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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.

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[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 ☐

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.

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

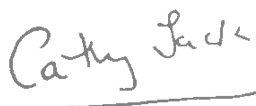
Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy 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:

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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)					

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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.

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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.

<table>
<tr><td colspan="4"></td></tr>
<tr><td colspan="2">Shared Learning
</td><td>Ref. No.</td><td>Date issued:</td></tr>
<tr><td colspan="4">Safety Message:</td></tr>
<tr><td colspan="4">Summary of Event</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Learning Points</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Learning applicable to:</td></tr>
<tr><td>Specific Directorate(s) (specify):</td><td></td><td>Trustwide</td><td></td></tr>
<tr><td>Other (specify):</td><td></td><td>Regional</td><td></td></tr>
<tr><td colspan="4">Action Required (for discussion and agreement at Learning from Experience Steering Group / SAI Group or other appropriate group)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Approved by:</td><td colspan="2">Designation:</td><td>Date approved:</td></tr>
</table>

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)

<u>**BHSCT RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)**</u>

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.

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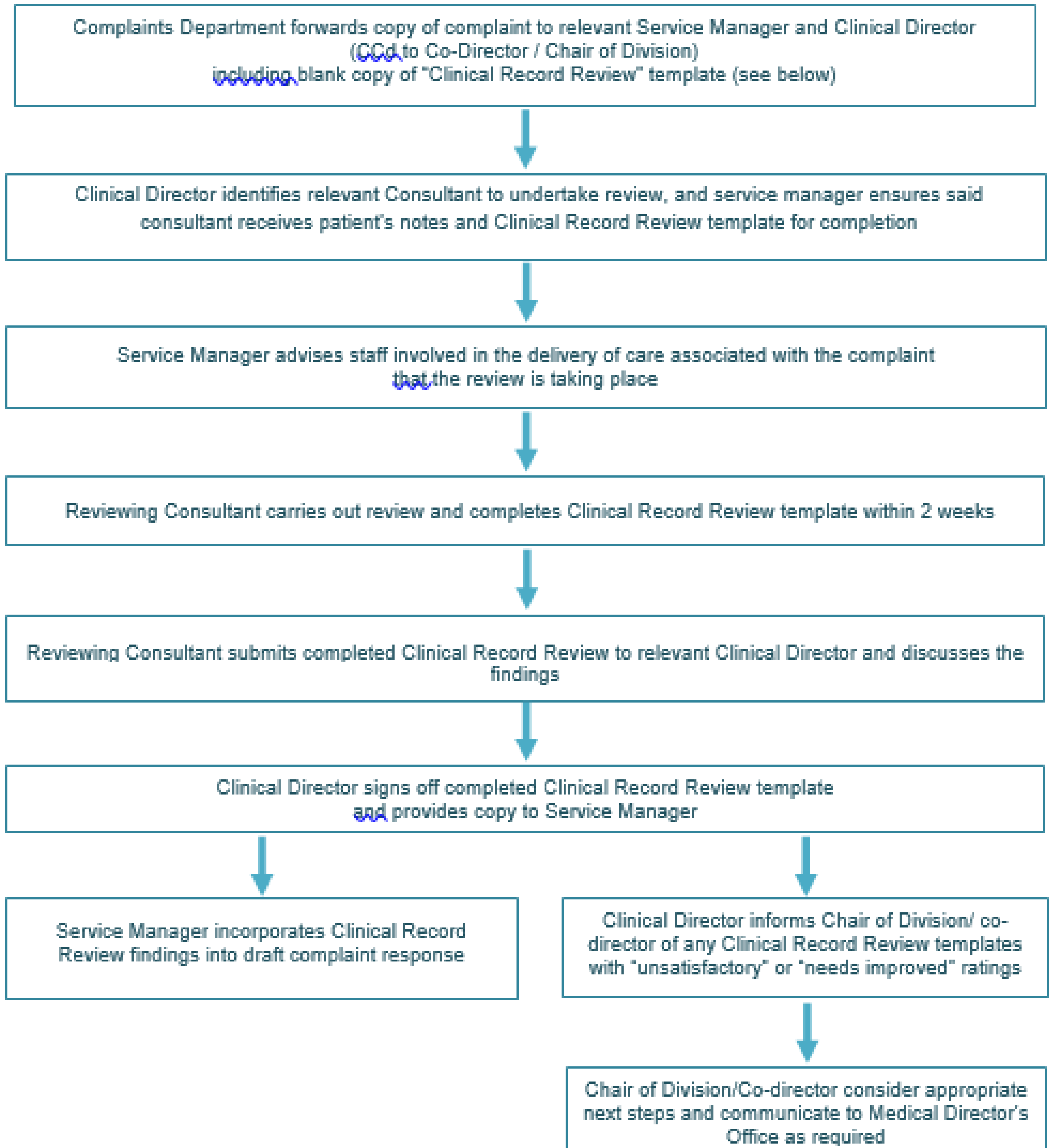
Clinical Record Review – Process

