of Crangle's colleagues gave him a copy of the CCTV footage. Crangle in turn gave this to another colleague (D) working for another company, but who was also involved in an organisation which shared information to prevent crime (City Link Crime Directive). D gave the footage to the police. Crangle was then dismissed. The ET found in Crangle's favour commenting that the disclosure of confidential information to prevent crime is reasonable.

Harper v Torbay Council (2006)
Detriment: suppression of internal audit report.

Harper questioned the Council's tendering process for new refuse lorries and was criticised for doing so. An internal audit report found that the process was seriously deficient, but Harper, who was not shown the report, was asked to sign a letter confirming that he agreed there was no wrongdoing. Harper refused and raised the issue with external auditors. He was then subjected to numerous detriments and was eventually dismissed. The ET found in Harper's favour, citing as examples of detriment the excessive criticism, a failure to provide a reference, a transfer out of his department, stress, and a refusal to allow him to return to work. The ET included the fact that the Council insisted that he sign a two-line false summary of the audit report and suppression of the internal report as further examples of detriment. The ET mentioned that even though Harper had become intransigent in the later stages of the dispute, everything flowed from the Council's actions or inactions. It said: "from the moment Mr Harper made disclosures his job

• Manipulation of exclusion rates from school • Property company withholding payments to investors • Staff in government department fiddling overtime • Police officer beating and kicking a suspect • Care home charging local

30 PIDA cases

was, as he unfortunately correctly predicted, in jeopardy. There was a cover-up, there was a failure to manage, there was deception". An award of £208,356 including £10,000 for aggravated damages was made.

Holbrook v Queen Mary's Sidcup NHS Trust (2006)
Wider external disclosure; patient confidentiality.

Holbrook worked as a radiographer for QMS NHS Trust and was on duty when two patients were brought in to A&E following a road traffic accident. Patient A had serious injuries and patient B, a police officer, on duty and in uniform, had suffered a head injury. Holbrook was called to A&E to take x-rays of patient A and while speaking to her became aware from colleagues that there was a suspicion that B had been drinking – he had the smell of alcohol on his breath and appeared to be behaving erratically. After some discussion with colleagues about whether or not patient B had had a breath test, Holbrook decided to call the police anonymously, using his mobile phone. While he did not identify the patient, he did identify the hospital and it was easy for the police to identify the officer involved in those circumstances. The police traced Holbrook's mobile and he was then called by a police inspector to whom he repeated his concern. Unbeknown to Holbrook patient B had undertaken a breath test and a blood sample had been taken: both were negative. Holbrook was disciplined and dismissed for breaching patient confidentiality. The ET found that, even though the respondent conceded that this was a disclosure made in good faith and of an exceptionally serious nature, and that Holbrook had a reasonable belief that the allegations he made were substantially true, it was nevertheless unreasonable for Holbrook to have called the police without checking with senior colleagues first. It was found to be relevant that in relation to clinical decisions, Holbrook had readily checked with senior colleagues and yet had failed to do so about this issue.

Milani v Medirest (2006)
Disclosure to responsible person; reinstatement.

Milani worked for Medirest, a cleaning contractor, and was in charge of laundry for elderly patients at Charing Cross Hospital. In mid-2005, her bosses ordered that new mops and cloths were to be disinfected by thermal washing (i.e. without detergent) in the same machines used for the patients' laundry. As it turned out, the mops were washed at 60° and not the 90° needed because they had been wrongly labelled. Milani feared these new arrangements risked infecting the patients' clothes and padlocked her machines. When her bosses threatened her with a charge of gross misconduct, Milani removed the padlocks and then wrote to the hospital's CEO. He was very concerned and launched an investigation. Milani was then dismissed. An ET held that Milani's concerns were well-founded and, entirely unpersuaded by the reasons Medirest claimed for Milani's dismissal, found her letter to the CEO was the real reason for her dismissal. Encouraged by the hospital, Medirest then agreed to reinstate Milani and also gave her £7,000 compensation.

Stuart-Gausden v Bello System Services & Graham Rowlands (2006)
Aggravated damages.

The heating had broken in the First Respondent's office in cold weather. One member of staff went anonymously to the local Environmental Health Officer (EHO). When the EHO officer arrived on site the Second Respondent reacted angrily. The First Respondent then brought in gas heaters but staff complained of drowsiness, dizziness and nausea to Stuart-Gausden, one telling her that the Second Respondent and Human Resources were uninterested in taking accident reports. Stuart-Gausden smelt gas fumes on arriving at work the following day and based on the Second Respondent's previous responses immediately called the EHO. Later that day a colleague collapsed with breathing difficulties, chest pains and nausea. Stuart-Gausden called an ambulance. The EHO officer arrived at the same time as the ambulance and Stuart-Gausden told him what had happened. EHO found that the heaters should have been tested though it was later discovered they were legal. The First Respondent installed infrared heating which then overloaded the electrical system and shut down the computers causing further inconvenience. Stuart-Gausden was later called in and subjected to aggressive questioning. The following day Stuart-Gausden was suspended for allegations relating to incidents that the tribunal found the First Respondent had known about already and which had not previously given them cause for concern. The tribunal found the real reason for dismissal was because of the protected disclosures to the EHO. Aggravated damages were awarded partly as a result of the manner in which unnecessary details of Stuart-Gausden's personal life were mentioned during the hearing. Award not known.

Bandy v West Norfolk Community Transport Limited (2007)
Causation; no proper investigation; external disclosure to school; parent and local authority.

Bandy was an escort on a minibus which transported disabled children from various villages to schools. Bandy had concerns about the bus driver who appeared to have an unhealthy interest in a 14 year old girl, drove recklessly and often smelt of alcohol. Bandy raised her concerns with the Respondent but they did not investigate, merely giving a warning to the driver. The driver's behaviour towards Bandy then deteriorated. Bandy broke down and told the deputy head of a local school and a parent of her concerns. The parent removed her child from the bus. Bandy went on to raise her concerns with the local authority and was dismissed the same day. The ET found the dismissal was because of her disclosure to the parent, school and local authority. Award not known.

Connolly v Q Healthcare Ltd (2007)
Constructive dismissal and injury to feelings.

Connolly was financial controller of the Respondent, a dental and facial plastic surgery clinic in Harley Street. Connolly discovered numerous problems with tax and PAYE payments. The Respondent suggested hiding its true tax liability by destroying and re-creating invoices, hiding invoices

authority for care residents did not receive • Insurance broker getting commission by making up bogus clients • Contamination of food process during refurbishment of a factory • Airport workers offloading expensive cargo recklessly

30 PIDA cases

and telling investigators their server was down. Connolly refused to do so, informed his employer that such conduct was illegal, and was subsequently locked out of the computer system and had various responsibilities taken from him. He was also denied the 5% shareholding in the company that he had previously been offered. Connolly resigned. The tribunal held he was unfairly dismissed for making a protected disclosure. Award: £21,700 including £10,000 for injury to feelings.

Fraser v The Royal Free Hampstead NHS Trust (2008)
Danger of anonymous disclosure.

Fraser was a social worker employed by an agency and not the Trust. He was concerned that his manager, Ms Ross, was not fulfilling her contractual duties in relation to time keeping, seeing patients and filling in a movement book. He raised this with Ms Ross' manager. This manager subsequently left without passing on the concern. Fraser further complained that a report prepared by him had been buried by the department. An anonymous letter complaining about Ms Ross was then sent to the Trust. Ms Ross believed the letter was sent by Fraser. Ms Ross then failed to inform Fraser of a permanent job at the Trust and fired him on performance issues a few weeks later in what the tribunal described as a high-handed and vindictive manner. While the tribunal sympathised with Fraser as to the manner in which he had been treated, they concluded that he had been sacked due to Ms Ross's mistaken belief he was responsible for sending the letter and could not make out a causal link between his genuine disclosures and the detriments suffered.

Laing v London City Airports (2008)
Successful interim relief application.

Laing reported that a colleague was asleep whilst operating the X-ray security machine at London City Airport. Laing was then bullied and harassed and submitted a grievance. This was dismissed. Laing appealed and said she would have to take an ET claim for detriment. Laing was then summarily dismissed for a fundamental breakdown in relationships and successfully applied for interim relief.

Glencross v Network Rail Infrastructure (2008)
Correction of a false statement a protected disclosure.

Glencross worked for Network Rail Infrastructure Ltd and was involved in the maintenance of the overhead lines using a wooden cut-off ladder instead of the correct piece of equipment – an 'acro-jack'. Glencross described the use of a ladder as a 'fast but dangerous way of doing work'. In March 2004 Glencross' colleague, Taylor, slipped, fell off the ladder and broke his ankle. Their manager pressurised them into giving false statements saying that the proper equipment had been used. Matters came to a head when a personal injury solicitor hired by Glencross' colleague provided the company with true statements from Glencross and Taylor describing the accident. Glencross became subject to disciplinary proceedings for, amongst other matters, changing his statement. Glencross was sacked. The ET found that changing the statement amounted to a protected disclosure and awarded Glencross £203,000.

Lake v British Transport Police (2008)
Delay in disclosure irrelevant.

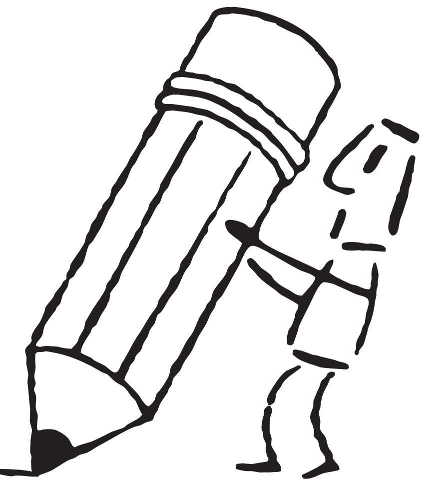
Lake worked as a police officer for the British Transport Police (BTP). In 1997 Lake attended a fatality with two colleagues. One of the colleagues, a sergeant, found a piece of skull and retained it as 'a trophy' before giving it to the other colleague. In December 2001 this colleague showed the piece of skull to Lake who chose not to report the incident until May 2002. The sergeant and the other colleague were soon arrested but the Crown Prosecution Service decided not to prosecute. The relationship between Lake and the sergeant became hostile, and each filed a series of complaints against the other. The BTP then initiated an investigation of Lake who was sacked for not reporting the original incident sooner. The ET found that Lake had made a protected disclosure and awarded him over £280,000.

Lees v Abbey Dale Care Homes (2008)
Constructive dismissal; causation.

Lees worked as a nurse at a care home and raised concerns with the Respondent that two carers were providing inadequate care to two residents. Lees arrived at work one morning and was informed a resident had died and the undertakers were on their way. Lees's understanding was that, in the event of a sudden death, the police and GP on call were to be informed and no one was to touch the body. Lees then called to cancel the undertakers and reported the incident to the police. She told the police she and other staff were concerned as this was the second sudden death in a month and the residents were literally "dying in their chairs". She asked the police to inform the coroner. Lees told her employer that she had said this. Her relationships with the carers she had criticised deteriorated. Lees later spoke to her employer about the health and safety of the residents and stated she would be unable to continue to work if matters did not improve. Lees resigned shortly after – her letter made no mention of the resident's death and her conversation with the police. The ET commented that the employer had taken steps in relation to advice from the coroner and individual residents' care plans and had addressed each of the concerns that Lees raised. Lees could not show that she was constructively dismissed as there was 1) no detriment resulting from her disclosure and 2) no breach of the employment contract.

Geduld v Cavendish Munro Professional Risks Management Ltd (EAT 2009)
Bare allegation does not amount to a disclosure.

Geduld worked as a director of an insurance brokerage. After relations between Geduld and the other directors deteriorated, discussions took place between the parties to buy out Geduld's shareholding. Geduld then contacted a solicitor who sent a letter to the company saying that Geduld had suffered unfair prejudice as a minority shareholder. Geduld was then sacked the next day. The EAT found that the solicitor's letter set out a statement of his position in share negotiations rather than conveying information which amounted to a protected disclosure. The EAT also suggested that employee allegations unsupported by specific information are not qualifying disclosures under PIDA. Geduld's claim failed.



FROM THE MINISTER FOR HEALTH,
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For Action:

Chief Executives of HSC Bodies[1];
Chief Fire Officer

For information:

Director of Human Resources of each body

Our Ref: SUB/325/2012

22 March 2012

Dear Colleague

Please bring the content of this letter to the attention of all your employees, and make available with it your whistleblowing policy.

MESSAGE FROM EDWIN POOTS

YOUR RIGHT TO WHISTLE BLOW

1. I am committed to the highest possible standards of conduct, openness, honesty and accountability in our Services. In line with that commitment I expect staff to act on any genuine concerns they might have about any aspect of an organisation's work or colleagues, in the knowledge that such action has support from the highest level. I want every member of staff to be very confident that managers at all levels will respond positively to expressions of concern, and that, should it be necessary, you will be protected from victimisation if you make a genuine concern known under the whistleblowing arrangements.

You have the right to be heard by management if you have concerns about any ethical or safety issue, and a responsibility to speak up

2. The first kind of action that is appropriate is to speak up within your team or to the appropriate manager. The principles of clinical and social care governance empower all staff to speak up if they see or become aware of practice which is unsafe or which creates unacceptable risks to patients or clients.

[1] The Health and Social Care Board, HSC Trusts, the Public Health Agency, the Business Services Organisation, the Northern Ireland Blood Transfusion Service Agency, the Northern Ireland Guardian ad Litem Agency, the Northern Ireland Practice & Education Council for Nursing, Midwifery & Health Visiting (NIPEC), the Northern Ireland Social Care Council (NISCC), the Patient & Client Council, the Northern Ireland Regulation and Quality Improvement Authority and the Northern Ireland Medical and Dental Training Agency (NIMDTA)

It is the responsibility of any member of staff who is challenged on that basis to give proper consideration to the points being made by any colleague.
Similar principles should apply in all the other aspects of our services away from the clinical or social care front line. Managers and leaders at all levels are responsible for creating and sustaining an atmosphere of mutual support, mutual learning, and conduct based on the priority of the quality and safety of services and the health, well-being and dignity of the patients, clients, family members and carers whom we all serve. By far the most important concern for me, and for all who lead and manage HSC organisations, all DHSSPS' Arms Length Bodies and the Department itself, is to ensure that we provide the best possible services to patients, clients, and the wider public, and I am sure you share that commitment.

If speaking up is a problem, whistleblowing is both your right and your duty

3. If you have any concern that speaking up in good faith in the way I have described would lead to a problem, there are statutory procedures that protect you if you chose to blow the whistle and draw attention to something that is a cause for concern. All HSC staff have a moral duty to pass on any concerns to someone who can deal with it. I should therefore personally encourage you to speak up where you have genuine concerns about issues such as patient safety or possible malpractice in your workplace and reassure you that genuine concerns will be resolved quickly and effectively.

4. There is a common misconception that whistle blowing is solely fraud related. In effect whistle blowing can be wide ranging covering issues around health and safety e.g. unsafe products or working conditions.

5. Whistle blowing refers to "making a disclosure in the public interest" and it means that concerns relating to unlawful conduct, financial malpractice, dangers to the public or the environment, or actions otherwise contrary to the public interest can be reported in the workplace following the correct procedures and protecting employment rights. There should be an established whistle blowing policy and procedure within your organisation which should be followed for reporting your concerns.

6. I fully recognise that the decision to report a concern can be a difficult one to make. However, if what you are saying is true, you should have nothing to fear because you will be doing your duty to your employer and those for whom you provide a service.

7. I will not tolerate any harassment or victimisation (including informal pressures) and will take appropriate action to protect you when you raise a concern in good faith. If you report concerns reasonably and in good faith you are also formally protected against victimisation under The Public Interest Disclosure (Northern Ireland) Order 1998 (revised 2004).

