

Title:	Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments		
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Ownership:	Dr Chris Hagan, Medical Director		
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Date	Version	Author	Comments
25/06/2019	3.1	Rachel Maxwell	Initial Draft
20/09/2019	3.2	Rachel Maxwell	Amendments / Comments
08/01/2020	3.3	Rachel Maxwell	Amendments to reflect Medical Director's Comments

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.

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 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

- 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)

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 required)
- inform their line manager and other team members (if appropriate) when they receive a written compliment from service users

4.0 KEY POLICY PRINCIPLES

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

Information and Communication						
Environment						
Other						

**Social Media refers to compliments received by official Facebook and Twitter accounts only*

All compliments received by the Chief Executive or Complaints Department will be acknowledged and shared with the staff/department named, and details recorded on Datix.

4.4 How can complaints be made?

Every assistance will be given to individuals who wish to make a complaint, including the provision of interpreter services or any other service that may enhance the communication of the complaint to the organisation. Patients must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint.

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

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

Complaints may be made to any member of staff - for example receptionists, medical or care staff. In many cases complaints are made orally and front-line staff may resolve the complaint "on the spot". As such, all front-line staff must be trained and supported to respond sensitively to comments; concerns and complaints raised and be able to distinguish those issues that would be better referred elsewhere.

Front line staff should familiarise themselves with the the DoH Guidance in relation to the Health and Social Care Complaints Procedure, and the Parliamentary Health Service Ombudsman's principles for dealing with and managing complaints.

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

4.5 Complaint Management processes

Where a concern or complaint is made within a Service Area, every attempt should be made to achieve resolution at that time.¹ Where frontline resolution has been unsuccessful, the complainant should then be offered the option of contacting the Complaints Department.

All formal complaints must be formally acknowledged within 2 working days. Where possible the complainant's issues and expected outcomes from the complaint will be clarified and a timescale for response agreed. The format of the response will also be agreed with the complainant, this may be verbal (by phone or at a meeting), by email or written letter.

¹ All complaints raised with front line staff should be recorded on "Frontline Resolution" forms (these can be found on the Trust intranet, see Appendix 7) including details of any actions taken and the outcome of such. Completed forms should be forwarded to the Complaints Department for entry onto the Datix system.

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.

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

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.

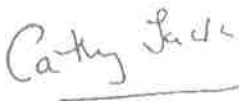
SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



Chris Hagan
Interim Medical Director

Date: 8 April 2020



Cathy Jack
Chief Executive

Date: 8 April 2020

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

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Action Taken

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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**

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:

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)				

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.

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.

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.

BHSCT RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency	Probability
<i>Almost certain</i>	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
<i>Likely</i>	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
<i>Possible</i>	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
<i>Unlikely</i>	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
<i>Rare</i>	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