This process should be followed for all complaints relating to Quality of Treatment and Care



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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

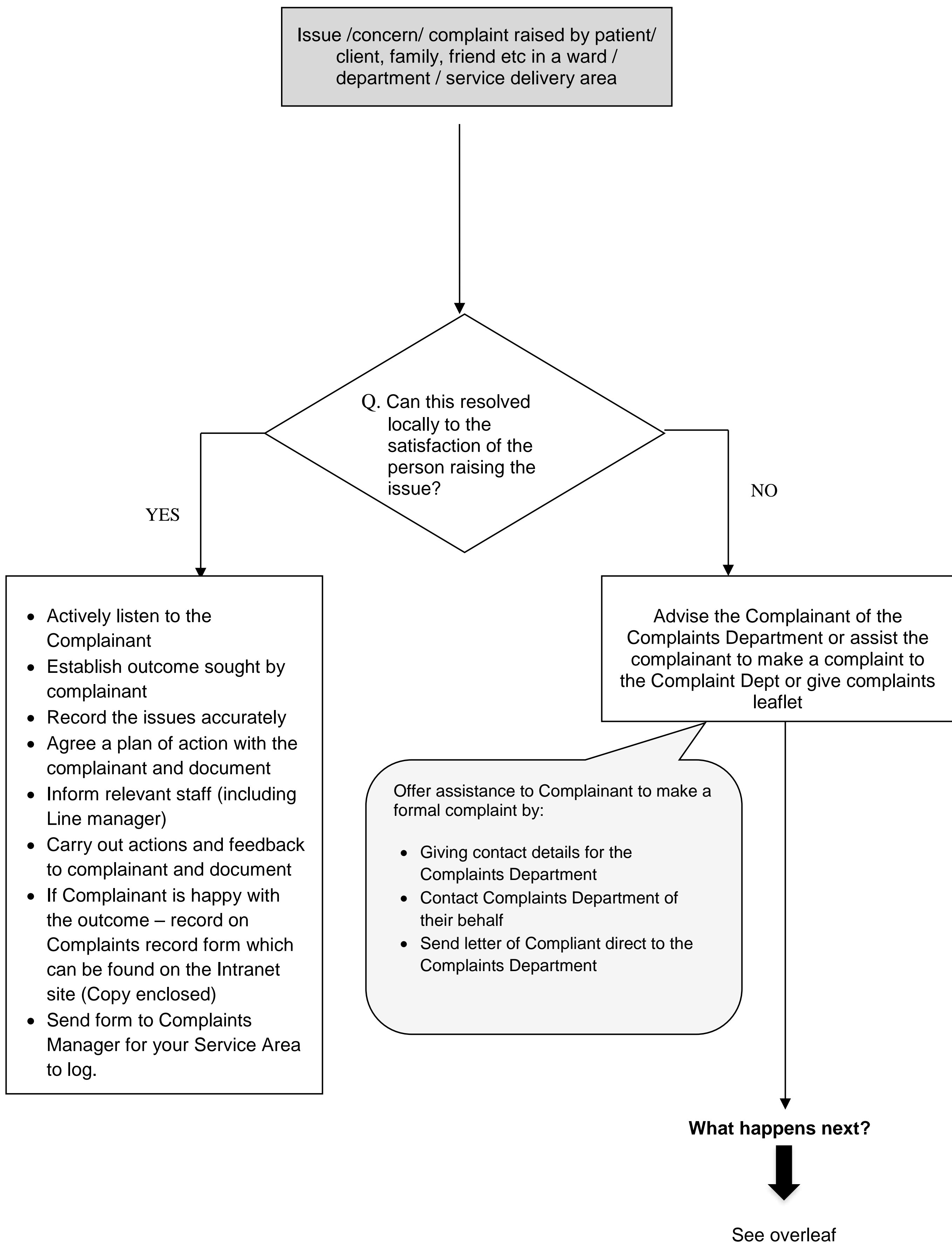
Satisfactory care:- *Care which complies in all aspects with the standard expected taking into consideration the wider systemic issues.*

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



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.