8. Your organisation's whistleblowing policy sets out how to go about expressing a concern both internally and, should it be necessary, outside line management. Each organisation's policy should make it clear that ultimately, you have the right to direct your concern to me.

Confidentiality of personal information about patients, families and members of staff must be protected

9. If you need to make a disclosure in the public interest it is important to be mindful of the need to avoid a breach of the privacy and confidentiality of personal information. It is wrong to give details of the condition or treatment of any patient or client without their explicit consent. Also, personnel records are protected by Data Protection legislation, and there are procedures for investigation and accountability of all staff in the HSC, in ALBs or within DHSSPS as part of the NI Civil Service, which should not be prejudiced or undermined by public or any other inappropriate disclosures of information. There are independent watchdog organisations, including the Northern Ireland Audit Office and the Regulation and Quality Improvement Authority which have specific duties to investigate confidential disclosure while protecting the person making the disclosure. The Patient and Client Council exists to act in the interests of patients and clients and to help with complaints. Where the duty to protect personal information is broken, it is sometimes necessary to investigate, however, any such investigation process should create no difficulty and hold no fear for anyone acting to disclose legitimate concerns in the public interest, as described above.

Conclusion

10. Finally, I would like to encourage you to feel confident in raising concerns and to question and act upon genuine concerns that you may have in relation to your workplace. This is a vital element of good public service based on the values and principles that are at the heart of Health and Social Care and all the related organisations.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

Investigation
by the National Audit Office

Government whistleblowing policies

JANUARY 2014

Our vision is to help the nation spend wisely.

Our public audit perspective helps Parliament hold government to account and improve public services.

The National Audit Office scrutinises public spending for Parliament and is independent of government. The Comptroller and Auditor General (C&AG), Amyas Morse, is an Officer of the House of Commons and leads the NAO, which employs some 860 staff. The C&AG certifies the accounts of all government departments and many other public sector bodies. He has statutory authority to examine and report to Parliament on whether departments and the bodies they fund have used their resources efficiently, effectively, and with economy. Our studies evaluate the value for money of public spending, nationally and locally. Our recommendations and reports on good practice help government improve public services, and our work led to audited savings of almost £1.2 billion in 2012.

Investigation by the National Audit Office

Government whistleblowing policies

JANUARY 2014

Investigations

We investigate specific allegations of wrongdoing in the public sector; or in response to intelligence or assertions suggesting that wrongdoing is likely.

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Contents

Summary 4

Part One
Context 5

Part Two
Whistleblowing policies 14

Appendix One
Methodology 25

The National Audit Office study team consisted of:
Alan Banks, Jennifer Bayliss, Sarah Hipkiss and Sian Jones, under the direction of Paul Oliffe.

This report can be found on the National Audit Office website at www.nao.org.uk

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Summary

1 Whistleblowing is when an employee reports suspected wrongdoing. Officially this is called 'making a disclosure in the public interest'. Whistleblowing is important to safeguard the effective delivery of public services, and to ensure value for money. It serves to protect and reassure the workforce, and to maintain a healthy working culture and an efficient organisation.

2 Whistleblowing has become much more high profile in recent years; as well publicised cases such as Hillsborough and the Mid Staffordshire NHS Foundation Trust inquiry have shown. A greater public need for transparency, coupled with wider access to knowledge and information and its dissemination through social and other media, mean that there is an increasing scope to uncover and report on wrongdoing.

3 Having a good quality whistleblowing policy is particularly important in the current economic climate. A clear, accessible policy is vital during cost reductions to protect the public purse from waste, as well as to improve trust in public institutions. Government delivery chains are becoming more devolved, introducing complexity into the process for making disclosures and monitoring cases. There is the risk that employees at 'arm's-length' to departments are not aware of their rights and do not know how to blow the whistle.

4 This is the first phase of a series of work on whistleblowing. This report provides the context around whistleblowing and examines the procedures in place for employees to whistleblow within government departments. We focus on the importance of a framework to support whistleblowing, namely having a high quality, clear and accessible policy and process. However, having this framework is only the first step. Phase two of our work will be focused on examining how departments implement and publicise policies, the skills and culture needed to support them, and the role of the 'prescribed person'.

5 We reviewed 39 whistleblowing policies across government against eight criteria on a five-point scale. We identified common areas of strength and areas for improvement. We often found strong performance in setting a positive environment for whistleblowing to occur. In general, the policies aimed to engage with whistleblowers; they clearly expressed the importance of whistleblowing to the organisation, and highlighted the moral obligation to report concerns. However, the policies we reviewed sometimes failed to outline suitable alternatives to line managers when making a disclosure or explain when the confidentiality of a whistleblower may be compromised. Some policies did not mention the risks and limitations of disclosures outside the organisation or highlight the benefits of seeking independent advice.

Part One

Context

Defining whistleblowing

1.1 GOV.UK defines whistleblowing as "when a worker reports suspected wrongdoing at work".[1] **Figure 1** overleaf outlines one such scenario. These wrongdoings are often related to financial mismanagement, such as misrepresenting earnings and false accounting, but can also have more immediate consequences, as highlighted by the recent whistleblowing nurse from the Mid Staffordshire NHS Foundation Trust. The whistleblower reported instances of faulty equipment, poor mixes of staff skills and falsifying patient records. A subsequent report into the hospital's practices found widespread poor patient care and a focus on systems and targets rather than patient outcomes.

1.2 An employee can report things that are not right, are illegal or if anyone is neglecting their duties,[2] including:

- when someone's health and safety is in danger;
- environmental damage;
- a criminal offence; or
- when the organisation is not obeying the law (for example not having the right insurance).[3]

1.3 Whistleblowing can be more broadly defined as simply 'raising a concern'.[4] People outside of an organisation, including stakeholders, suppliers and consumers, can also raise concerns. It is different from making a complaint or raising a grievance. Whistleblowers can often act out of a feeling a fairness or ethics rather than a personal complaint. As Public Concern at Work states, it is important to note that:

> "… the person blowing the whistle is usually not directly, personally affected by the danger or illegality. Consequentially, the whistleblower rarely has a personal interest in the outcome of any investigation into their concern – they are simply trying to alert others. For this reason, the whistleblower should not be expected to prove the malpractice. He or she is a messenger raising a concern so that others can address it".[5]

1 Information published online by GOV.UK, available at: www.gov.uk/whistleblowing/overview, accessed 17 December 2013.
2 In this report we use the term 'employee' to refer to those individuals who are protected by the Public Interest Disclosure Act 1998 (as amended). This includes contractors, trainees, and agency staff in addition to individuals under a contract of employment.
3 See footnote 1.
4 Some public organisations treat the terms 'whistleblowing' and 'raising a concern' as distinct and have separate policies for each. For the purposes of this report, we use the terms interchangeably.
5 *Where's whistleblowing now? 10 years of legal protection for whistleblowers*, Public Concern at Work, March 2010.

Figure 1
Whistleblowing: a scenario

Imagine you work for a central government department. You work in a small team with one other colleague. The team gives grants to new businesses working in the technology sector. Your manager oversees several other teams and so is not involved in the day-to-day activities of you and your colleague.

One day, your colleague is on leave when your manager asks you to compile some data on previous awards. To complete his request you need to look in detail at previous awards that your colleague has made. While compiling the data you notice something odd. The awards do not seem to be made consistently and some enterprises are favoured over others. It appears that a lot of companies owned by your colleague's friends have been chosen over other companies. Is this fraud? You hesitate to think such a thing but there are too many instances for it to be a coincidence. What can you do?

You use the department's intranet to research your options. It sounds like the organisation's whistleblowing policy addresses your dilemma. You wish this was not the case but it seems like you are going to be a whistleblower. You do not want to get your colleague into trouble but you cannot ignore these unfair allocations of public funds. You go to knock on your manager's door…

Source: National Audit Office

1.4 The term whistleblowing can have negative connotations of telling tales or being disloyal to colleagues. Some bodies choose to use the terms 'raising a concern' or 'speaking up' in their policies to avoid these negative associations. However, a recent survey of the public by Public Concern at Work found that the term is increasingly being seen in a more positive light. In 2013, 39 per cent of respondents viewed the word positively, compared to 36 per cent in 2007.[6]

Whistleblowing is important

Protect and reassure the workforce

1.5 The British Standards' *Whistleblowing Arrangements Code of Practice* highlights that:

> "… the first people to know of any risk will usually be those who work in or for the organisation. Yet while these are the people best placed to raise the concern before damage is done, they often fear they have the most to lose if they do speak up. Research for the Institute of Business Ethics has shown that while one in four workers are aware of misconduct at work, more than half (52 per cent) of those stay silent".[7]

6 The surveys were undertaken by YouGov, commissioned by Public Concern at Work. Data for 2013 is found at: www.pcaw.org.uk/files//news_attachments/Results%20for%20PCAW-YouGov%20Survey.pdf (accessed 17 December 2013), the data for 2007 is in Where's whistleblowing now? 10 years of legal protection for whistleblowers.

7 *Whistleblowing arrangements Code of Practice*, PAS 1998:2008, British standards, July 2008.

1.6 Many people who have blown the whistle have done so because they have a strong sense that something they have seen or heard in their workplace is not right, ethical, or compliant with workplace regulations. But while they feel compelled to raise the alarm, they may also be concerned for several reasons. They are concerned that:

- they will not be protected against retaliation for reporting a concern;
- the issue should be investigated appropriately; and
- any 'wrongs' are righted.

To blow the whistle makes people vulnerable, so there must be clear, comprehensive and accessible policies to support and reassure staff at what is likely to be an extremely stressful time.

Foster a healthy culture and improve efficiency

1.7 Organisations should view whistleblowers as an early warning system to let them address problems before they escalate. As the British Standards' *Whistleblowing Arrangements Code of Practice* notes:

> "… the main reason enlightened organisations implement whistleblowing arrangements is that they recognise that it makes good business sense. An organisation where the value of open whistleblowing is recognised will be better able to:
>
> - deter wrongdoing;
> - pick up potential problems early;
> - enable critical information to get to the people who need to know and can address the issue;
> - demonstrate to stakeholders, regulators and the courts that they are accountable and well managed;
> - reduce the risk of anonymous and malicious leaks;
> - minimise costs and compensation from accidents, investigations, litigation and regulatory inspections; and
> - maintain and enhance its reputation".[8]

8 See footnote 7.

1.8 Organisations that have strong clear policies to encourage whistleblowers and the ability to support them can often show that they are improving by learning lessons from what they find. The willingness to examine areas of potential weakness and listen to all staff, including on the front line, means these organisations can address issues and concerns early on. These organisations are more likely to be the ones that avoid the disasters and negative publicity that come from these policies failing.

Need for transparency

1.9 At a time of increased austerity measures and deeper cuts to government spending, taxpayers are concerned that public money is well spent. There have been several well publicised scandals involving the cover-up of wrongdoing despite allegations being made (such as Hillsborough, and most recently Mid Staffordshire NHS Foundation Trust). These facts have led to a demand for wider transparency in our public institutions, and means that a whistleblowing process is vital for employees to raise and address their concerns.

Complex delivery chains

1.10 The way the government implements policies has become more complex as delivery chains have become devolved. In more complex delivery chains there is a greater distance between those that are accountable and those that are delivering, and the delivery itself can often be more intricate. These factors increase the risk of ineffective oversight arrangements, highlighting the need for greater clarity in the process for reporting concerns across long delivery chains.

Legal framework for whistleblowing

The Public Interest Disclosure Act 1998

1.11 Almost every inquiry into scandals and disasters in the 1980s and early 1990s including the Clapham rail crash, the Piper Alpha disaster, the Zeebrugge ferry tragedy, and the collapse of Barings Bank, found that employees knew of the dangers that existed but had either been too scared to sound the alarm or had raised the matter incorrectly or with the wrong person.

1.12 To address this, the Nolan Committee on Standards in Public Life in 1995 said that unless staff thought it safe and acceptable to raise concerns internally, they were likely to stay silent, raise it anonymously or leak the information. Dr Tony Wright, MP, asked Public Concern at Work and the Campaign for Freedom of Information to draft a whistleblower protection law to raise the issue in Parliament. The Public Interest Disclosure Act (commonly known as PIDA) was the legislative response, and received royal assent on 2 July 1998.

Legislation and case law

1.13 There is now a body of case law around PIDA including decisions on key elements of the legislation, such as employment status and showing an employee has suffered harm. The Enterprise and Regulatory Reform Act received royal assent in April 2013. It makes three key changes to the law on whistleblowing by:

- amending the definition of 'qualifying disclosure' to introduce a public interest test;
- removing the requirement that certain disclosures be made in good faith, replacing this with a power to reduce compensation where a disclosure is not made in good faith; and
- introducing 'vicarious liability' for employers if an employee is subjected to detriment by a co-worker for making a protected disclosure.

1.14 This legislative activity reflects a strong desire to bolster whistleblowing in response to recent scandals, such as that seen in Mid Staffordshire NHS Foundation Trust. **Figure 2** outlines some of the key points of the Act.

Figure 2
The Public Interest Disclosure Act 1998 (PIDA), as amended

An act to protect individuals who make certain disclosures of information in the public interest. It defines disclosures qualifying for protection as "… any disclosure of information which in the reasonable belief of the worker making the disclosure is in the public interest, tends to show one or more of the following:

- that a criminal offence has been committed, is being committed or is likely to be committed;
- that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
- that a miscarriage of justice has occurred, is occurring or is likely to occur;
- that the health or safety of any individual has been, is being or is likely to be endangered;
- that the environment has been, is being or is likely to be damaged; or
- that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be, deliberately concealed."

Notes

1 The definition of 'worker' is extended by section 43K of the Employment Rights Act 1996 but it does not cover the self-employed (except for those in the NHS), volunteers, the intelligence services or the armed forces.

2 The act also sets out when a qualifying disclosure will be protected.

3 If an employee blows the whistle anonymously he or she is likely to face problems with what is described as 'causation'. For an employee to win protection a tribunal must be satisfied that the employee was victimised by the employer because (and hence the employer knew that) the employee had blown the whistle.

Source: Public Interest Disclosure Act 1998, available at: www.legislation.gov.uk/ukpga/1998/23/contents, accessed 17 December 2013

1.15 The legislation introduced through PIDA does not seek to directly encourage or protect whistleblowers in the normal course of their duties. PIDA is applied when a whistleblower has suffered harm as a result of their actions in making a disclosure in the public interest. PIDA only has an effect if it can be shown that an employer's actions, in response to this disclosure, have been detrimental to the person making it. This can only be assessed through the courts when an employment tribunal case is brought.

1.16 Between 1999 and 2009, there were 1,761 PIDA-related claims, 19 per cent of judgments from these were to do with financial malpractice.[9] **Figure 3** outlines some examples of cases brought under PIDA legislation.

Government obligations for whistleblowing

1.17 While PIDA protects whistleblowers, it does not require organisations to set up or promote whistleblowing policies. Instead, the objectives underpinning PIDA encourage employers to:

- positively consider the benefits of introducing a whistleblowing policy or, if they have one, review and refresh it and promote it effectively;
- recognise it is in their own interests to introduce and promote effective whistleblowing policies; and
- make it clear through the management line and across the organisation that it is safe and acceptable for employees to raise a concern about malpractice. This may be as part of the policy or separately.[10]

1.18 In addition to the requirements of PIDA, the Constitutional Reform and Governance Act 2010 confirmed in legislation that there should be a civil service code. The civil service code outlines the core values of the civil service: integrity, honesty, objectivity and impartiality. It sets out the standards of behaviour expected of civil servants and the duties of civil service employers. Civil servants who consider that they are being required to act in a way which conflicts with the code, or where they are aware of actions by others that are in conflict with the code, should raise a concern in line with the code and report this immediately within their department. If a civil servant raises a concern within their department and is not satisfied with the response, the civil service code management code encourages employees to contact the independent Civil Service Commission. The Commission is also a source of independent advice for civil servants.