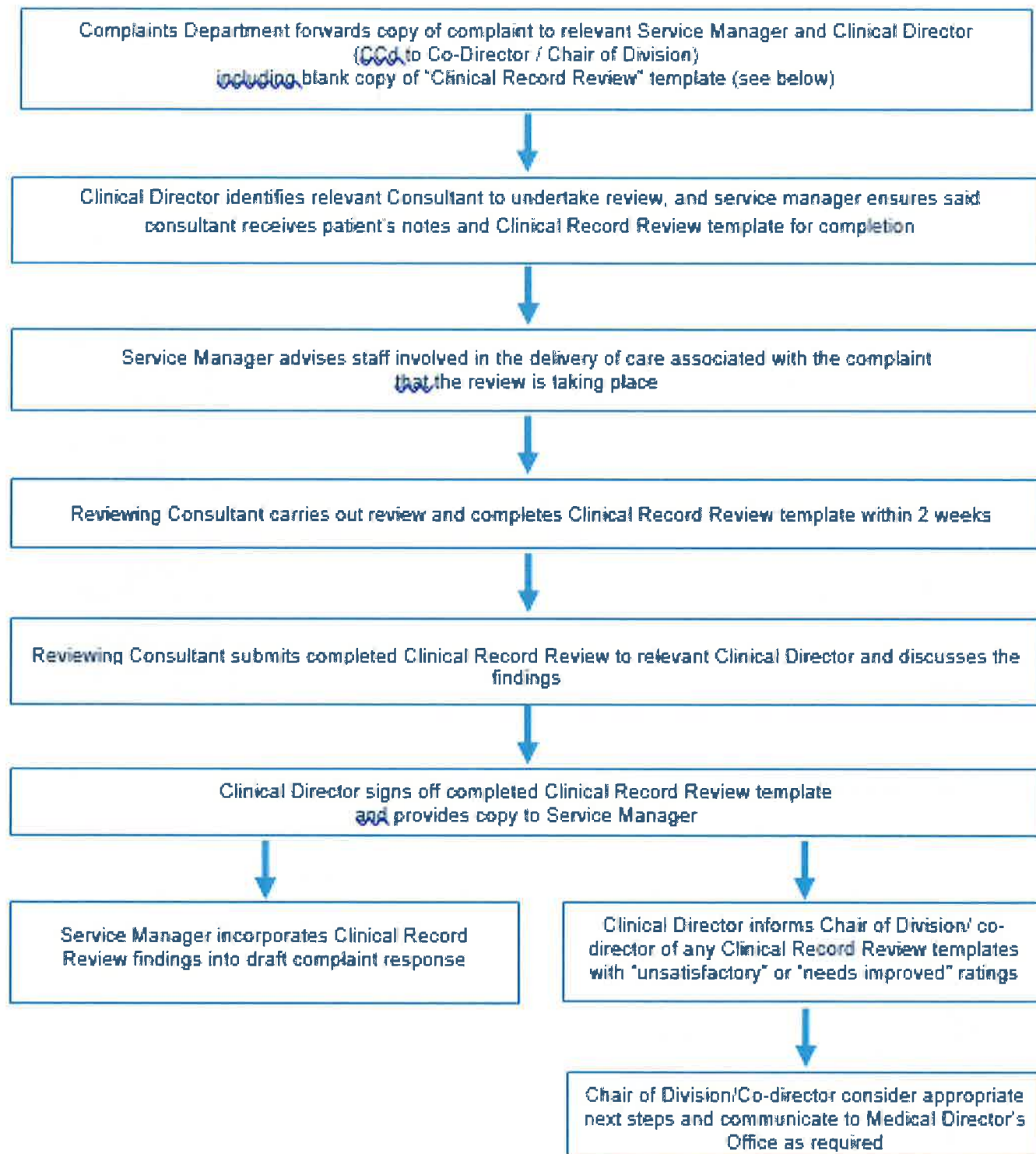
Likelihood Scoring Descriptors	Consequence Levels				
	Insignificant(1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
	Almost Certain (5)	Medium	High	Extreme	Extreme
	Likely (4)	Low	Medium	High	Extreme
	Possible (3)	Low	Medium	High	Extreme
	Unlikely (2)	Low	Medium	High	High
	Rare (1)	Low	Medium	High	High

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.