↓

Investigating Manager will undertake appropriate investigation (including Clinical Record Review / Independent Review where relevant) and provide draft response letter – reviewed and approved by Co-Director – to relevant Complaints Manager **within 10 working days**

↓

Complaints Manager will Quality Assure (QA) the approved draft response including ensuring that all points of the complaint are adequately addressed

↓

Complaints Manager forwards QAd draft response and associated files to the relevant Director's office for signature

↓

Director reviews final draft response. If required, Director sends to Service Area (copied to Complaints Manager) for any amendments. Service Area returns amended response to Director (copied to Complaints Manager) for final approval.

↓

Director carries out final QA review and signs off.
Response issued to complainant by Trust HQ (copied to Complaints Admin).

↓

Complaint Manager will ensure signed copy of the response is issued to all relevant staff, and records all aspects of complaints process on Datix

↓

Learning from complaint to be identified by the Service Area. Co-Director ensures progression of any required actions arising from learning, including appropriate sharing of learning
(NB: In all such cases the Governance Manager will be advised)

↓

Service Area will forward completed form identifying all staff where the complaint investigation has identified potential areas of concern to the Complaints Department within **2 weeks** of the complaint being closed.

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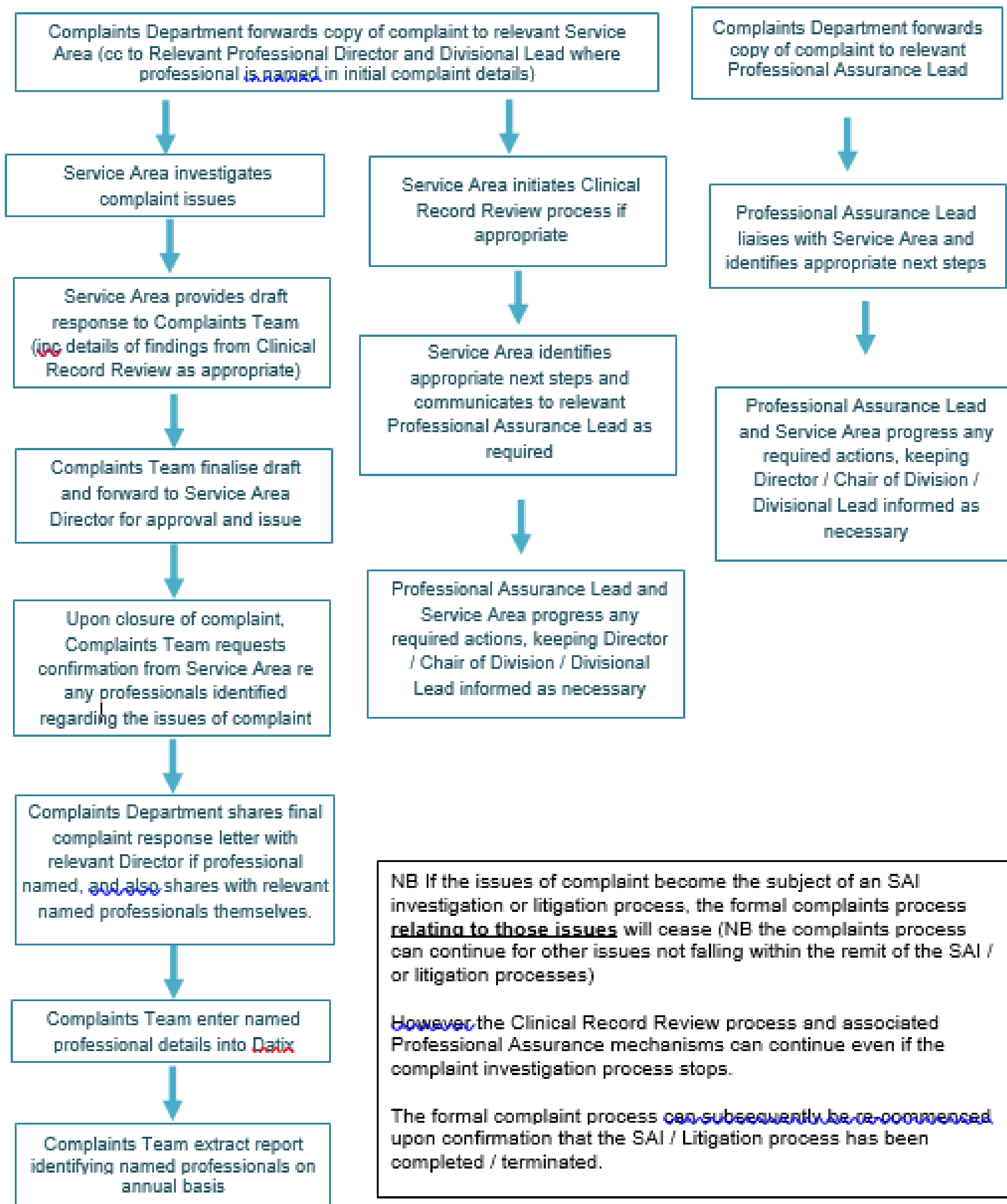
Professional Assurance Process - Complaints