9 *Where's whistleblowing now? 10 years of legal protection for whistleblowers*, Public Concern at Work, March 2010.
10 Public Concern at Work: A *Guide to PIDA*, available at: www.pcaw.org.uk/guide-to-pida, accessed 5 December 2013.

Figure 3

Examples of cases brought under PIDA legislation

Lingard v HM Prison Service (2004)

Detriment: Claimant's identity revealed

Lingard, a prison officer at Wakefield Prison, raised concerns with senior managers that a fellow officer had arranged a bogus assault charge to be filed against a prisoner and had heard colleagues say he had asked them to plant pornography in the cell of a convicted paedophile. Without telling her, Lingard's managers identified her to staff as the source. She was ostracised by colleagues and offered no support by the Prison Service, even when the situation was clearly causing her stress. An enquiry by outside officers seemed indifferent when key documents went missing and a senior manager argued Lingard's whistleblowing showed she was disloyal. She was forced out. When she took and won a PIDA case, the ET found that the governor of the prison was 'dripping with hostility' to Lingard and that his claim that he was not aware that whistleblowers in the prison service were victimised was 'simply not credible'. She was awarded £477,602. The Director General of the Prison Service told the BBC the case was indefensible and that lessons needed to be learned from it.

Collins v The National Trust (2005)

Disclosure to the media protected

Collins was a National Trust (NT) warden in charge of a stretch of north east coastline, which included the site of a former quarry. Coastal erosion had created a real risk that chemicals and waste from the quarry would leak on to the beach. The NT and the local council had long been in dispute about what should be done and by whom. Collins was shown in confidence by the NT a report the council had obtained which highlighted the risks of further erosion. As the report was already a year old, Collins thought the site should be closed. Two weeks later he passed the report to the local media, who wrote it up and quoted Collins. As a result, he was dismissed. He made a successful PIDA claim. The tribunal found that the disclosure was protected as an 'exceptionally serious' concern because children played on the beach and the public, relying on the NT's reputation, would think it safe. Award not known.

Fraser v The Royal Free Hampstead NHS Trust (2008)

Danger of anonymous disclosure

Fraser was a social worker employed by an agency and not the Trust. He was concerned that his manager, Ms Ross, was not fulfilling her contractual duties in relation to time keeping, seeing patients and filling in a movement book. He raised this with Ms Ross's manager. This manager subsequently left without passing on the concern. Fraser further complained that a report prepared by him had been buried by the department. An anonymous letter complaining about Ms Ross was then sent to the trust. Ms Ross believed the letter was sent by Fraser. Ms Ross then failed to inform Fraser of a permanent job at the Trust and fired him on performance issues a few weeks later in what the tribunal described as a high-handed and vindicate manner. While the tribunal sympathised with Fraser as to the manner in which he had been treated, they concluded that he had been sacked due to Ms Ross's mistaken belief he was responsible for sending the letter and could not make out a causal link between his genuine disclosures and the detriments suffered.

Source: *Where's whistleblowing now? 10 years of legal protection for whistleblowers*, Public Concern at Work, March 2010

1.19 While being alert to their responsibilities under the Official Secrets Act and the security policies of their department, civil servants are encouraged to report criminal or other unlawful activity to the police or other appropriate regulatory authorities. Government bodies should address this option in their whistleblowing policies to ensure that civil servants are clear on possible routes for raising a concern to comply with both pieces of legislation. The advice in the civil service code primarily promotes internal reporting, and does not reference the role of the prescribed persons, however the provisions contained in PIDA set out protection for whistleblowers who raise a concern to external prescribed persons. Departments face the challenge of producing a policy which satisfies the statutory positions of both.

1.20 There are various other documents that encourage government departments and arm's-length bodies to introduce whistleblowing arrangements, including the corporate governance code and Managing Public Money. The Civil Service Employee Policy Service provides HR policy assistance across government departments to promote simplified and modernised policies and practices. We have worked closely with this service during our review, and the service is currently leading a piece of work on behalf of departments to support them in addressing the issues we have raised.

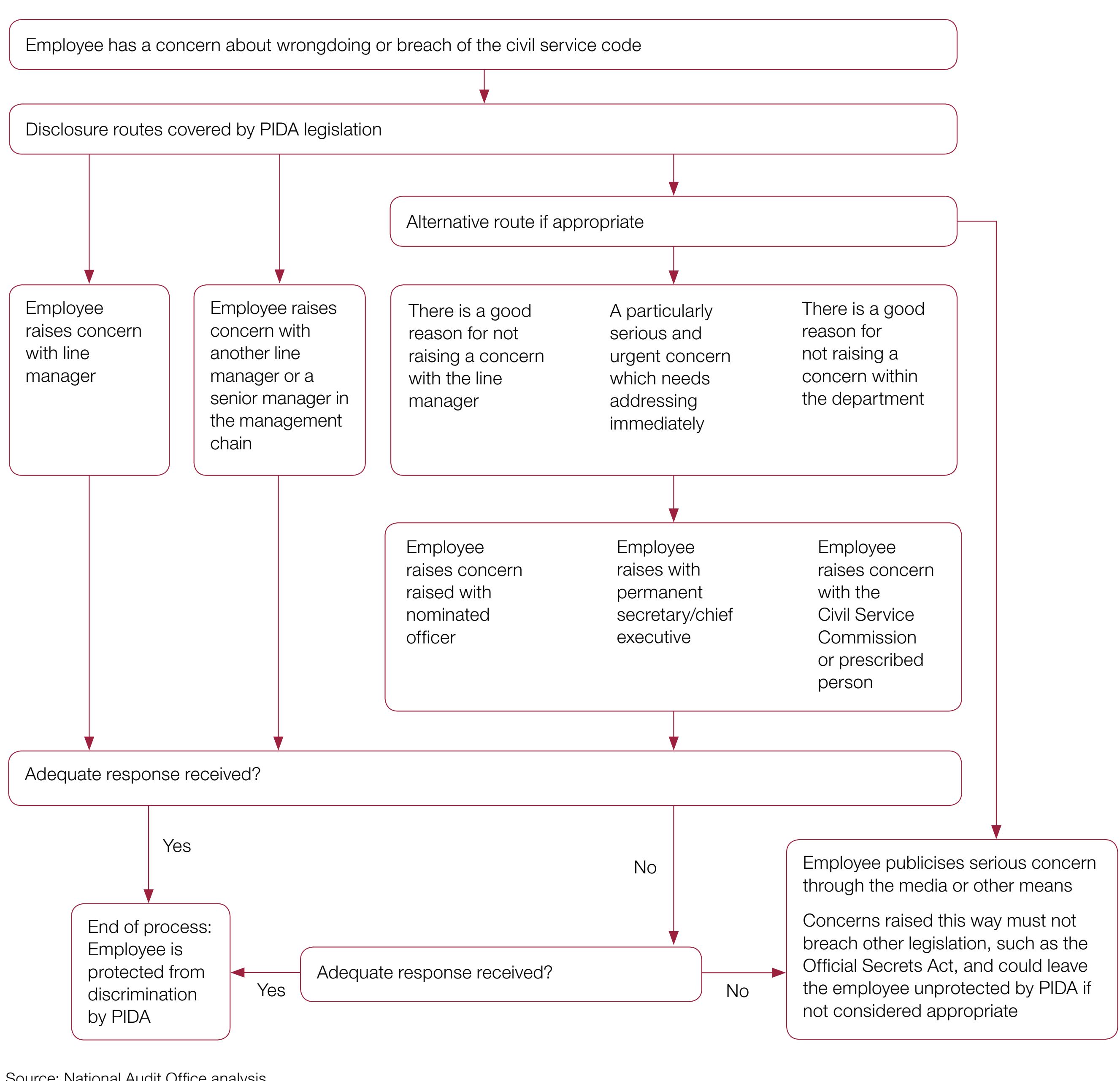
How employees blow the whistle

1.21 The way employees 'blow the whistle' generally follows a standard process. This involves raising a concern with their line manager, or another manager if appropriate in the first instance. This action should then trigger the process. Policies should also state an alternative to line management, so people can use different routes if there is good reason to do so. **Figure 4** gives an example of a generic whistleblowing process.

1.22 The personal cost of whistleblowing can be high and some people may be tempted not to put their names to reports. Most organisations will investigate anonymous disclosures but this can be open to abuse and organisations generally discourage anonymous reports. Confidential reporting recognises the potential personal cost to whistleblowers and allows the person to remain unidentified, while providing a channel for further communication. This method of reporting reduces malicious reports and allows the investigator to get more information.

Figure 4

Example of a whistleblowing process



Source: National Audit Office analysis

Part Two

Whistleblowing policies

Main criteria for an effective policy

2.1 Stakeholders with interest and expertise in whistleblowing generally agree about the criteria that should be included in a good-quality policy (**Figure 5**). A more detailed version can be found in the supplementary document published alongside this report.

Whistleblowing policies across central government are generally of good quality

2.2 We reviewed 39 policies against our eight criteria on a five-point scale. **Figure 6** on pages 16 and 17 shows our assessment for each organisation against each of the criteria. Strengths and areas for improvement are outlined in more detail in paragraph 2.4 onwards. During our review, many departments updated their policies in light of our comments, or have committed to doing so.

2.3 Having a good policy however is only part of implementing appropriate whistleblowing arrangements. The organisations' behaviour and culture are equally as important as having a good whistleblowing policy.

Figure 5

Main criteria to include in a whistleblowing policy

Commitment, clarity and tone from the top

Guidance should make clear that any concerns are welcomed and will be treated seriously.

Guidance should reassure the reader who may be thinking of raising a concern that the organisation's leadership will take the concern seriously and will not punish the employee if the concern turns out to be untrue, as long as they had reasonable suspicion of wrongdoing.

Addressing concerns and providing feedback

Whistleblowing policies should set out procedures for handling concerns. This should reassure employees that their concerns will be taken seriously and will ensure that instances of malpractice are identified and dealt with appropriately.

Openness, confidentiality and anonymity

Guidance should make sensible and realistic statements about respecting whistleblowers' confidentiality. Guidance should also outline the potential issues that could arise from employees reporting concerns who wish to remain anonymous.

Reassuring potential whistleblowers

Guidance should make clear that it is an offence for management and staff to victimise employees thinking of making a complaint. Similarly, it should make clear that employees who deliberately raise malicious and unfounded grievances will be subject to disciplinary action.

"I've seen/heard something and I think I should report it – but who to and how?"

Offering an alternative to line management

Concerns may relate to behaviours of line managers or employees may be unwilling to discuss concerns with immediate management. Thus alternative channels inside the organisation should be offered.

Whistleblowing to external bodies (prescribed persons)

Guidance should make employees aware of how they can raise concerns outside the department, e.g. to an external auditor or regulator. This is an obligation for officials in certain circumstances, for example where there is evidence of criminal activity.

Access to independent advice

Employees may need advice where they feel unsure or unaware of how to raise a concern. Guidance should indicate where employees can seek advice.

Structure

It is important that guidance is easy to use so that readers are clear as to how they should take their concerns forward. The policy should cover all areas expected under best practice. It should be clear, concise and avoid including irrelevant detail that might confuse readers.

Note

1 These are from our main criteria against which we judged policies. A copy of the policy checklist can be found in our supplementary document.

Source: National Audit Office, building on Public Concern At Work criteria, and external experts

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Figure 6

Evaluation of whistleblowing policies

	Setting a positive environment for a whistleblowing policy		
	Commitment, clarity and tone from the top	Structure	Offering an alternative to line management
Cabinet Office	yellow	yellow	red
Charity Commission	light green	dark green	dark green
Crown Prosecution Service	light green	light green	light green
Department for Business, Innovation & Skills	light green	dark green	dark green
Department for Communities and Local Government	light green	light green	light green
Department for Culture, Media & Sport	light green	dark green	dark green
Department for Education	light green	light green	dark green
Department of Energy & Climate Change	light green	light green	orange
Department for Environment, Food & Rural Affairs	light green	dark green	dark green
Department for International Development	dark green	light green	light green
Department for Transport	light green	light green	light green
Department for Work & Pensions	light green	light green	light green
Department of Health	light green	light green	light green
Export Credits Guarantee Department	orange	orange	orange
Food Standards Agency	light green	light green	light green
Foreign & Commonwealth Office	light green	dark green	light green
Government Actuary's Department	light green	light green	light green
HM Land Registry	light green	light green	dark green
HM Revenue & Customs	light green	light green	yellow
HM Treasury	orange	yellow	orange
Home Office	light green	light green	light green
Ministry of Defence (Civilian)	light green	dark green	dark green
Ministry of Justice	light green	light green	light green
National Audit Office	dark green	light green	dark green
National Savings & Investments	light green	yellow	orange
Northern Ireland Office	light green	light green	dark green
Office for National Statistics	yellow	yellow	light green
Office for Standards in Education, Children's Services and Skills	yellow	orange	red
Office of Fair Trading	light green	light green	light green
Office of Gas and Electricity Markets	light green	dark green	dark green
Office of Qualifications and Examinations Regulation	light green	light green	dark green
Office of Rail Regulation	light green	light green	yellow
Serious Fraud Office	dark green	light green	light green
The Crown Estate	yellow	light green	light green
The National Archives	light green	light green	red
The Supreme Court	yellow	yellow	yellow
The Treasury Solicitor's Department	light green	light green	light green
The Water Services Regulation Authority	dark green	light green	yellow
UK Trade & Investment	yellow	orange	light green

Note

1 We assessed these policies on a relative scale shown above.

Source: National Audit Office analysis

Supporting whistleblowers
Reassuring potential whistleblowers
Addressing concerns
Openness and confidentiality
Access to independent advice
Options for whistleblowing to external bodies (prescribed persons)
Poor
Satisfactory
Excellent

Our evaluation

2.4 We identified common areas of strength and areas for improvement across organisations.[11]

Strong performance: setting a positive environment for a whistleblowing policy

2.5 Between 28 and 31 policies were assessed as either good or excellent, for the five criteria that focus on the background and purpose of the policy.[12] These policies often had the following qualities:

- ✔ Clearly expressed, woven into all organisational levels and viewed as an important source of information and organisational performance improvement.
- ✔ Clear about when whistleblowing is appropriate and when other processes are better suited to resolving concerns.
- ✔ Specify specialist contacts, such as nominated officers, who are trained to engage with whistleblowers and are aware of the sensitivities.
- ✔ Reassure potential whistleblowers that their information is valued and that they will not be treated adversely should they have the courage to raise their concerns.
- ✔ Aim to engage with whistleblowers and inform them of the outcome of any investigation into the concerns raised.
- ✔ Well structured, with processes in clear and easy-to-understand formats.
- ✗ Despite 28 policies being assessed as good or excellent for offering whistleblowers a suitable alternative to line management when reporting concerns, seven policies were poor (red or amber) because the suggested routes for reporting were often to too senior staff.

11 These observations cannot be quantified as they concern a range of criteria.

12 This covers the following criteria: commitment, clarity and tone from the top; structure; offering an alternative to line management; reassuring potential whistleblowers; and addressing concerns.

Areas for improvement: supporting whistleblowers

2.6 Between four and five of the policies were poor in the three criteria that are designed to support whistleblowers.[13] These policies often do not do the following:

✗ Clarify the differences between confidentiality and remaining anonymous, and the impact that this decision may have on the investigation of the disclosure.

✗ Highlight the benefits of seeking independent advice and the potential sources of specialist support available.

✗ Provide information on when it may be appropriate to make disclosures outside of the organisation, the risks and limitations of this and the roles of prescribed persons.

2.7 As part of this work, we reviewed our own whistleblowing policy. We found it was strong in two areas: reassuring the reader that the leadership team is committed to high ethical standards and will welcome any concerns; and providing named contact details for potential whistleblowers to approach. It could be improved in some areas, for example including a flow chart to guide the reader through the process and explaining the risks of disclosure to the media.

13 This covers the following criteria: openness and confidentiality; access to independent advice; and options for whistleblowing to external bodies (prescribed persons).