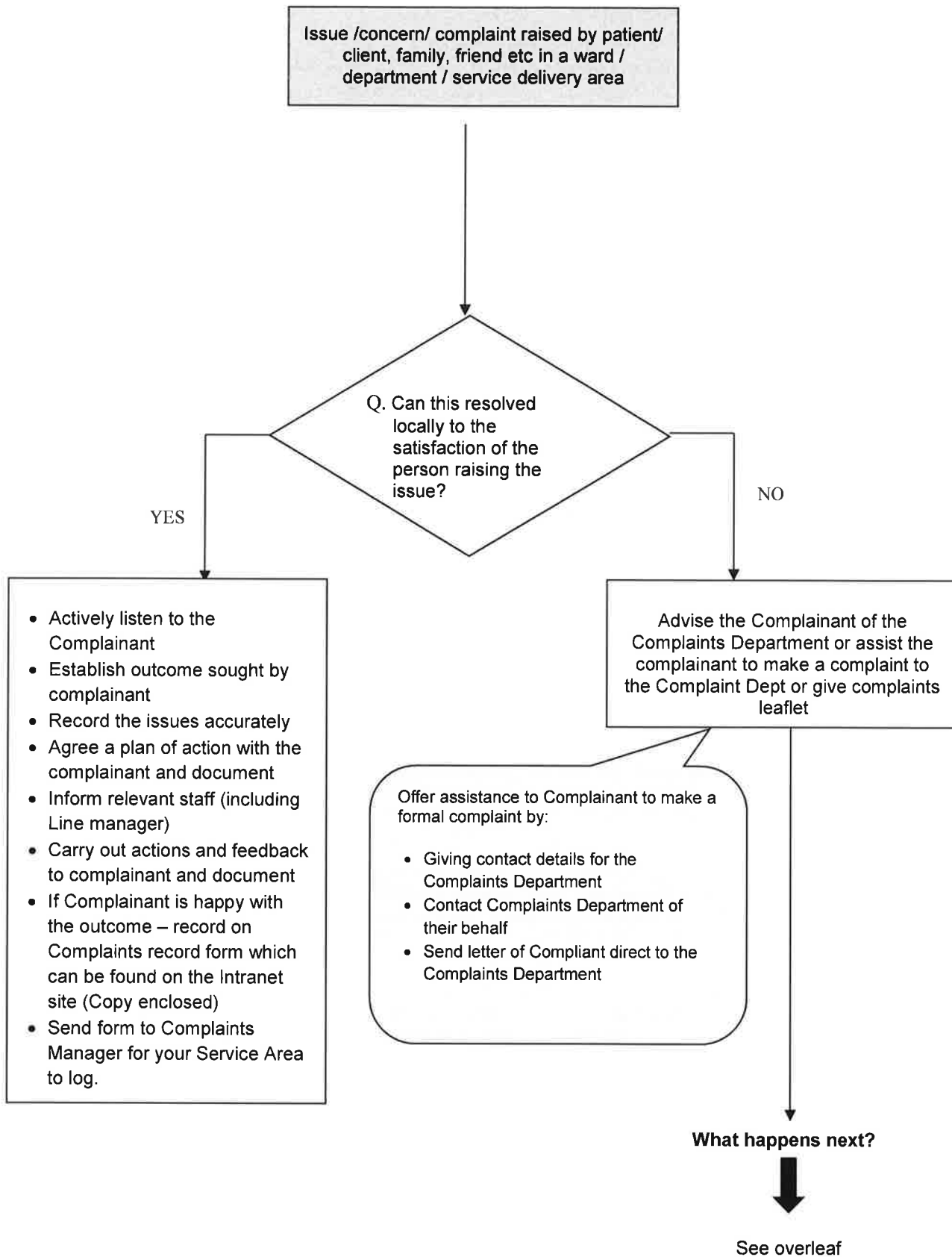
Clinical Record Review – Process

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



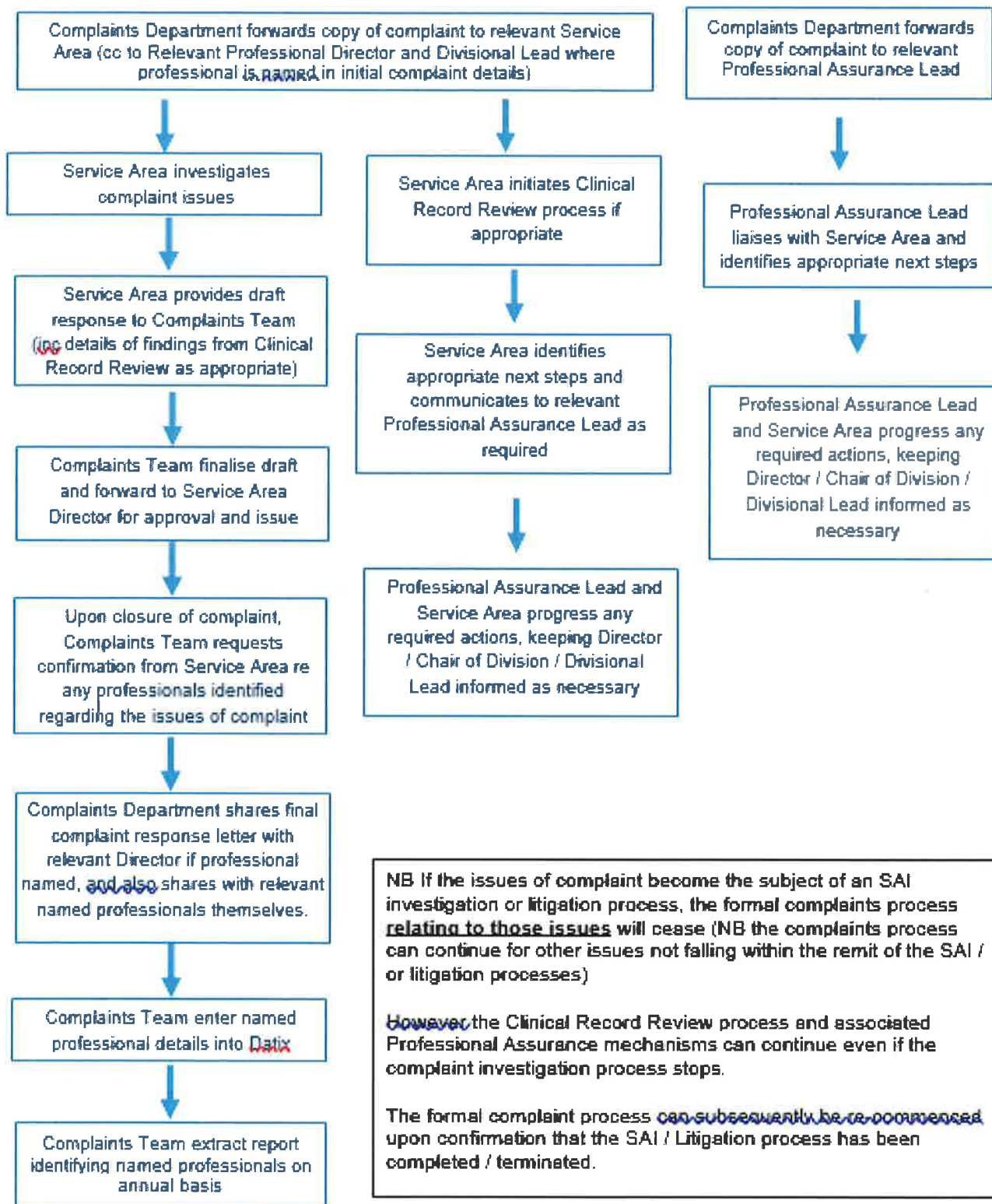
Appendix 4

Complaint Process Flowcharts



Professional Assurance Process - Complaints

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



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

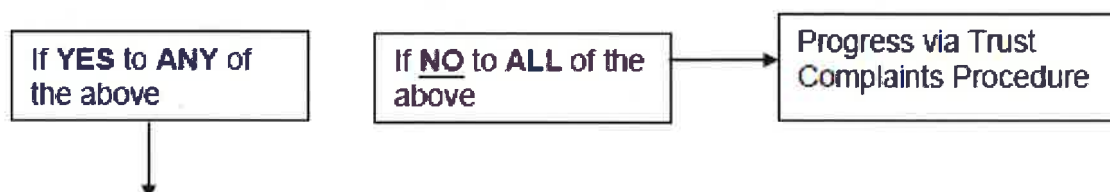
“A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust’s exercise of its functions under Part IV of, and paragraph 6 of Schedule 5 to, the Children Order.”
(Guidance and Regulations – Vol.4, Para 12.5 – DHSS)



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.



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 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.