Process to be followed for any complaint received where a professional is named



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

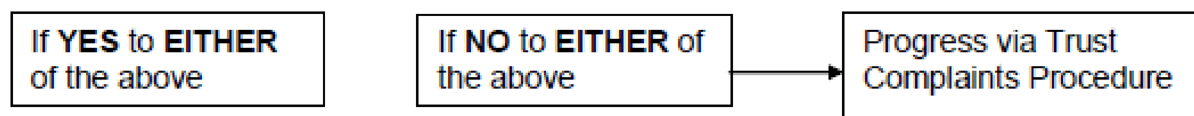
Children Order Representations and Complaints Procedure

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

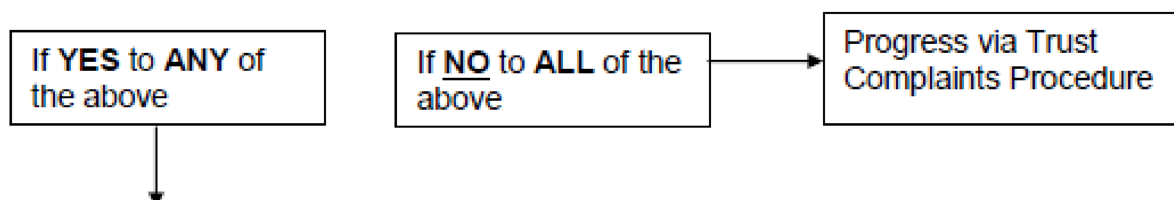
"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and paragraph 6 of Schedule 5 to, the Children Order." (Guidance and Regulations – Vol.4, Para 12.5 – DHSS)



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. <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

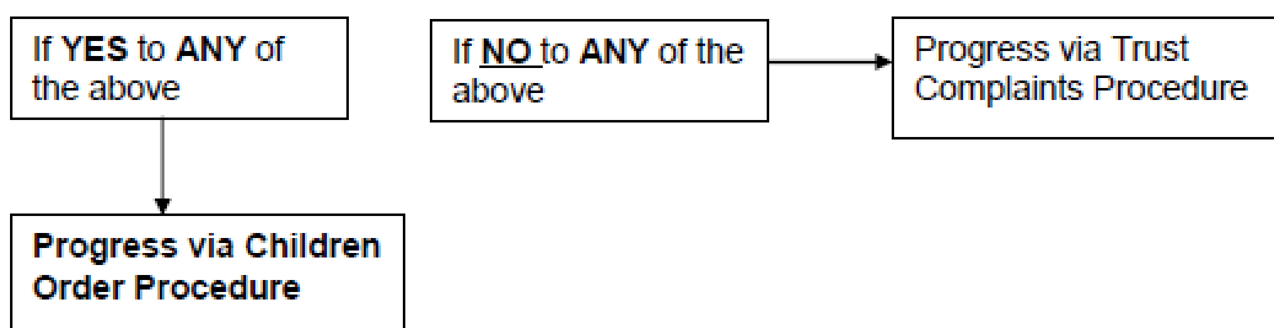
c. A parent **of his/her**

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 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.