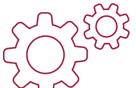
Setting a positive environment for a whistleblowing policy

Commitment, clarity and tone from the top

Number of departments with each rating

2.8 Most organisations scored highly on this criterion. Those that scored the highest were where:

- there was a stated commitment from the top of the organisation to maintaining high ethical standards;
- language is personal, inviting and reassuring;
- guidance encourages individual to report an issue and emphasises there is no need for proof of the concern; and
- guidance covers management's obligations, responsibility and commitment to investigate concerns.



Having a permanent secretary own the 'foreword' to the policy with accompanying photo would indicate tone from the top and also provide a personal touch.

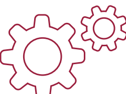
Structure

Number of departments with each rating

3	5	24	7

2.9 Many policies scored highly on this criterion, which relates to policies being concise, consistent, and with clear signposting of sections, with FAQs and examples to help the reader understand.

2.10 Policies that scored poorly on this criterion were overly brief or lacked key information. The language was often overly complex, formal or convoluted.

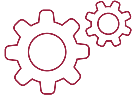


A concise, clear and logically structured policy helps employees to understand the process. Policies that have flow charts or similar pictorial and diagrammatic representations that outline the step-by-step process are useful techniques to support a well laid-out policy.

Offering an alternative to line management

Number of departments with each rating	3	4	4	17	11

2.11 This criterion has the most poor (red or amber) ratings. Policies that received the lower scores failed to offer a suitable alternative to the line manager, directing the whistleblower to someone who could be too senior for the whistleblower to feel comfortable approaching. The policies that scored highly offered the line manager as the first point of call, and also gave details of specific alternative appropriate contacts where employees feel unable to raise concerns with their line manager. Furthermore, these better policies explain that a person with suitable skills will investigate the different types of disclosures.



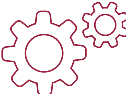
Departments should give viable and appropriate alternative reporting lines aside from line management, and be as specific as possible (including names, telephone numbers and email addresses that are valid and up to date). This will make employees feel they have realistic alternative reporting lines.

Reassuring potential whistleblowers

Number of departments with each rating	3	5	31

2.12 Most policies scored well on this criterion, although no policies received an excellent rating. Those policies that had the highest score had the following characteristics:

- The policy says that where concerns are honestly believed to be true, staff will not suffer detriment, even if the concerns prove unfounded. However, where employees deliberately raise malicious or unfounded grievances they will be subject to disciplinary action.
- It makes clear that the organisation will not tolerate any form of harassment, bullying or victimisation of any individual who has raised a genuine concern.



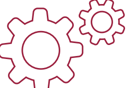
Clearly outlining the need for potential whistleblowers to honestly believe that wrongdoing is occurring, or is likely to, should reassure those with genuine concerns and deter others from knowingly supplying false information. Equally, stating that whistleblowers will be protected against any reprisal may encourage them to come forward.

Addressing concerns and providing feedback

Number of departments with each rating

2.13 Most policies scored well on this criterion. Those policies that had the highest scores were those that clarified to whistleblowers how their concerns would be treated by:

- clearly outlining the process, including indicative timescales and the nature of feedback that can be expected;
- describing the process clearly and concisely, with an informal tone;
- explaining employees' rights; and
- explaining roles and responsibilities so that employees know who they should report to, and who to ask for support and advice.



Explaining the procedure step-by-step can help a whistleblower to understand how the process will operate. Indicating timescales for review meetings or feedback will also provide valuable information for a potential whistleblower.

Supporting whistleblowers

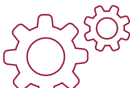
Openness, confidentiality and anonymity

Number of departments with each rating

2	2	15	19	1

2.14 There were more varied scores for this criterion. The policies that scored at the lower end of the scale were those that did not clarify the difference between remaining anonymous and identifying oneself on a confidential basis or make realistic statements about protecting confidentiality.

2.15 The policies that scored highly were those that encouraged employees to raise concerns openly, while discussion about the drawbacks of anonymity was included. Some policies also discussed the issue of confidentiality and potential difficulties involved in maintaining it.



Being realistic and honest about the pros and cons of confidentiality and anonymity, and also of the possibility of being identified, will mean that employees will be able to make a fully informed decision as to their options.

Access to independent advice

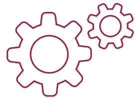
Number of departments with each rating				
	4	10	11	14

2.16 This was the criterion with the most varied range of scores: it has both the highest number of red ratings and the highest number of dark green ratings.

2.17 The poorest scoring policies were those where there was:

- no reference to independent advice; or
- limited reference but no supporting explanation as to the type of advice given, or how to access it.

2.18 Conversely, the top scoring policies were those where a number of viable external and independent sources were given, along with accompanying explanatory narrative and contact details. These policies also gave employees guidance on the potential breach of their legal duty of confidentiality in communicating confidential information that would not pass a public interest test.



There are a number of sources of free and independent advice for employees, depending on circumstance, such as the Civil Service Commission, the Citizens Advice Bureau, Public Concern at Work, their Employee Assistance Programme, and the Health and Safety Executive. These sources will give employees an opportunity to get an independent perspective on their concerns, before they report anything formally.

Whistleblowing to external bodies (prescribed persons)

Number of departments with each rating					
	2	3	17	15	2

2.19 This criterion received the least number of good or excellent ratings with most policies receiving a rating of satisfactory. Those with red or amber ratings were where the role of the Civil Service Commission, regulators or prescribed persons were not mentioned, whereas those with higher scores explained the role, and also the associated protection under PIDA when reporting to prescribed persons.

Outlining the appropriate routes and including up-to-date contact details allow an employee to report a concern while maintaining their PIDA protection. These routes are likely to include the Civil Service Commission and prescribed persons. A collated list of prescribed persons can be found on the Department for Business, Innovation & Skills' website.[14] It is equally important to explain the routes through which employees will not be PIDA protected, unless particular circumstances apply.

14 List of prescribed persons can be found on the Department for Business, Innovation & Skills' website: www.gov.uk/government/uploads/system/uploads/attachment_data/file/183340/11-641-blowing-the-whistle-to-a-prescribed-person.pdf

Skills and capacity

2.20 Addressing the points above will allow an organisation to have a high-quality whistleblowing policy but producing a policy is only the first step. For a whistleblowing policy to be successful the organisation must create the right culture. An organisation with an open and accountable environment, with those at the top taking the lead on the whistleblowing policy, can show that whistleblowers' concerns are taken seriously and valued. Such organisations can tackle risks to the organisation, employees and the public early on.

2.21 The policy must be supported throughout the organisation and be led or sponsored by an appropriate member at the most senior level. They should ensure that the policy is periodically reviewed and that it is working effectively. The policy development should involve senior managers, staff associations, trade unions and any other interested parties such as providers or specialist staff. The sponsor should make sure that policy development and good practice is reflected in the policy and its implementation.

2.22 The main contacts for whistleblowing disclosures should have the full support of the organisation, the power to respond to disclosures and have access to relevant staff and information. These contacts must be able to give advice on the policy, and help others to make or receive reports and support whistleblowers and managers. They must be accessible and approachable. They must remain impartial but be friendly and engaged and have experience of investigative interviewing techniques.

2.23 In our next report we will examine in more detail how policies are implemented and publicised, and the skills and culture needed to support an effective policy. We will also examine the role of the prescribed person and how this works in whistleblowing.

Appendix One

Methodology

1 We reviewed 39 policies using an evaluative checklist. The checklist can be found in our supplementary document.

2 We interviewed a range of stakeholders including:

- Association of Certified Fraud Examiners
- Chartered Institute for Public Finance and Accountancy (CIPFA)
- Civil Service Employment Policy (CSEP) – Civil Service expert service
- Expolink
- Public Concern at Work
- Transparency International
- Whistleblowers UK

3 We also liaised closely with CSEP throughout clearance of the report.

4 We reviewed relevant literature, including documents relating to UK legislation and in other comparable countries.

5 We discussed our work and findings and sought advice from experts in the field of whistleblowing. We are grateful to Professor David Lewis, Professor of Employment Law, Middlesex University Law School and Ian A Younger CFE, APCIP, PgCAIP Certified Fraud Examiner for their guidance and assistance during this work.

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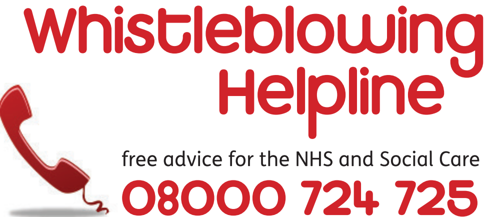
RAISING CONCERNS AT WORK

Whistleblowing Guidance for Workers and Employers in Health and Social Care



CONTENTS

Foreword by Secretary of State for Health 4
Introduction 5
Why is it important to raise concerns? 6
- What the research says 6
- Expectations within our sector 7
- The relationship to the safeguarding framework 8
What the law says - summary 8
Top tips 9
- Top tips for workers 9
- Advice and support 12
- Flowchart of whistleblowing process 14
- Guidance for Managers 15
- What to do when a worker reports a concern 16
- Top tips for managers 16
- Employer guidance 19
- Responsibilities of employer 19
- Standards for policies 21
- Model policy for small organisations 23
- Settlement agreements 25
- What does good practice look like? - Some case studies 27
What the law says - detail of PIDA 29
The role of prescribed persons 31
Frequently asked questions (FAQs) 32
Further information and links 35
Appendices 39
- List of prescribed persons 39
- Model letter for staff to raise concerns internally 41
Notes 43

FOREWORD BY SECRETARY OF STATE FOR HEALTH

Dear colleagues

I am pleased to welcome the publication of this guidance on raising concerns at work.

People who raise concerns ('whistleblowers') have sometimes had difficult experiences in the past. The failures of Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital were overshadowed by secrecy and a defensive culture - a refusal to listen to staff, patients and carers who felt strongly enough to raise concerns and on countless occasions were not listened to. I hope we are moving to a defining moment where the response to Robert Francis's Public Inquiry will create a culture of openness with greater accountability and a relentless focus on safety in an NHS which puts compassion at its heart. I urge all employers and staff to work together towards embedding a culture in which it is the norm to report on problems and to act on them.

This guidance aims to support employers and employees to make the process of raising concerns work better in the future. Staff in the health and social care sector should never be stopped from raising concerns about patient safety. Staff should be supported and protected when they raise concerns, as well as praised for their courage and thanked by management as a key part of the effort to build the safe, effective and compassionate culture that patients, service users, the public and the overwhelming majority of staff across health and social care expect.

Yours sincerely

Rt Hon. Jeremy Hunt MP

Secretary of State for Health

INTRODUCTION

Health and Social care services exist to promote the health, wellbeing and dignity of patients and service users and the people who deliver these services want to do the best for those they serve. However, there will be occasions when wrongdoing occurs in the workplace. This is why encouraging workers to raise concerns openly as part of normal day-to-day practice is an important part of improving the quality of service user support and patient safety. When concerns are raised at an early stage, corrective action can be put in place to ensure high quality and compassionate care based on individual human rights.

The importance of raising concerns at work in the public interest (or "*whistleblowing*") is recognised by employers, workers, trade union and the general public. Working in partnership with Trade Unions, staff associations and employee representatives is an important part of ensuring fairness and promoting awareness of the policies, procedures and support mechanisms which a good employer will have in place.

We would like to acknowledge the contribution and input towards this guidance made by key stakeholders. There are too many for us to thank individually, but they include Trade Unions, employers' associations, campaigning groups, regulators, professional bodies and whistleblowers themselves. The contents of this Guidance have been endorsed by the Social Partnership Forum and the Social Care Institute for Excellence.

How to use this Guidance:

After the first introductory pages, the body of the Guidance is made up of three main sections: one aimed at **workers**, one at **operational managers**, and one at **employers**. Each section can be easily identified by its colour coding and text in the border of the page. All pages relating to workers have a turquoise border, pages for managers have a pink border, and pages for employers have a gold border. The Contents page sets out the structure of the Guidance in more detail.

We hope you find it useful – please get in touch if you need further help by contacting the Whistleblowing Helpline on 08000 724725, or email enquiries@wbhelpline.org.uk

WHY IS IT IMPORTANT TO RAISE CONCERNS?

It is important for individuals to feel safe and listened to when raising concerns. An open approach to whistleblowing promotes the values of openness, transparency and candour and encourages employees to treat patients and service users with dignity, respect and compassion. In that way, the wellbeing and safety of patients and service users and the provision of good care become part of the culture, and are seen as "*the way we do things around here*".

From the employer's point of view, there are good business reasons for listening to workers who raise concerns, as it gives an opportunity to stop poor practice at an early stage before it becomes normalised and serious incidents take place. Whistleblowing has been shown to be an effective way to achieve service improvement, leading to better patient care and promoting dignity.

From the workers' perspective, the freedom to raise concerns without fear means that they have the confidence to go ahead and "*do the right thing*". It is part of encouraging workers to reflect on practice as a way of learning.

What the research says

There have been a number of reports into whistleblowing and people's experience of whistleblowing. Recent research includes the Whistleblowing Helpline's Bridging the Gap report, the 2012 NHS Staff Survey, the Royal College of Nursing survey in April 2013 and Public Concern at Work and the University of Greenwich's report "*Whistleblowing: the inside story*" in May 2013. The main findings are summarised below:

- There is a gap between the proportion of people who know about the raising concerns (or "*whistleblowing*") policy and the proportion of individuals who feel safe to use it. For example, the 2013 NHS Staff Survey found that although 89% of staff say they know how to report concerns, only 71% would actually feel safe to raise concerns.
- The Royal College of Nursing survey and the Bridging the Gap report show there are a number of barriers which prevent workers from speaking out, which include being viewed as a troublemaker, the fear of reprisals from managers and/or colleagues and feeling that nothing will be done to address the concern.
- 60% of whistleblowers received no response or feedback (negative or positive) from management. *(Taken from the PC@W survey)*.
- 83% of workers only blow the whistle twice internally, meaning organisations have a limited opportunity to address the concern before it escalates. Swift and appropriate action needs to be taken. *(Taken from the PC@W survey)*.
- If people report concerns to the Care Quality Commission (CQC) at the second or third time a concern is raised, it decreases the chances of dismissal. However the likelihood of formal reprisals is increased. *(Taken from the PC@W survey)*.
- Newer workers are most likely to blow the whistle (39% have less than 2 years' service). *(Taken from the PC@W survey)*.

The whistleblower can experience considerable stress and isolation as the Bridging the Gap report shows. For sources of support, see the section on advice and support on page 12.

People who raise concerns ("*whistleblowers*") have sometimes had difficult experiences in the past and we need to ensure that they are supported and protected, in line with the need for an open, transparent and honest culture. This guidance aims to support employers and employees to make the process of raising concerns work better in the future.

Expectations within our sector

As a worker in health or social care, there are moral, ethical and professional issues to consider in relation to raising concerns.

Staff registered with a professional regulatory body such as the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC) have to adhere to their respective codes of conduct. Professional codes of conduct usually place a duty on the practitioner to raise concerns where they see instances of poor practice or wrongdoing. The professional regulators are able to offer advice to whistleblowers as well as register complaints against their members.

Social workers, now registered with the Health and Care Professions Council, are subject to the HCPC's standards of conduct, performance and ethics which state that practitioners 'must act in the best interests of service users' and 'must protect service users' from danger (Health and Care Professions Council, 2012).

Large numbers of workers in the sector are not regulated in this way, but will be expected to raise concerns in the interests of patients and service users.

The **Social Care Code of Conduct**, which sets out what is expected of adult social care workers, refers to whistleblowing in the first principle, and this is reinforced in the Social Care Commitment.

The **NHS Constitution** emphasises the importance of honesty and openness and was updated in March 2013. It pledges that the NHS will "*encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998*".