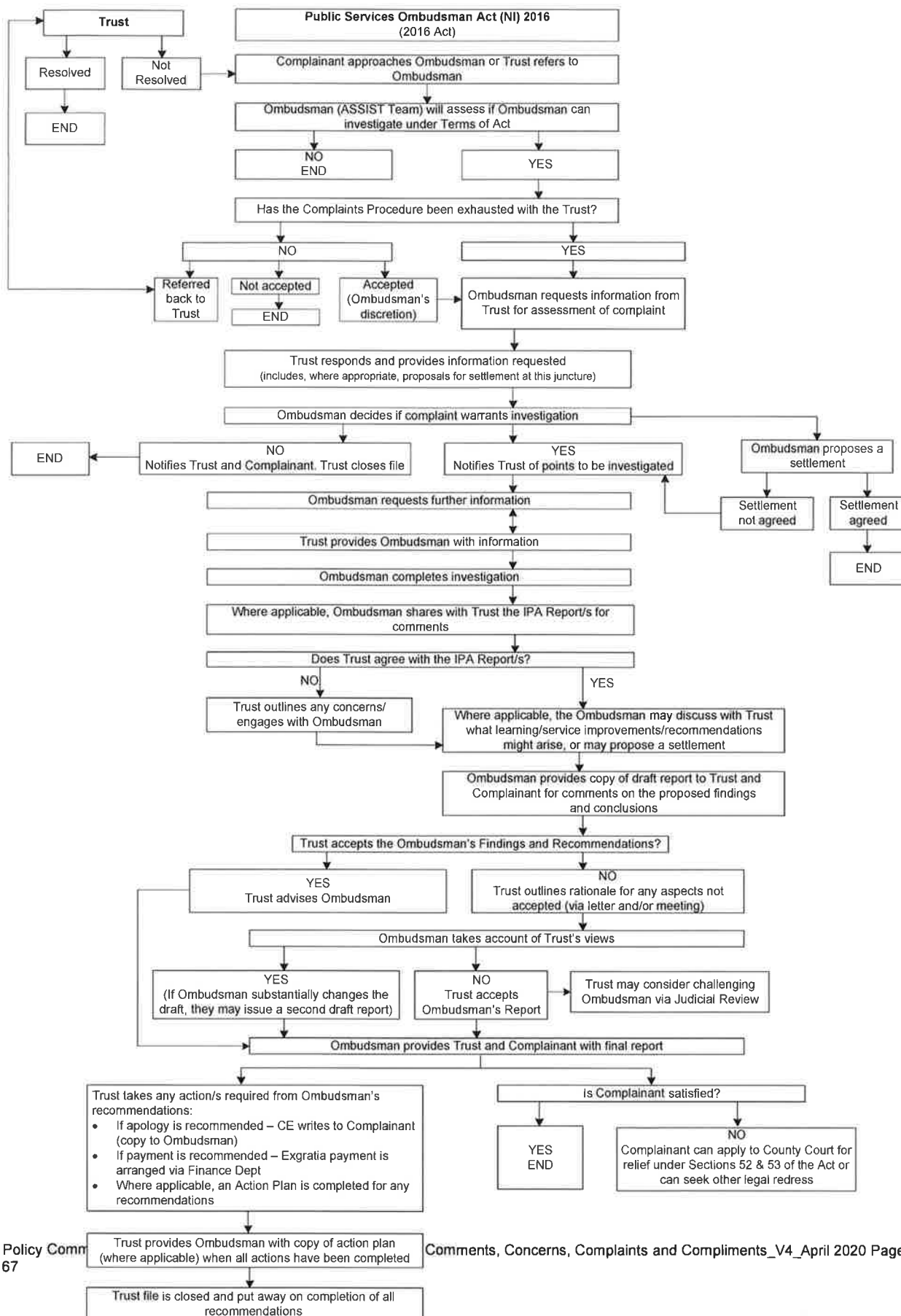
1. Complaints Admin will open a File to hold all documentation in relation to the Ombudsman's correspondence.
2. Senior Complaints Manager and Complaints Manager will discuss and agree an action plan and confirm which Co-Director will take responsibility for overseeing a response.
3. Complaints Admin 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.