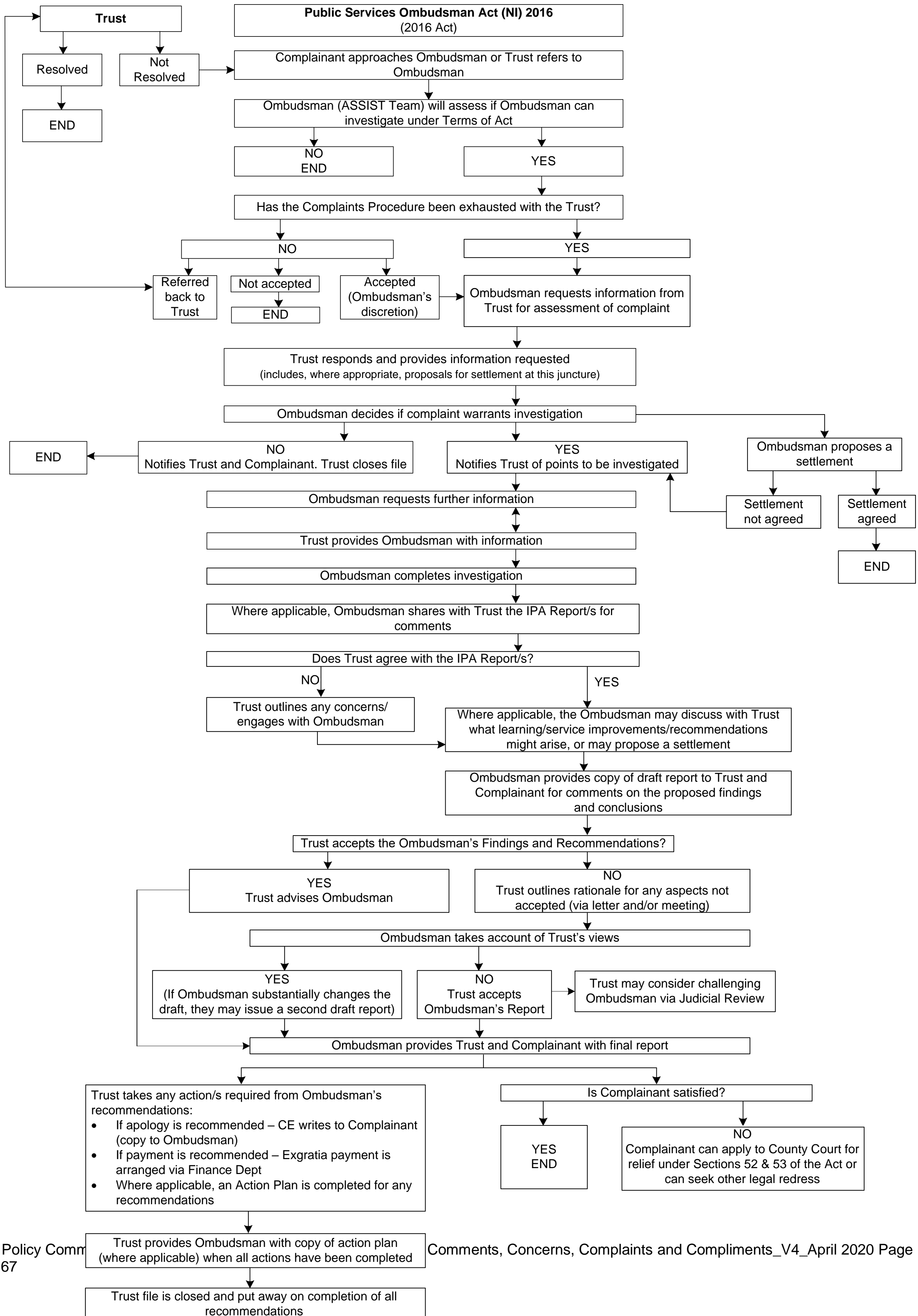
1. On receipt of the Ombudsman's Draft Report, the Complaints Manager will email a copy of the Draft report to all key stakeholders and advise of timescale for response.
2. Complaints Manager may arrange a meeting of all relevant staff to:
   a) Consider and agree the issues raised in the draft findings 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)



NIPSO Correspondence Protocol - Requests for information, 3 week timeframe

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 – <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 B below) must be completed by Service Area and submitted to Director for sign off. Complaints Team will then submit to NIPSO.*

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Northern Ireland Public Services Ombudsman – Response Tracker APPENDIX A

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							

Please complete this template and return via e-mail to the relevant Complaints Manager within **2 working days of receipt**

Northern Ireland Public Services Ombudsman – Extension Request Template APPENDIX B

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.*

Belfast Health and Social Care Trust
caring supporting improving together **Northern Ireland Public Services Ombudsman – Response QA Checklist Template** APPENDIX C

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.