For the latest version of the NHS Constitution, follow this link:
www.gov.uk/government/publications/the-nhs-constitution-for-england

The professional duty of candour

The report of the Mid-Staffordshire Foundation Trust Public Inquiry, better known as the Francis report, was published in February 2013. In the Government's final response to the Francis report, "*Hard Truths*", published in November 2013, it was stated that the GMC, the NMC and other professional regulators are to develop a consistent approach to the professional duty of candour for doctors, nurses and other health professionals, making clear a requirement to be open with patients and families when mistakes occur, whether the mistake is serious or not. The guidance will make clear that obstructing colleagues in being candid will be a breach of their professional codes.

The relationship to the safeguarding framework:

Safeguarding the health and wellbeing of patients and service users means they should not be exposed to abuse, whether physical, psychological, sexual or financial, neglect or institutional abuse. It is not the worker's responsibility to investigate or decide if abuse has happened, only to make sure that the appropriate agencies are told about their concerns or suspicions. Workers should make sure that they understand and follow their local authority's safeguarding policies regarding referral of their concern to the appropriate agency via the designated safeguarding officer, a manager or themselves, if possible on the same day as they have the concern.

Following a number of high profile events, the government introduced the Public Interest Disclosure Act 1998 (PIDA), which provides legal protection against detriment for workers who raise concerns in the public interest (also known as making a disclosure) about a danger, risk, malpractice or wrongdoing in the workplace which affects others.

To be protected, the disclosure must be in the public interest, the worker must have a reasonable belief that the information shows that one of the categories of wrongdoing listed in the legislation has occurred or is likely to occur, and the concern must be raised in the correct way.

PIDA is a complex piece of legislation and more detail is provided on page 29. The way PIDA works is for the worker to be able to claim a remedy at an Employment Tribunal if they are subjected to bad treatment as a result of their whistleblowing.

TOP TIPS

The following tips are intended to support workers in raising concerns and to help managers respond appropriately when handling concerns raised.

It is important to create a culture of openness and transparency, where workers feel safe and are encouraged to speak up. For this to happen the Board and senior management will need to demonstrate that they are committed to open dialogue and communication. They will also need to ensure that the safety and wellbeing of patients and service users are seen as the responsibility of everyone involved in the provision of health and social care services.

Raising concerns as soon as possible is an effective early warning of wrongdoing, malpractice or risks. Where possible, opportunities to raise concerns should be embedded into routine discussions on service delivery and patient care, (e.g. problem solving, service review, performance improvement, quality assessment, training and development).

Top tips for workers

Whistleblowing is when you speak out about something you are concerned about at work because you think it needs bringing out into the open for the public good. It can be a hard decision to do this. Here are some top tips to help you make your decision in an informed way and to help you access any support you may need:

1. **Read the whistleblowing policy and procedure where you work.** (This is sometimes called the "*Raising Concerns Policy*"). It should tell you:
   - what type of concerns are covered
   - when and how a concern should be raised and who with.

   In larger organisations, you can normally find the policy on the staff intranet or ask the HR department. In smaller organisations, you might find it in the Staff Handbook or you could ask your manager for a copy. You need to follow the procedure to make sure you remain protected under the law – this is called the **Public Interest Disclosure Act 1998 (PIDA)**.

   You can get independent advice by contacting your Trade Union representative, the Whistleblowing Helpline on 08000 724725, an HR manager or a Citizens Advice Bureau. In some circumstances, you may also wish to obtain independent legal advice.

2. **Raise the concern immediately or at the earliest opportunity.**

   If you believe that something is wrong, you do not need proof. Speaking out early could stop the issue from becoming more serious, dangerous or damaging.

3. **Think about whether your concern can be discussed in an informal way** or at things like supervision meetings, at your appraisal, team or departmental meetings or at staff forums.

4. **Find out if other workers share your concerns.**

   If so, you may be able to raise your concern as a group - there can be strength in numbers.

5. **Check your organisation's policy to find out who you should report your concerns to.**

   Your line manager is usually the first person to go to. If you believe that your manager may be involved or you feel unable to raise it with them, you may need to go to another manager or someone else that is listed in the whistleblowing policy. If you work for a small organisation where there are no more senior managers, then you might need to go to a regulator such as the Care Quality Commission (CQC).

   If you think the ways to report are not clear or you do not feel supported or safe then you should contact HR or your Trade Union for advice in the first instance. Alternatively, you may wish to seek independent confidential advice from the national Whistleblowing Helpline. You can call them on 08000 724 725.

6. **Try to see if you can sort things out inside your organisation first.**

   But if you are not satisfied, then you might need to tell someone outside of where you work. This might mean telling your professional regulator or the CQC. These are listed on page 39.

   Reporting anything to the media should always be the LAST thing you turn to. Try all the other places talked about first – particularly if what you want to report involves private or confidential information.

7. **When you report your concern, focus on as much factual information/evidence as possible.**

   This means things like being specific about;

   - dates and times
   - what happened and the order of events
   - who was involved
   - any witnesses.

   Act honestly and professionally at all times in the interests of patients and service users.

8. **Try to present the situation as clearly and with as much information as possible – either verbally or in writing.**

   Identify what you believe to be the key issues and risks. For example, is there a risk to the patient/service user or is it to do with a professional/clinical practice etc.?
   Writing it down will help you to get your thoughts in order particularly if you are upset, worried or feeling emotional about it. Your trade union and the Whistleblowing Helpline can offer support.

   Provide as much supporting information as you can, for example files or emails. ALWAYS ask for further advice, for example from your Trade Union or professional body, if these contain private or confidential information.

9. **Check out the process and what will happen next.**

   Talk about what might happen next with your manager or the person nominated in the whistleblowing policy.

   You will need to give them a reasonable amount of time to check the facts and to find out more if they need to, before they feed back to you.

   Respect the fact that your manager may need to keep some information private and confidential if it relates to other people.

   Try to cooperate with any investigation into what you have reported and the attempts to resolve the issues and put things right.

   You are entitled to get support from a work colleague or union representative at any meeting to discuss your concerns or during any investigation that takes place.

10. **Keep track of what is happening.**

    Even if you raise your concern verbally, you should also keep a record in writing of any discussions relating to your concern – this means things like the dates things happened, who you talked to, what was said, what the response was.

    One way of keeping track of things is to email the manager/nominated person after any discussion with a summary of the main points. Make it clear that you are raising a concern in line with your organisation's whistleblowing policy and the **Public Interest Disclosure Act 1998 (PIDA)**. This is the law to do with whistleblowing.

11. **Maintain confidentiality.**

    It is best if you can speak out openly about what you think, although you can ask for your identity to be kept confidential.

    The person/manager with whom you talk about things should make every effort to protect your identity. However, there may be times when, because of the nature of the investigation or what you want to say, it will be necessary to say who you are publicly. If this IS going to happen then the person you raise your concerns with should make every effort to let you know first.

    Remember, if you work in a small team then people you work with might guess or work out your identity. If this happens, tell your manager and let him/her know if you are being bullied or harrassed or being treated badly as a result.

    Concerns raised anonymously – this means when you do not reveal your name - can be more difficult to deal with and investigate in the best way. More action is likely and possible if your identity is known when you report something.

12. If you are not satisfied...

If you feel your concern has not been addressed or the issues have not been resolved to achieve a solution and positive outcome, you should use the sources of support and help available to pursue the matter. Not speaking up might mean that poor care will carry on and may even get worse.

If this is the case, you will need to refer to your organisation's policy in order to be clear about what action you can take and where you can go next.

If there is nothing more you can do inside your organisation, then you can raise a concern with a regulator. This means somewhere like the **Care Quality Commission (CQC)**. They have a confidential number you can call on 03000 616161. If your concern is regarding an individual professional's practice, the professional regulator would be best placed to take action - a list of them is given on page 39. If you do this, you need to have reason to believe that the information you give and any allegation you make is substantially true – if you only suspect something then that is not enough when you report concerns outside of where you work. You can raise your concern with a regulator such as the Care Quality Commission even if you have left your job. And, as from 6 April 2014, members of the House of Commons (MPs) have been added to the list of 'prescribed persons' (see page 39).

Talking to the police or the media are also protected under the PIDA law, but only under certain circumstances. For example, if you genuinely believe you would be victimised or bullied if you raised the matter internally or with a regulator, you would probably be protected.

Going to the media should always be the last resort. Doing this could have an impact on your employment and it is a good idea to get advice before telling anyone outside of work.

If you are leaving your employment, your employer may ask you to sign a settlement agreement. Before doing this, read the further information on page 25 and seek advice from an independent advisor or the Whistleblowing Helpline.

Remember...

PIDA is there to protect you. So if you are being bullied or experience bad treatment as a result of raising a concern, tell your manager, Trade Union representative, or HR.

Sources of good advice are listed below. Remember, the Whistleblowing Helpline is available to help advise on the whistleblowing process – our phone number is 08000 724725.

Advice and support

People who have raised concerns often say they feel isolated and unsure of what to do. It is important to access appropriate support at an early stage. There are different types of advice and support available:

- Advice on the whistleblowing process – how to raise a concern:
  - Available from the HR department of your organisation, the National Whistleblowing Helpline, or your Trade Union.
  - In certain cases, a public law solicitor may be appropriate.
- Local support for you in the workplace and representation at formal meetings.
  - Your Trade Union, professional body or work colleagues.
- Emotional and/or therapeutic support.
  - Counselling services via your employer or your GP. If you have no access to counselling services please call the helpline to discuss how we might be able to help.

National contact details for these organisations are given below.

Trade Unions:

Royal College of Nursing (RCN), 0345 772 6300 www.rcn.org.uk/raisingconcerns

Royal College of Midwives (RCM), 0300 303 0444 www.rcm.org.uk

UNISON, 0845 355 0845 www.unison.org.uk

Unite, 020 7611 2500 www.unitetheunion.org

British Medical Association (BMA), 020 7387 4499 www.bma.org.uk

Chartered Society of Physiotherapy www.csp.org.uk

Managers in Partnership www.miphealth.org.uk

GMB www.gmb.org.uk

British Dietetic Association www.bda.uk.com

British Orthoptic Society www.orthoptics.org.uk

Federation of Clinical Scientists www.acb.org.uk

Hospital Consultants & Specialists Association www.hcsa.com

Society of Chiropodists and Podiatrists www.feetforlife.org

Society of Radiographers www.sor.org

British Association of Occupational Therapists www.cot.co.uk

Independent organisations:

Whistleblowing Helpline, 08000 724 725 www.wbhelpline.org.uk

Public Concern at Work, 020 7404 6609 www.pcaw.co.uk

The College of Social Work is the new professional body for social work. Its website is: www.tcsw.org.uk/home/

Medical Defence Union, 0800 716 646 www.themdu.com

Medical and Dental Defence Union of Scotland, 0845 270 2034 www.mddus.com

Patients First, www.patientsfirst.org.uk

FLOWCHART OF WHISTLEBLOWING PROCESS

WORKERS

This flowchart sets out the stages in raising a concern and shows the management levels for internal disclosure. In a small organisation, there may not be more than one or two levels of management to whom you can escalate your concerns. In these cases, you should consider escalating your concern to the regulator or other prescribed person at an earlier stage than is shown on the flowchart.

SEEK ADVICE

Getting Advice

If you are not sure whether or how to raise a concern at any stage, you should get advice from your Trade Union, the Whistleblowing Helpline or your professional body/regulator.

08000 724 725

Students can speak to their tutor/mentor.

- You wish to raise a concern
- Find your organisation's Whistleblowing Policy
  - Aware of what to do?
  - Not sure of what to do? → Seek advice from Trade Union/HR/external helpline/internal hotline (if this exists) → Aware of what to do?

STAGE 1 INFORMAL

- Discussed informally with appropriate manager → RESOLVED
- Not Resolved → Unable to raise concern at any level within the organisation
- Unable to raise concern at any level within the organisation → Refer externally to prescribed person/Legal Advisor

STAGE 2 FORMAL

Key Points

- Take immediate action
- Protect client confidentially
- Refer to your employer's Whistleblowing policy or other guidance
- Keep an accurate record of your concerns and action taken
- Read TOP TIPS section of the Raising concerns guidelines

- Formally raise your concern with Designated Senior Manager → No action taken
- Timescales & confidentiality agreed between the concern raiser and the Designated Manager
- Investigating manager appointed and supplied with info by Designated Manager
- Investigating manager conducts witness interviews, examines docs. etc
- Write an investigation report with recommendations
- Investigating Manager feeds back to Designated Manager
- Investigating Manager feeds back to the concern raiser → RESOLVED
- Not Resolved

STAGE 3 SENIOR MANAGER

- Raise your concern with Chief Executive → RESOLVED
- Not Resolved

STAGE 4 EXTERNAL

- Seek additional advice/support
- Refer externally to prescribed person/Legal Advisor

Guidance for Managers

Create a good culture to allow workers to feel confident about raising concerns

1. **Consider your management style.**

- Read through the section on the responsibilities for employers on page 19, which sets out what support your organisation should be providing to help you to respond positively to workers who raise concerns at work (also known as "*blowing the whistle*"). It's important that you are approachable, and foster a climate of openness and mutual respect.

2. **Be prepared.**

- Find, read and understand the whistleblowing policy and procedure where you work. (This is sometimes called the "*Raising Concerns*" or "*Speaking Up*" policy). The policy will help you to:
  - Understand your role and responsibilities as a manager in how to respond to and handle concerns raised. Seek advice from HR when required, where this available.
  - Know how and where to escalate serious concerns which need to be dealt with by senior staff, and explain this to the worker raising the concern.
- Attend any training provided, or request training when needed. In a smaller organisation, find out what training may be available and arrange to attend.
- Train workers to understand and practice values and demonstrate acceptable behaviour in their everyday work. In social care, the Common Induction Standards have to be completed by every worker new to social care and new and aspiring managers are recommended to use the Manager Induction Standards. Both of these require understanding of raising concerns/ whistleblowing procedures.
- Train and inform staff about their personal responsibility for respectful treatment of co-workers who raise concerns for the public good, and their legal liability for any bad treatment (for more detail, see page 33).

3. **Offer support and encourage early action.**

- Support and encourage workers to raise concerns at the earliest opportunity. Concerns at work could be a regular agenda item for discussion in normal communication and regular meetings such as 1:1 meetings, team meetings and departmental meetings.
- Focus on constructive discussion and dialogue, finding a solution, making improvements and dealing with risk.
- Be approachable and encourage workers to check if they are unsure what is appropriate and to admit mistakes rather than concealing them, so that they can be remedied.
- Identify any training or development needs for workers to support competency in the role.

What to do when a worker reports a concern

Top tips for managers

1. **Listen carefully to any worker raising a concern.**

- Commit to taking the matter seriously.
- Thank the person for raising it (even if you think they may be mistaken).
- Acknowledge how they may be feeling, that it may be a difficult or stressful situation, and offer reassurance.
- Respect the worker's belief that they are raising a genuine concern in the public interest.
- Treat this as being reasonable.
- Avoid prejudging whether this is correct or valid until an appropriate investigation has taken place.

2. **Respond positively and clearly.**

- Reassure the person that the concern will be looked into promptly and (where appropriate) investigated thoroughly and fairly as soon as possible.
- Manage expectations of the individual - discuss next steps, reasonable timeframes, and arrangements for feedback on the outcome.
- Respect a worker's request for confidentiality and any concerns about their job or career, but explain any circumstances where there may be limits on confidentiality (see page 32, FAQs).
- Offer advice about the type of support available to them (e.g. relevant contacts they can speak to such as: a designated whistleblowing lead within the organisation, HR, Trade Union, counselling, occupational health, or where they can seek independent advice – such as the Whistleblowing Helpline, or Citizen's Advice Bureau).
- Be clear on what the worker should do and where they should go if they experience any reprisals or unacceptable behaviour, e.g. bullying, harassment or victimisation, from managers or colleagues.
- Give the individual a copy or refer them to your organisation's whistleblowing or "raising concerns" policy.