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 Group to 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)



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 required escalation to ensure provision of required information by [Insert BHSCT HQ Deadline] ?
			Name	Contact details	
1	Populated by Complaints Team – to be reviewed by Service Area				
2					
3					
4					
Any additional issues identified by Service Area requiring provision of information as part of NIPSO response:					
5					
6					

Complaint C/xxxx/xx NIPSO Ref xxxxx 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?	☐	☐	☐	
<u>Complaints Department</u>					
Completed by: _____ Role: _____ Date: _____					
<u>Trust HQ</u>					
Comments: (about any required amendments or other concerns)					
Signed..... (Director) Date.....					

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.

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

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.

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.

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.

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.



Department of
Health

An Roinn Sláinte

Männystrie O Poustie

www.health-ni.gov.uk

**GUIDANCE IN RELATION
TO THE**

**HEALTH AND SOCIAL CARE
COMPLAINTS PROCEDURE**

Updated April 2022

REVISIONS TO HSC COMPLAINTS PROCEDURE

Title	Update/Action	Date Effective
Guidance in relation to the Health and Social Care Complaints Procedure	Updated to reflect the closure of the Health and Social Care (HSC) Board and migration of functions to Strategic Planning and Performance Group (SPPG), DoH.	01 April 2022
Guidance in relation to the Health and Social Care Complaints Procedure	Introduced in place of: Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	01 April 2019
Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	Introduced in place of: (HPSS) Complaints Procedure 1996	01 April 2009
Health and Personal Social Services (HPSS) Complaints Procedure 1996	Revoked and replaced with new Guidance	31 March 2009

AMENDMENTS TO COMPLAINTS DIRECTIONS

Directions	Details	Date Effective
Health and Social Care Complaints Procedure Directions	The Main Directions were amended for the third time at: CURRENTLY WITH DSO	Xx xxxxx 2022
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The HSC Board Directions were revoked. CURRENTLY WITH DSO	Xx xxxxxx 2022
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The PHA Directions were amended for the second time at: CURRENTLY WITH DSO	Xx xxxx 2022

Directions	Details	Date Effective
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The BSO Directions were amended for the second time at: CURRENTLY WITH DSO	Xx xxxx 2022
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The BSO Directions were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	01 April 2019 2019 No. 4
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The PHA Directions were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and	01 April 2019 2019 No. 3

Directions	Details	Date Effective
	- Paragraph 7(4) where paragraph 7(4A) was added in regard to SAls. - Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol	
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The HSC Board Directions were amended for the third time at: - Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman - Paragraph 2 (Interpretation), where the definition of an SAI was added; - Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAls; and - Paragraph 7(4) where paragraph 7(4A) was added in regard to SAls. - Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol - Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b)	01 April 2019 2019 No. 2

Directions	Details	Date Effective
	substitute(b) The HSC Board Complaints Manager acts impartially as “honest broker” to the complainant and Practice/Practitioner in the resolution of the complaint.	
Health and Social Care Complaints Procedure Directions	The Main Directions were amended for the second time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—update to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as “honest broker” to the complainant and Practice/Practitioner in the resolution of the complaint.	01 April 2019 2019 No. 1

Directions	Details	Date Effective
	Paragraph 14 (Response) of the principal Directions omit sub-paragraph (7).	
Complaints about Family Health Services Practitioners and Pilot Scheme Providers (Amendment) Directions (Northern Ireland) 2013	The HSC Board Directions were amended for the second time in regard to the handling of complaints under paragraph 12(5)(b) at: - Paragraph 18(c) (Response) was amended to include sub-paragraph 18(c)(i) to respond to the complainant within 20 days when the HSC Board has been asked to act as 'honest broker'; and - Sub-paragraph 18(c) (ii) to respond to the complainant within 10 days in all other cases.	02 September 2013 2013 No. 12
Health and Social Care Complaints Procedure Directions (Amendment) (Northern Ireland) 2009	The Main Directions were amended for the first time at: - Paragraph 2 (Interpretation), where the definition of an SAI was added; - Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and - Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	02 September 2013 2013 No. 11
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The Directions were introduced. Known as BSO Directions	26 July 2010
Directions to the Regional Agency for Public Health	The Directions were introduced. Known as PHA Directions	26 July 2010