3. **Ensure a fair process of investigation.**

- Ensure any investigation is carried out fairly and thoroughly.
- Keep an open mind – you may not want to believe all that you hear, but it's important to remain objective.
- Focus on the information that is being disclosed, not on the worker who is raising the concern.
- Don't let personal views influence your assessment of the issues.
- Recognise any strong emotions you may have and ask for help if you need it. (It is not unusual to have feelings such as anger, shock or distress).

4. **Assess how serious and urgent the risk is.**

- Decide whether the concern would be best dealt with under the whistleblowing policy or some other procedure (such as grievance).
- Don't dismiss the disclosure as an exaggeration or being trivial unless there is clear evidence to support this assessment.
- Decide whether the assistance of, or referral to, senior managers or a specialist function (e.g. Finance) is desirable or necessary.
- Where there are grounds for concern, take prompt action to investigate or if the concern is potentially very serious or wide-reaching make sure this is escalated to the most appropriate person within the organisation to undertake further investigations.

5. **Maintain good communication with the worker who raised the concern.**

- Keep the worker advised and informed on progress.
- Update on any changes or delays in process.
- Give feedback on the outcome to the worker.
- Explain any action to be taken (or not), but maintain confidentiality where this involves other parties.
- Explain any mistaken perceptions or misunderstandings which may have occurred.
- Ideally feedback should be given face to face and followed up in writing.

6. **Act fairly.**

- Understand that you are accountable for your actions.
- Be clear on any action taken or not taken and the reasons for this.
- Never attempt to ignore or cover up evidence of wrongdoing.
- Always remember that you may have to explain how you have handled the concern.
- Don't ever penalise someone for making a disclosure that proves unfounded if, despite making a mistake, s/he genuinely believed that the information was true.

7. **Seek appropriate advice and/or support where required.**

- If you are uncertain about how to proceed with a concern, always seek advice from HR or other relevant person/department within your organisation that has lead responsibility for personnel functions.
- They will also be able to support and advise you throughout any investigations you need to undertake into the issues raised, and in undertaking any actions required as a result of evidence being presented.

8. **Keep clear concise records of all discussions.**

- Date(s), what was said, response given by whom.

- Keep a record/log of all concerns raised (can be anonymised).
- Note the nature of the concern.
- Record how the investigation was conducted,
- Record outcome, decisions or action taken.
- Retain record for a minimum of five years.

9. **Follow up action.**

- Consider the potential actions:
  - Is this a serious disciplinary matter?
  - Are there alternative ways to achieve constructive, positive solutions for future improvement rather than simply apportioning blame?
  - Address any issues of competence or ability highlighted, via training and development.
- Report on issues identified to the Board or owner (perhaps through your organisational monitoring system – see page 20).
- Make recommendations across the organisation where appropriate i.e. feed into the 'bigger picture' and take remedial, proactive and preventative action where it is needed.
- Take steps to help share any learning, establish long-term solutions and prevent recurrence of the issue elsewhere in the organisation.
- Raise any issues identified in other relevant forums e.g.
  - Health and safety,
  - Risk assessment,
  - Incident reporting,
  - Quality reviews,
  - Service or performance reviews,
  - Business planning discussions,
  - Training and development reviews.

10. **Ensure the process has a positive outcome**

- Publicise and 'celebrate' positive outcomes/actions/improvements resulting from someone raising a concern and speaking up (the person need not be named). This may encourage others to do the same.
- Provide appropriate feedback on the outcome to the person raising the concern.
- Build or rebuild working relationships and teams after a concern has been raised (the whistle has been blown) with appropriate support and advice from HR, Trade Unions etc.
- Check on the worker's wellbeing at regular intervals to ensure they have not suffered any disadvantage, bullying, harassment or victimisation as a consequence of raising a concern.

EMPLOYER GUIDANCE

Whether you are from a large or small organisation, THIS GUIDANCE IS FOR YOU

Employers need to make sure they have clear mechanisms in place for workers to raise concerns, and gain commitment from the top level of management in the organisation.

Responsibilities of employer:

This section focuses on the responsibilities of the employer. It also provides links to examples of policies on raising concerns/whistleblowing from a range of organisations, and sets out standards for policies.

Key responsibility	Examples of how this can be achieved
Engage workers in the development and delivery of services.	• Encourage ongoing open dialogue and feedback on matters relating to provision of care/service delivery through supervision, team or departmental meetings, staff forums etc. • Actively seek suggestions for improvement and regularly review ways of working. • Focus positively on shared responsibility for quality of service/care, continuous improvement, problem solving.
Establish and regularly review the organisation's Raising Concerns Policy (*or Whistleblowing Policy*) following best practice guidelines and recognise the business/financial benefits of 'getting it right'.	• Acting promptly and dealing with concerns at an early stage involves less time, effort, and cost and minimises risk or damage to the organisation. • Some policy standards are set out on page 21. • Good examples of policies are provided on page 22.
Communicate and promote the organisation's policy and procedure as widely as possible.	• Ensure all workers are informed about the policy and procedure and know where to find it e.g. through induction, regular training, posters, leaflets, attachments to payslips, noticeboards, intranet, team meetings/briefings. • Communicate this with the backing and support from Trade Unions where applicable.
Demonstrate clear leadership and develop a positive culture.	• Make it clear that the Board/management are committed to the organisation's policy. • Develop a statement of positive organisational values/expectations of all staff – this can underpin all aspects of people management (e.g. recruitment, training, development, performance). • Raise awareness of acceptable and unacceptable behaviour (through induction, training, appraisal, objective setting, organisation's code of behaviour, professional code of practice, professional standards etc). • Lead by example and be aware that your attitude and behaviour can influence the organisation's culture.

Key responsibility	Examples of how this can be achieved (cont.)
Provide training and/or briefings for all senior managers and all those with line management responsibilities.	• Provide additional/specific training for any managers or others with a designated role in handling concerns.
Provide training for workers on the organisation's policy and procedure and how they can raise concerns.	• Include in induction training and/or mandatory training days. • Provide further training/updates on any changes or developments to policy/procedure.
Identify appropriate people or functions to support workers who raise concerns.	• In larger organisations support will normally be available from Trade Unions, Human Resources, employee support workers, Occupational Health, counselling/employee assistance programmes etc. • Smaller organisations may want to identify a (trained) named person or refer workers to the national whistleblowing helpline. • Use internal feedback 'tools' or arrangements such as staff surveys, suggestion schemes etc to gauge/assess staff confidence and trust that they will be supported and their concerns will be dealt with.
Ensure compliance with the legal obligation to take all reasonable steps to prevent co-workers from subjecting "whistleblowers" to bad treatment or victimisation.	• Adopt a zero tolerance approach to any unacceptable behaviour towards an individual raising concerns e.g. reprisals, bullying, harassment, victimisation. • Make sure workers are clear that action will be taken where behaviour is unacceptable.
Set up a monitoring system where data on concerns raised formally through the raising concerns/whistleblowing procedure are recorded, logged, tracked and analysed.	• Regular reports to the Board/senior management summarising concerns which have been raised, (whether substantiated or not) will help to raise awareness of the concerns, identify trends and 'hot spots', and ensure issues are being dealt with properly.
Learn from the concerns raised, the action taken and the outcome.	• Consider adding statistical information such as the number and types of concerns raised and the outcomes of investigations into cases dealt with under the raising concerns/whistleblowing policy and procedure into the annual report. • This may help to move away from a 'blame culture' and normalise the raising of concerns as a way of improving services, encouraging others to come forward or feel confident that they will be listened to and valued.
Provide guarantees of protection for individuals who raise genuine concerns (whistleblowers).	• Make a clear statement of the organisation's commitment e.g. "*the Board/ senior management will ensure that any individual who raises a genuine concern under the raising concerns policy will not be at risk of losing their job or suffer any form of retribution as a result. Members of the Board will not tolerate the harassment or victimisation of anyone raising a genuine concern*". • Consider identifying a senior management role and/or a designated senior HR professional to protect and offer ongoing support to "*whistleblowers*" for some years after the initial disclosure is made.

Standards for policies

Policies on raising concerns in the public interest ('*whistleblowing*') should include key information, set out clear procedures for handling/dealing with concerns, ensure that legal requirements are met, and positively encourage staff to raise concerns at an early stage. The specific procedures under the policy may vary to suit the culture and structure of the organisation. The table below sets out standards for all policies that focus on both the legal requirements and best practice.

Standard Sections	Standard information
General points.	• Date of Policy (and version number). • Date of Policy Review. • Title to suit the culture of your organisation (e.g. 'raising concerns'/'speaking up' may be more appropriate than 'whistleblowing').
Introduction.	• Summary of the relevant legislation, context and definitions to explain the responsibilities of the organisation and the individual under the Public Interest Disclosure Act (PIDA). • Purpose of policy. ▪ Explain why your organisation believes raising concerns/speaking up is important to ensure patient/service user safety. ▪ Clearly state what is expected of workers (encourage them to report concerns and refer to professional codes of conduct). ▪ Describe your organisation's approach to openness and transparency so that workers are encouraged to raise concerns about wrongdoing, misconduct, poor practice etc and are reassured that this can be done safely. ▪ State that the aim of the policy is to provide an internal mechanism for reporting, investigating and remedying any wrongdoing in the workplace. • Confirm who has overall responsibility within your organisation for ensuring the policy works effectively and procedures are followed. This may be a designated Whistleblowing Officer, the Chief Executive or other trusted senior position. • Make a clear statement of the organisation's commitment e.g. "*The Board/senior management will ensure that any individual who raises a genuine concern under the raising concerns policy will not be at risk of losing their job or suffer any form or retribution as a result. Members of the Board will not tolerate the harassment or victimisation of anyone raising a genuine concern*".
Scope of the Policy.	• Be clear on who the policy applies to. The law applies to workers, so that employees and agency workers are covered. As a matter of good practice, it is recommended that policies include volunteers although the policy should be explicit about the lack of protection under PIDA. • Explain how to raise concerns about someone who works for another employer (see page 34). • Explain the difference between a disclosure in the public interest and a personal grievance. • Give examples of the type of concerns that should be raised and disclosures that would be protected under the law. • Identify/cross reference any related policies/procedures e.g. safeguarding, disciplinary, grievance, bullying and harassment.

Adopt a zero tolerance approach to any unacceptable behaviour towards an individual raising concerns e.g. reprisals, bullying, harassment, victimisation.

EMPLOYERS

Standard Sections	Standard information (cont.)
Procedure for raising a concern.	• Give reasons why concerns should normally be raised internally in the first instance with line management. For example, so that they can be dealt with promptly and informally wherever possible. • Confirm how the matter should normally be raised e.g. face to face, by telephone, in writing (may be letter or email). A model letter for staff to raise concerns can be found on page 41. • Explain the procedure for investigating the concern raised. • Indicate normal timescales involved in dealing with the concern. • Describe arrangements for keeping the individual informed/updated during an investigation and for giving feedback on the outcome. • Be clear as to whom the individual can report their concern if it cannot be raised with line management or if they are unhappy with how the matter is being handled e.g. referral to a more senior manager, internal hotline, named contact within the organisation (who could be the CEO, a Board member or similar). • Explain in what circumstances and how a concern may be appropriately raised outside the organisation (e.g. with regulator). • Emphasise the need to seek further advice e.g. from Trade Union, HR or independent helpline if considering wider disclosure (e.g. to police or the media). It will rarely if ever be appropriate to alert the media.
Confidentiality.	• Explain how concerns can be raised in confidence if the individual wishes to do this. • Be clear on any limits to confidentiality and any circumstances where the individual's identity may be made public e.g. during legal, disciplinary or police investigations and proceedings. • Confirm your organisation's position on anonymous reporting.
Support.	• Include information on sources of advice and support, e.g. Human Resources, Trade Union, the Whistleblowing Helpline or other independent helpline, counselling, employee assistance services. • Confirm any training available for workers on understanding the policy and procedure and how to raise a concern (e.g. at induction and at regular intervals thereafter). • Confirm specific training available for managers/named contacts to understand their role and responsibilities if a concern is raised with them. • Clearly state that victimisation, bullying or harassment of any person raising a concern will not be tolerated by the organisation and that co-workers who are involved in such activity may be subject to disciplinary proceedings and/or be personally liable under the law. • Consider designating a senior manager or Non-Executive Director to act as a "*whistleblowers' champion*", to check up on the welfare of the person raising a concern at regular intervals. • If the person has a mentor, that is another route for support.
Monitoring and review.	• Describe arrangements to monitor/log/record concerns raised formally under the procedure and the outcomes (whether found to be valid or not). • Confirm arrangements for reporting to the Board/senior management, so that they can be assured that issues are being dealt with properly. • Explain how the policy will be reviewed and how employee experience of using the policy will be assessed.
False allegations.	• Be clear on how your organisation views false allegations and what action will be taken if someone maliciously makes a disclosure that they know to be untrue. However, people making a genuine mistake will not be penalised.

The Whistleblowing Helpline collects examples of policies used by a range of organisations, large and small, all of which have significant strengths that we can recommend. To access these policies, visit www.wbhelpline.org.uk/resources/employer-policy-information/

Model policy for small organisations

[Name of Organisation]

Draft Whistleblowing Policy

Introduction

Whistleblowing refers to making a disclosure in the public interest regarding malpractice or wrongdoing in the workplace. This means that you should speak out if you have any concerns about inappropriate or unlawful conduct, financial mismanagement or poor practice and behaviour.

Policy Statement

At [name of organisation] we are committed to achieving the highest possible standards of service. In order to achieve this standard we encourage staff to use the whistleblowing policy to report any malpractice or illegal acts or omissions by people working at the [type of organisation e.g. care home, GP practice].

Law

This policy has been written to take into account the Public Interest Disclosure Act 1998, which protects workers from suffering bad treatment or losing their job because they have made a disclosure.

Procedure

All staff have a duty to support and maintain standards of care. If a staff member has any concerns regarding inappropriate behaviour, unlawful conduct, poor practice or behaviour they are expected to raise their concern. The following guidelines provide the steps for staff members to follow:

1. Your concern must be raised in the public interest – it should be something that needs to be reported for the public good.
2. In the first instance you should talk to [Line Manager] and discuss the issue.
3. If you feel that your concern is not being dealt with or you do not feel comfortable talking to [Line Manager] you should arrange a meeting with [more senior manager, possibly the owner or the Chief Executive].
4. If you still feel that your concern has not been dealt with to your satisfaction you can contact the regulatory body the Care Quality Commission on their disclosure line 03000 616161 or via their website www.cqc.org.uk You need to have reason to believe that the information you give and any allegation you make is substantially true (suspicion is not enough).

5. You should always seek to resolve the problem internally and exhaust all internal procedure before raising your concern more widely. In circumstances where you feel that your concern has not been dealt with in a satisfactory manner by the [organisation] or the Care Quality Commission you may be able to raise your concern more widely, for instance with the police or your M.P. Caution should be taken as this is strictly regulated by the law. You should seek advice prior to taking this step.

Examples of Concerns:

- Physical or emotional abuse.
- Bullying.
- Theft, fraud or bribery.
- Health and safety issues and risks.
- Abuse of power, position or authority.
- Failure to treat people with dignity.
- Financial mismanagement.

Patient Confidentiality

If you make the decision to raise a concern you should not breach patient confidentiality. Patient information can only be disclosed if you are requested to do so by the Police conducting an investigation.

Bullying or Harassment

If you experience bad treatment such as bullying or harassment because you have spoken up or raised a concern, let your manager know and ask to be protected in line with the Public Interest Disclosure Act.

Further Advice and Information

For further advice on whistleblowing contact the Whistleblowing Helpline for the NHS and Social Care 08000 724725, www.wbhelpline.org.uk If you are a member of a Trade Union, they will also be able to offer you guidance. [Sources of information and advice are in the Advice and support section on page “Advice and support” on page 12]

Settlement agreements

So-called "*gagging clauses*" in employment contracts and settlement agreements (previously called compromise agreements) are void insofar as they conflict with the protections provided by PIDA. The Government now requires the inclusion of an explicit clause in settlement agreements to make it clear that staff can make a disclosure in the public interest in accordance with PIDA, regardless of any confidentiality clause.