Directions	Details	Date Effective
and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints		
Amendment Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The HSC Board Directions were amended for the first time in respect to monitoring and the requirement by the Family Practitioner Services or pilot scheme provider to obtain consent from the complainant was removed at: Paragraph 21(2)(a) in regards to what the practitioner must send to the HSC Board and the timescale: and Paragraph 21(2) (b) in regards the practitioner sending the HSC Board quarterly complaints.	01 October 2009
Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The Directions were introduced. Known as HSC Board Directions	01 April 2009
Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009	The Directions were introduced. Known as Main Directions	01 April 2009

BACKGROUND

The HSC Complaints Procedure, '*Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*' was developed and published in 2009. It replaced the former Health and Personal Social Services (HPSS) Complaints Procedure 1996 and provided a streamlined health and social care (HSC) complaints process that applies equally to all HSC organisations. As such it presented a simple, consistent approach and set out complaints handling procedures with clear standards and guidance for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

The HSC Complaints Procedure (published 2009) was developed in conjunction with HSC organisations and publically consulted on before being finalised and published. It reflected the changing culture across HSC services and demonstrated an increased emphasis regarding the promotion of and need for **safety and quality** in service provision as well as the need to be open and transparent; and to learn from complaints and take action in order to reduce the risk of recurrence.

On the 1st April 2019 revised guidance was introduced and incorporated a number of legislative changes. The document was renamed, '*Guidance in relation to the Health and Social Care Complaints Procedure*' or '*HSC Complaints Procedure*' for short.

The HSC Complaints Procedure presents HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution and learning;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well-defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as the use of independent experts, lay persons and conciliation;
- resolve complaints quickly and efficiently;
- provide flexibility in relation to target response times;

- provide an appropriate and proportionate response within reasonable and agreed timescales;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the region.

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

[Standard 1: Accountability](#)

[Standard 2: Accessibility](#)

[Standard 3: Receiving complaints](#)

[Standard 4: Supporting complainants and staff](#)

[Standard 5: Investigation of complaints](#)

[Standard 6: Responding to complaints](#)

[Standard 7: Monitoring](#)

[Standard 8: Learning](#)

More details on each of the standards are provided in Annex 1 of this document.

It is recognised that sometimes, and even in despite of the best efforts of all concerned, there will be occasions when local resolution fails. Where this happens the complainant will be advised of their right to refer their complaint to the Ombudsman. The HSC Organisation also reserves the right to refer complaints to the Ombudsman.

Update – 01 April 2022

As a result of the migration of the HSC Board to the Department of Health this guidance has been amended to reflect the transfer of the HSC Board functions in respect of HSC Complaints to the Strategic Planning and Performance Group (SPPG) in the Department.

SPPG will on behalf of the Department of Health assume the roles and responsibilities previously undertaken by the HSC Board. This updated guidance is effective from 01 April 2022.

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SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

1.1 This document is an updated version of the HSC Complaints Procedure which was first published in 2009 and sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces any previous or existing guidance with effect from 01 April 2022 and continues to provide a streamlined complaints process which applies equally to all HSC organisations, including the HSC Trusts, Business Services Organisation (BSO), Public Health Agency (PHA), NI Blood Transfusion Service (NIBTS), Family Practitioner Services (FPS), Out of Hours services, pilot schemes and HSC prison healthcare. As such, it presents a simple, consistent approach for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

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

Local resolution

1.3 The purpose of local resolution is to enable the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10 working days within FPS settings). The expectations of service users should be

managed by HSC staff and any difficulties identified in being able to resolve a complaint within 20 days by local resolution should be communicated to the service user immediately.

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

Principles of an effective Complaints Procedure

1.6 The HSC Complaints Procedure has been developed around four key principles:

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

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements. Lessons learned during the complaints resolution process will assist organisations to make changes to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of not just resolving complaints but also learning from them. Furthermore, by highlighting the potential added value of complaints and subsequent quality and safety improvements made within HSC organisations the process becomes more acceptable and amenable to all.