Settlement agreements are a well established mechanism for ending the employment relationship between an employer and employee. These documents set out the terms and conditions agreed between the employer and the employee when they agree to settle a potential employment tribunal claim or other court proceedings. As such, they may be used in cases where a dispute involving whistleblowing arises. It is important to remember, however, that the majority of whistleblowing cases do not give rise to settlement agreements.

A settlement agreement is used to bring an employment relationship to an end in a manner which is mutually agreed by the parties. In some instances, they may be used where the employee and employer agree that the employment relationship can no longer proceed and must be brought to an end. They may also be used to resolve a dispute or issue, where the employment does not need to be terminated, for example a dispute over pay.

Over the years organisations have asked employees to sign settlement agreements which contain a provision for payment and confidentiality clauses which prevent people from talking about the agreement and the issues behind the dispute and/or dismissal or from making disparaging comments about either party. These types of clauses are commonly called "*gagging clauses*".

Although such clauses cannot prevent someone from making a "*protected disclosure*" under the Public Interest Disclosure Act 1998, where they are used some people may 'feel' as though they are prevented from making such a disclosure. It is generally these "*chilling effect*" type clauses that have proved problematic in the past when used in settlement agreements.

Confidentiality clauses can legitimately be used in a settlement agreement. However, it is important to note that any confidentiality clause between an employer and an employee or ex-employee which seeks to prevent the employee from making a "*protected disclosure*" in accordance with the Public Interest Disclosure Act 1998 is void and ineffective. This means that settlement agreements can not be used in an attempt to stop employees from whistleblowing.

The main features of a settlement agreement are as follows:

- They are legally binding.
- An employee may have to surrender their rights to bring a claim which is covered by the agreement.

- The employee will usually receive some form of payment and may be provided with a reference as part of the agreed terms.
- The parties must enter the agreement mutually and therefore the agreement is voluntary.
- They are normally reached following a process of discussion and negotiation or through a form of mediation.

The negotiation process is often confidential and "*without prejudice*". This means that if an agreement is not reached, the negotiations may not be admissible as evidence in claims before an employment tribunal or other court proceedings.

In order for a settlement agreement to be valid, there are certain statutory requirements which must be met:

- The agreement must be in writing.
- The agreement must relate to a particular complaint, or particular proceedings.
- The employee must have received legal advice from an independent adviser.
- The independent adviser must be identified in the agreement and have a current contract of insurance or professional indemnity insurance covering the risk of the claim against them by the employee in respect of advice.
- The agreement must state that the statutory provisions which set out the above conditions regulating the validity of the settlement agreement have been satisfied.

If these statutory requirements are not met the agreement will be invalid and cannot be enforced.

This section provides an overview of settlement agreements in relation to cases of whistleblowing. Advice should be sought prior to commencing any settlement negotiations.

Further details can be found in the following documents:

HSC 2004/001:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4069937.pdf

HSC 1999/138:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012081.pdf

http://www.nhsemployers.org/Aboutus/Publications/Documents/settlement-agreements.pdf

What does good practice look like? - Some case studies

We know from talking to people and the experience of others that some organisations can demonstrate best practice in responding to whistleblowing concerns. We have identified three case studies of good practice for you to consider.

Case study - staff training

mcch society ltd

Social care provider **mcch society ltd** (mcch) supports around 2,000 people with learning disabilities, autism and mental health needs across the South East. Providing a wide range of services that help people to live the lives they choose, mcch has over 25 years experience and employs over 1,600 staff. Services include registered care, supported living, respite, community support and children's playschemes. In addition, mcch also runs social enterprises, employment support services and wellbeing centres.

Safeguarding the people mcch supports is a key concern for mcch and it employs a dedicated Corporate Safeguarding Specialist, who is responsible for running a comprehensive training programme for its staff. Using the Skills for Care Qualification and Credit Framework Care Unit HSC 024, the training uses a realistic case study to demonstrate criteria five (know how to recognise and report unsafe practices).

Training is given to every new member of staff within their induction week (prior to staff commencing their employment) and refresher training is given to staff and volunteers every year. The training incorporates film clips showing the different types of abuse, individuals' personal perspectives of incidents that have happened to them and the initial process of dealing with reported abuse. This brings the training to life, by using real examples of safeguarding concerns, acted out by people mcch supports.

Every staff member and volunteer has access to the handouts and policies/procedures, which are also available in easy read, along with details of external support and a national helpline. They are also given a pocket-sized 'safeguarding card', which contains information about recognising abuse, how to respond (best practice in what you should and shouldn't do), reporting incidents and mcch's internal free whistleblowing phone line.

Case study - Staffordshire and Stoke On Trent partnership NHS Foundation Trust

Follow this link to see this case study about how Staffordshire and Stoke On Trent Partnership NHS Foundation Trust have created a more open and transparent environment to ensure that individuals have the support they need when they raise a concern.

www.nhsemployers.org/EmploymentPolicyAndPractice/UKEmploymentPractice/RaisingConcerns/Pages/StaffordshireandStokeOnTrentPartnershipNHSTrust.aspx

Case study - Wrightington, Wigan and Leigh NHS Foundation Trust (WWL)

The policy about raising concerns at WWL is called the Open Door Policy, and it clearly links to the organisation's cultural values of respect and dignity. It stresses the importance of the informal stage, where line managers are expected to deal with concerns promptly, sensitively and in a timely way. And it highlights the importance of wider communication of learning from concerns and the need for debriefing to the team/teambuilding after a concern has been raised.

An example of the policy working in practice occurred at the Sterile Services and Decontamination Unit (SSDU), which was opened in December 2010 and provides a Surgical Instrument Decontamination Service to all theatres, wards and clinics in WWL and Salford Royal (SRFT) Trusts. A change in management structure took place in early January 2012, and with this an attitude of openness was introduced and staff were encouraged to highlight any concerns with an understanding that direct positive action would be taken. The workforce were informed that gossip and rumour were not acceptable but if a serious concern was identified and raised then the employee should expect action.

Within the month of the new management structure an anonymous phone call was received from a member of staff identifying that an auditable process was not being implemented by a number of staff which could result in a breach in health and safety processes and ultimately cause risk and harm to patients.

An immediate investigation and audit of processes was put into practice both current and historic. The outcomes from this were documented and broadly communicated to both executive teams and the staff. Corrective measures were immediately put in place. This is a good example of the quality of the service improving as a direct result of staff raising a concern and being listened to.

The concern was welcomed by the new manager and sensitivity was used when communicating back to the informant. The manager ensured that the communication given to staff focused on the concerns and not how they were raised in order to preserve anonymity. The Trust Board also responded by summarising the outcomes and discreetly congratulated the member of staff who raised the concerns.

The unit then proceeded through a significant restructure which affected all staff. Due to the historic issues the new manager immediately implemented a programme of focused engagement with the staff and their representatives. The staff were encouraged to contribute to the proposals for change both in terms of processes and workforce.

During this there was an additional concern raised in relation to the implementation of the restructure. Again this concern was proactively responded to by not only the manager but the staff themselves. The individual was reassured and the unit again benefitted from the positive approach that was starting to embed and all staff have embraced a direct and open dialogue with the management team when concerns are identified.

WHAT THE LAW SAYS - DETAIL OF PIDA

What is the Public Interest Disclosure Act 1998 (PIDA)?

The Public Interest Disclosure Act 1998 protects whistleblowers from detrimental or unfavourable treatment and victimisation from their employers and co-workers after they have made a qualifying disclosure of a concern in the public interest.

The way PIDA works is to allow people to apply to an Employment Tribunal for a remedy or compensation if they feel they have suffered bad treatment as a result of whistleblowing. The Employment Tribunal route is, however, not an easy one. It is important to take advice from a Trade Union, solicitor or an independent helpline at an early stage to support you through this process.

Who is covered?

The Act covers all workers including those on temporary contracts or supplied by an agency, and trainees. PIDA does not cover volunteers or Governors of NHS Foundation Trusts (who are not employees of the Trust), and does not usually cover students

NOTE: Students should take advice if they are thinking of raising concerns during their placements. They can talk to their university tutor or lecturer, their mentor, professional body, trade union or independent helpline.

Will you be automatically protected if you make a disclosure?

As from 25 June 2013, to qualify for protection under PIDA a disclosure should be in relation to a concern which is in the "*public interest*". The public interest means the public good, not what is of interest to the public, and not the private interests of the person raising the concern. (For the difference between a grievance and a disclosure in the public interest, please see page 32). Whilst there is no longer a requirement for someone to have good faith when they raise a concern, an employment tribunal has the power to reduce any compensation award by up to 25% if it considers that the disclosure was made in bad faith (for example if the whistleblower's motives were to pursue a personal grudge against their manager).

What is a qualifying disclosure?

PIDA details six subject areas under which disclosures have to fit so as to be "qualifying disclosures":

- criminal offences;
- failure to comply with legal obligations;
- miscarriages of justice;
- threats to health and safety of an individual;
- damage to the environment; or
- a deliberate attempt to cover up any of the above.

Are all disclosures protected under PIDA?

Certain conditions must be met for a whistleblower to qualify for protection under the legislation, depending on to whom the disclosure is being made and whether it is being made internally or externally. To be protected, the disclosure must be in the public interest, the individual must have a reasonable belief that the information shows that one of the categories of wrongdoing listed in the legislation has occurred or is likely to occur (see **What is a qualifying disclosure?**, above), and the concern must be raised in the correct way.

Internal disclosures:

Workers are encouraged to make internal disclosures (raise concerns with their employer) with the view that employers will then have an opportunity to address the issue. If a worker makes a qualifying disclosure internally to an employer (or other reasonable person), they will be protected.

External disclosures:

If a disclosure is made externally there are conditions which need to be satisfied before a disclosure will be protected. One of these conditions must be met if a worker is considering making an external disclosure.

- If the disclosure is made to a "*prescribed person*" (a list of prescribed persons is made under PIDA, and you can find details of relevant prescribed persons for the NHS and social care in the Appendix at page 39), the worker must reasonably believe that the concern that they are raising is one which is relevant to that prescribed person (i.e. comes under their area of responsibility as a regulator) and that the disclosure is substantially true;
- A worker can also be protected if they reasonably believe that the disclosure is substantially true, the disclosure is not made for personal gain, it is reasonable to make the disclosure, and one of the following conditions apply:
  - at the time he/she makes the disclosure, the worker reasonably believes that he/she will be subjected to a detriment by his/her employer if he/she makes a disclosure to his/her employer; or
  - the worker reasonably believes that it is likely that evidence relating to the failure/ wrongdoing will be concealed or destroyed if the disclosure is made to the employer; or
  - the worker has previously made a disclosure to his/her employer.
- Additional conditions apply to other, wider disclosures to the police or the media. These disclosures can be protected if the worker reasonably believes that the disclosure is substantially true, the disclosure is of an exceptionally serious nature, and it is reasonable to make the disclosure.

Please note that these conditions do not apply to disclosures made to legal advisors in the course of obtaining legal advice.

Other considerations:

The government has now extended whistleblowing protection to allow workers who blow the whistle protection against bullying and harassment by co-workers. Co-workers who victimise whistleblowers could be held personally liable for their actions. Where bullying and harassment has taken place by co-workers, employers can be held vicariously liable (also responsible) for the actions of these employees unless they can show that they took reasonable steps to prevent victimisation. **For further information see the government website:** www.gov.uk/whistleblowing

The role of prescribed persons

Whilst your organisation's policy will hopefully give you the reassurance you need to raise your concern internally, there may be circumstances where it would be appropriate to report a concern to an outside body.

Special provision is made for disclosures to organisations or people designated as "*prescribed persons*" under PIDA. Those relevant to the NHS and social care include: the Care Quality Commission, Monitor, the Health and Safety Executive, the Charity Commissioners for England and Wales and the professional regulatory bodies. You can find details of prescribed persons for health and social care on page 39. From 6 April 2014, members of the House of Commons (M.P.s) have been added to the list of prescribed persons.

Such disclosures will be protected where the whistleblower meets the tests for internal disclosures and additionally, honestly and reasonably believes that the information and any allegation contained in it are substantially true.

The role of the Care Quality Commission (CQC)

The CQC is the regulator of healthcare and adult social care in England. It has a specially trained team at its National Customer Service Centre, that deals with all whistleblowing concerns that come to it. All whistleblowing emails, phone calls, letters, concerns raised in person at one of their offices or during an inspection, are routed and logged through the central team. The team then tracks each stage of follow-up until completion. All relevant concerns are passed to, and handled by, the local CQC inspector responsible for the care provider in question.

The Care Quality Commission is using staff surveys and the whistleblowing concerns it receives as part of the data in its new intelligent monitoring system, and since September 2013 the Care Quality Commission's new inspection system includes discussions with hospitals about how they deal with, and handle, whistleblowers.

FREQUENTLY ASKED QUESTIONS (FAQS)

1. Is whistleblowing the same as making a complaint?

Whistleblowing is about reporting a concern at work, and the Public Interest Disclosure Act only applies to workers raising concerns at work. Consequently the whistleblowing process cannot be used by a service user to make a complaint about poor care. If an individual or a carer has a complaint about poor care, they should ask to see the complaints procedure of the service about which they are complaining. All health and social care services are required to have a complaints procedure in place. The Care Quality Commission gives information about how to make a complaint on their website on link: www.cqc.org.uk/public/sharing-your-experience

2. What is the difference between a grievance and a public interest disclosure?

When someone raises a grievance, this tends to be an issue, problem or complaint about their work, working conditions or employment rights. The person wishes to complain to management about their treatment and they have a personal interest in ensuring the issue is addressed.

A concern raised through a protected public interest disclosure (a whistleblow) tends to be about malpractice or serious wrongdoing such as dangerous or criminal activity which affects others (e.g. patients or service users, members of the public, or their employer).

The whistleblower is not usually directly, personally affected by the danger or illegality. Therefore, the whistleblower should be treated as a messenger alerting others to a concern so that they can address it, and not be expected to prove the malpractice. They do not have a vested interest in the outcome of the whistleblow, unlike a grievance where they will normally be expected to be able to prove their case under the grievance procedure.

When an individual raises a concern with a manager, they should consider whether it is a qualifying whistleblowing issue or whether the matter is a personal employment issue which would be more appropriately dealt with through the organisation's grievance procedure.

3. Can a concern be raised in confidence or anonymously?

Workers are often concerned about possible reprisals and can ask for their identity to be kept confidential. If they want do this, the employer should make every effort to keep their identity secret. There may be circumstances in which, because of the nature of the investigation or disclosure, it will be necessary to disclose their identity. For example this could occur in connection with associated disciplinary, legal or police investigations. Where this is the case this should be fully discussed with the worker.

Concerns raised anonymously can be more difficult to deal with and investigate appropriately as the investigating manager may have little or no confirmed evidence to substantiate the allegations and cannot obtain further information from the worker or give them feedback. More action is likely or possible if concerns are not raised anonymously. It may be possible to raise the concern as a team/ group of colleagues if the worker does not want their individual identity to be known.

4. What about using confidential information?

In terms of confidential patient information, if you intend to report a concern outside of your health or social care team which might reveal someone's identity, you should get advice from your professional body or Trade Union. In particular, if you are thinking about things such as filming individuals you should be aware of the implications for their dignity and privacy. In the past, Employment Tribunals have not been sympathetic towards this kind of 'undercover' act as whistleblowing is primarily about disclosing information.

5. What about bullying and harassment?

*The Enterprise and Regulatory Reform Act imposed a new personal liability on co-workers who victimise or harass whistleblowers as well as vicarious liability on the part of their employers. Unless an employer has taken reasonable steps to prevent this type of victimisation by co-workers, it will be deemed liable for the acts of its staff. This means that it is no longer enough to deal with incidents of bullying or harassment as and when they arise, on a case by case basis. The only basis upon which an employer will now be able to defend itself against liability for the actions of its staff will be by proactive steps. In order to demonstrate a "**reasonable steps**" defence, an employer will need to anticipate conduct such as bullying and harassment.*

Having a clear policy is a vital first step, but it is just as important to ensure the communication of the policy and offering any necessary training to ensure it is put into effect. Undertaking any of these steps after the event is too late. It will also be important to take appropriate action if any workers are found guilty of causing detriments to other workers.

Proactive management to build/rebuild working relationships/teams after a concern has been raised (whistle has been blown) is recommended, with appropriate support and advice from HR, Trade Unions etc. It is always best to anticipate repercussions or reprisals and to take action to nip these types of behaviour in the bud.

6. What happens when you have concerns about someone who is employed by another organisation (e.g. in a multidisciplinary team)?

If you have concerns about someone's practice who works for another employer, you may wish to approach the person directly on an informal basis. If this is not possible or appropriate, you should report these concerns to your own manager and they should raise your concerns with the manager of the person about whom you have concerns.

7. What happens if someone has left their job (or been dismissed) but wants to pursue their concern?

If someone has raised a concern with their employer and then subsequently leaves their employment or has been dismissed, as a result of raising the concern, they could still be given protection under PIDA. However, if someone chooses to leave their employment or is dismissed and later decides to pursue a concern, it is unlikely that they would be protected under PIDA. Whilst there may not be protection under PIDA, if they wish to pursue the concern, the CQC have a disclosure line they can ring on 03000 616161. They can use this service to alert the CQC to a concern in confidence or anonymously. For full details, follow this link:
www.cqc.org.uk/content/whistleblowing-quick-guide-raising-concern-cqc

8. When an organisation is drafting its Whistleblowing Policy, it usually defines the scope of the policy, so that it is clear who the policy applies to. The law applies to workers, so that employees and agency workers are covered. What about subcontracted workers?

When drafting a whistleblowing policy it is important to consider the wider scope of the workforce. If an organisation contracts out work, they will need to think about how to approach subcontractors. One way of dealing with this is to establish that the subcontractor has its own effective whistleblowing procedures or agrees that the organisation's whistleblowing policy is adopted in relation to a threat or risk to the organisation. These options can be achieved through contractual arrangements with the subcontractor and legal advice should be sought.

FURTHER INFORMATION AND LINKS

NHS and Healthcare

Berwick, Professor Don (2013) "*A Promise to Learn: A Commitment to Act: Improving the Safety of Patients in England*" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

The Care Quality Commission gives advice on whistleblowing in the following pages: http://www.cqc.org.uk/sites/default/files/media/documents/20120117_whistleblowing_quick_guide_final_update.pdf

Care Quality Commission "*Whistleblowing: guidance for workers of registered care providers*", October 2012 (currently unavailable on website)

Care Quality Commission "*Whistleblowing: guidance for providers who are registered with the Care Quality Commission*", December 2011: http://www.cqc.org.uk/sites/default/files/media/documents/20120117_whistleblowing_quick_guide_final_update.pdf

Department of Health "*Confidentiality: NHS Code of Practice (2003) and supplementary code of practice on public interest disclosures (2010)*"

Department of Health (2013) "*Hard Truths: the journey to putting patients first*", Vols. 1 & 2 and Command Paper. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

Department of Health "*NHS Constitution*" (2013 edition) www.gov.uk/government/publications/the-nhs-constitution-for-england

Department of Health (2013) Patients First and Foremost: The Initial Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry, March 2013 https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, London: Stationery Office. Vols 1, 2 & 3. http://www.midstaffspublicinquiry.com/report

Rt. Hon Ann Clwyd MP and Professor Tricia Hart (2013) A Review of the NHS Hospitals Complaints System: Putting Patients Back in the picture.

General Dental Council gives advice on raising concerns at: http://www.gdc-uk.org/Dentalprofessionals/Fitnesstopractise/Pages/Advice-on-raising-concerns.aspx

General Medical Council (GMC) (2012) "*Raising and acting on concerns about patient safety*" http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp

The GMC has also developed a decision-making tool for doctors with concerns about patient safety to help them decide what to do: www.gmc-uk.org/guidance/ethical_guidance/decision_tool.asp

General Optical Council gives information on raising concerns at:
http://www.optical.org/en/Investigating_complaints/

General Osteopathic Council gives advice on raising concerns at:
http://www.osteopathy.org.uk/information/complaints/

General Pharmaceutical Council gives advice on raising concerns at:
http://pharmacyregulation.org/raising-concerns

Health Service Circular HSC 1999/198 "*The Public Interest Disclosure Act 1998: Whistleblowing in the NHS*", NHS Executive, 1999

Monitor is a regulator for the health sector and gives details of how to raise a concern with them at http://www.monitor-nhsft.gov.uk/about-monitor/contact-us/whistleblowing-policy

The **NHS Employers** organisation provides advice, guidance and examples of effective practice for NHS organisations on a wide range of workforce issues, including raising (whistleblowing) concerns and the use of settlement agreements and confidentiality clauses – see further information at
www.nhsemployers.org/raisingconcerns

Nursing and Midwifery Council Guidance on www.nmc-uk.org/Documents/NMC-Publications/NMC-Raising-and-escalating-concerns.pdf

Royal College of Nursing "*Raising concerns: a guide for RCN members*", March 2013
http://www.rcn.org.uk/support/raising_concerns

Royal College of Nursing "*Speaking Out – Whistleblowing Helpline*" gives straightforward guidance for nurses: http://www.rcn.org.uk/__data/assets/pdf_file/0015/510180/004391.pdf

Royal College of Surgeons gives guidance for surgeons "*Acting on Concerns*" at
http://www.rcseng.ac.uk/publications/docs/acting-on-concerns?searchterm=acting+on+concerns

Whistleblowing Helpline website www.wbhelpline.org.uk

Social Care

Care Quality Commission gives advice on whistleblowing in the following pages:
http://www.cqc.org.uk/sites/default/files/media/documents/20120117_whistleblowing_quick_guide_final_update.pdf

Care Quality Commission "*Whistleblowing: guidance for workers of registered care providers*", October 2012 (currently unavailable on website)

Care Quality Commission "*Whistleblowing: guidance for providers who are registered with the Care Quality Commission*", December 2011: http://www.cqc.org.uk/sites/default/files/media/documents/20120117_whistleblowing_quick_guide_final_update.pdf

Department of Health (2012) Transforming Care: A National Response to Winterbourne View Hospital. tinyurl.com/winterbourne-resp

The Social Care Institute for Excellence (SCIE) has webpages on whistleblowing for employees and employers on: www.scie.org.uk/publications/guides/guide15/whistleblowing/

Department of Health (2000) "*No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*" https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care

Department of Health (2009) "*The report on the consultation on the review of "No Secrets"*"

Health and Care Professions Council gives advice on raising concerns at: http://www.hpc-uk.org/complaints/

Skills for Care – the Social Care Commitment – a promise to improve the quality of care and support in adult social care www.thesocialcarecommitment.org.uk/Home/About

Skills for Care: the Common Induction Standards and Manager Induction Standards – find out more at: www.skillsforcare.org.uk/Standards/Standards.aspx

Skills for Care: the Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England – find out more at: www.skillsforcare.org.uk/Document-library/Standards/National-minimum-training-standard-and-code/CodeofConduct.pdf

Whistleblowing Helpline website www.wbhelpline.org.uk

General

Audit Commission for England and Wales has a document on Whistleblowing and the Public Interest Disclosure Act which can be downloaded from http://www.audit-commission.gov.uk/about-us/contact-us/whistleblowing/

British Standards Institute "*Code of Practice on Whistleblowing Arrangements*", PAS 1998:2008

Charity Commissioners for England and Wales gives guidance on whistleblowing at: http://www.charitycommission.gov.uk/detailed-guidance/protecting-your-charity/guidance-for-auditors-and-independent-examiners/the-public-interest-disclosure-act/

Chartered Institute of Personnel and Development "*Whistleblowing*" CIPD factsheet, revised May 2013 http://www.cipd.co.uk/hr-resources/factsheets/whistleblowing.aspx

Chartered Institute of Personnel and Development "*Whistleblowing law FAQs*"

Department for Business Innovation & Skills "*The Whistleblowing Framework: Call for Evidence*", July 2013

The Government's website on whistleblowing: www.gov.uk/whistleblowing

The Health and Safety Executive provides information on raising concerns on:
http://www.hse.gov.uk/contact/concerns.htm

National Audit Office "*Assessment criteria for whistleblowing policies*" January 2014
http://www.nao.org.uk/wp-content/uploads/2014/01/Assessment-criteria-for-whistleblowing-policies.pdf

National Audit Office "*Making a whistleblowing policy work*", March 2014
http://www.nao.org.uk/wp-content/uploads/2015/03/Making-a-whistleblowing-policy-work-summary.pdf

The Pensions Regulator gives information on raising concerns on:
http://www.thepensionsregulator.gov.uk/individuals/reporting-a-concern.aspx

Public Concern at Work and the University of Greenwich (2013) "*Whistleblowing: the Inside Story – a study of the experiences of 1,000 whistleblowers*", Public Concern at Work.

The Whistleblowing Commission (2013) "*Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK*", Public Concern at Work.

The Whistleblowing Helpline (2013) "*Bridging the Gap*".
http://www.wbhelpline.org.uk/category/campaigns/

Training tools and resources

The Whistleblowing Helpline can provide training packages on raising concerns for delivery to workers, and training for managers on how to respond positively to workers raising concerns.
To find out more, email enquiries@wbhelpline.org.uk, telephone 08000 724725 or visit the Whistleblowing Helpline website www.wbhelpline.org.uk

The North West Dignity Leads Network have produced a training package on Speaking Up on Poor Practice aimed at staff who witness poor practice in social care and health. It uses a workbook approach, offering guidance on assessing the situation and deciding what action to take. As well as giving practical suggestions on handling the situation, the package includes case studies and practice scenarios.
The pack is available for free download from www.nwdignity.co.uk/challenge-poor-practice

LIST OF PRESCRIBED PERSONS

a) The secondary legislation under PIDA lists "prescribed persons". The following are the most relevant to the health and care sectors:

Care Quality Commission, 03000 616 161 www.cqc.org.uk

Monitor, 020 7340 2400 – the regulator for the health sector, making sure the system works effectively for patients www.monitor-nhsft.gov.uk

Nursing and Midwifery Council (NMC) http://www.nmc-uk.org/

General Chiropractic Council (GCC) http://www.gcc-uk.org/page.cfm

General Dental Council (GDC) http://www.gdc-uk.org/Pages/default.aspx

General Medical Council (GMC) – regulator for medical doctors throughout the UK in all healthcare sectors 0161 923 6602 www.gmc-uk.org

Health and Care Professions Council (HCPC) – regulator for the allied health professions 0845 300 6184 http://www.hpc-uk.org/

General Optical Council (GOC) http://www.optical.org/

General Osteopathic Council (GOsC) http://www.osteopathy.org.uk/

General Pharmaceutical Council (GPhC) http://pharmacyregulation.org/

Audit Commission for England and Wales and auditors appointed by the Commission to audit the accounts of local government, and health service, bodies www.audit-commission.gov.uk

Charity Commissioners for England and Wales www.charitycommission.gov.uk

Comptroller and Auditor General

Children's Commissioner

Health and Safety Executive www.hse.gov.uk

Information Commissioner

Pensions Regulator www.thepensionsregulator.gov.uk

b) Other persons to which a protected disclosure may be made:

These include the Secretary of State for Health and other health and social care Ministers, and legal advisers (provided other criteria and procedural requirements in PIDA are met). With effect from 6 April 2014, members of the House of Commons (M.P.s) have been added to the list of prescribed persons, in respect of any matter listed in the Schedule (which includes health and social care).

c) Other bodies to which a concern may be raised, but it will not be treated as a protected disclosure within the meaning of PIDA:

Department of Health (England), 020 7210 4850 www.dh.gov.uk

Professional Standards Authority for Health and Social Care, 020 7389 8030 www.professionalstandards.org.uk

The **NHS Fraud and Corruption Reporting Line** is 0800 028 40 60. All calls will be treated in confidence and investigated by professionally trained staff.
Email: ciu@nhsprotect.gsi.gov.uk www.reportnhsfraud.nhs.uk

This guidance is intended for workers/employers in England. For Scotland and Wales, other prescribed persons and organisations exist:

Wales:

Care and Social Services Inspectorate Wales – Responsible for social services and care homes 0300 060 3300 www.cssiw.org.uk

Health Inspectorate Wales – Responsible for all NHS-funded care (including independent hospitals) 029 2092 8850 www.hiw.org.uk

Department for Health and Social Services (Wales):

English 0845 010 3300

Welsh 0845 010 4400 www.wales.gov.uk

Scotland:

Care Inspectorate 0845 600 9527 www.careinspectorate.com

Healthcare Improvement Scotland

Edinburgh 0131 623 4300

Glasgow 0141 225 6999

http://www.healthcareimprovementscotland.org/

The Scottish Government 0131 556 8400 or 0845 7741 741 www.scotland.gov.uk

Scottish Social Services Council www.sssc.uk.com

Social Care and Social Work Improvement Scotland www.cne-siar.gov.uk

MODEL LETTER FOR STAFF TO RAISE CONCERNS INTERNALLY

Raising Concerns Disclosure Form
STRICTLY CONFIDENTIAL

This form is to be completed by individuals who want to raise a concern under the Public Interest Disclosure Act 1998. Please send when complete to one of the [employer to insert names/job titles of appropriate managers as per organisation's policy], in an envelope marked Private and Confidential.

SECTION 1 – DETAILS OF THE PERSON RAISING THE CONCERN

If you wish to remain anonymous, please go straight to section 2. However please note that whilst such concerns will be given due consideration, it will not be possible to progress matters in accordance with this policy (cross refer to the section of your policy which deals with anonymous reporting)

Name:..

Home Address: ....

....

....

Home contact number/mobile:...

Work Address: ....

....

....

Work contact number/mobile...

Which address do you wish any correspondence to be sent to? :

Home address/Work address (please delete as appropriate)

Date disclosure form submitted:...

SECTION 2 – DETAILS OF THE DISCLOSURE

What is your concern about? (please tick)

- ☐ Patient/service user care
- ☐ Patient/service user safety
- ☐ Conduct (including malpractice, unethical conduct)
- ☐ Criminal offence/legal obligation
- ☐ Professional/clinical practice or competence

Other (please state)..

Who is involved? Please list witnesses and anyone carrying out the act causing you concern, and the date(s), time and place(s) the act occurred:

....

....

Please describe what has happened/what you think will happen. Please provide as much detail as you can (use additional sheets of paper as needed):

....

....

SECTION 3 – PERSONAL INVOLVEMENT/PERSONAL INTEREST

Please declare any personal interest you may have in this matter (i.e. does the outcome of this matter have the potential to affect you personally in any way?)

....

Have you personally been involved in this matter previously? YES / NO

If yes, please outline your involvement:

....

SECTION 4 – EXPRESSED PREFERENCES

Do you wish your identity to be kept confidential (bearing in mind that, depending on the nature of the investigation or disclosure, it may become necessary to disclose your identity)? YES/NO

NOTES

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Role of the Whistleblowing Helpline:

The Whistleblowing Helpline offers free*, confidential and independent advice about whistleblowing processes to people working in the NHS and adult social care.

The helpline can be reached by telephoning 08000 724725,
emailing enquiries@wbhelpline.org.uk or visiting the website on www.wbhelpline.org.uk

The helpline is available weekdays between 08.00 and 18.00 with an out of hours answering service on weekends and public holidays.

*Call charges from mobiles may vary.