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

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

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users and/or their representatives. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and use the lessons learned to improve quality and safety.

What the HSC Complaints Procedure covers

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

- HSC Trusts
 - hospital and community services
 - registered establishments and agencies where the care is funded by the HSC
 - HSC funded staff or facilities in private pay beds
 - HSC prison healthcare
- Business services organisation (BSO)
 - services provided relevant to health and social care
- Public Health agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- Family practitioner Services (FPS)

1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993¹ as an alternative to making an application to the courts.

¹ Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.

What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care² or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

1.13 Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC organisation should ensure that there are other processes in place which can be referred to in order to deal with these concerns. For example:

- [staff grievances](#)
- [an investigation under the disciplinary procedure](#)
- [an investigation by one of the professional regulatory bodies](#)
- [services commissioned by DoH](#)
- [requests for information under Freedom of Information](#) or [access to records under the UK General Data Protection Regulation \(GDPR\) and Data Protection Act 2018](#)
- [independent inquiries and criminal investigations](#)
- [the Children Order Representations and Complaints Procedure](#)
- [adult safeguarding](#)
- [child protection procedures](#)
- [Coroners cases](#)
- [legal action](#)
- [Serious Adverse Incidents \(SAIs\)](#)
- [Whistleblowing](#)³

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

² The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at <http://www.gdc-uk.org/>

³ [Public Interest Disclosure \(Northern Ireland\) Order 1998](#)

Manager for onward transmission to the appropriate department. Where a complaint is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication. If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure

1.16 Disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body (see paragraph 1.20 below). The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

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

1.18 The Chief Executive (or designated senior person⁴) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part

⁴ A designated Senior Person should be a Director (or Nominee)

in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

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

Investigation by a Professional Regulatory Body

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

Services Commissioned by the DoH

1.21 Complaints about commissioning and the purchasing of services can be made generally; or by, or on behalf of, any individual personally affected by a commissioning decision taken by the department, and will be dealt with under the DoH Complaints Procedure.

Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000⁵ and requests for access to health or social care records under the UK General Data Protection Regulation (GDPR)⁶ and Data Protection Act 2018.

⁵ Freedom of Information Act 2000: <http://www.legislation.gov.uk/ukpga/2000/36/contents>

⁶ General Data Protection Regulation (GDPR): <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr>

Independent Inquiries and Criminal Investigations

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

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints procedure.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in [Annex 14](#). The HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995⁷.

Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016⁸) and the associated '*Protocol for Joint Investigation of Adult Safeguarding Cases*' (August 2016⁹) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust¹⁰. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint

⁷ Children (NI) Order 1995: <http://www.legislation.gov.uk/nisi/1995/755/contents>

⁸ Adult Safeguarding Operational Procedures: [Adult Safeguarding \(hscni.net\)](http://hscni.net/AdultSafeguarding)

⁹ Protocol for Joint Investigation of Adult Safeguarding Cases: [DRAFT \(hscni.net\)](http://hscni.net/DRAFT)

¹⁰ Information about and contact details for HSC Trusts can be accessed at the following link - <https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect>

not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures

1.27 Any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

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

Coroners Cases

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

Legal Action

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

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

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

Serious Adverse Incidents (SAI)

1.32 Complaints may indicate the need for a Serious Adverse Incident (SAI) review. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI review is under way. They must also indicate to all concerned that the HSC Complaints Procedure may still continue during the SAI review. However, only those aspects of the complaint not falling within the scope of the SAI review will continue via the HSC Complaints Procedure.

1.33 The overall consideration must be to ensure that when the review is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

Whistleblowing

1.34 The Department of Health has a framework and model policy in place for HSC organisations on Whistleblowing¹¹. All HSC organisations should have their own separate procedures in place.

¹¹ <https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-whistleblowing.PDF>

SECTION 2 – MAKING A COMPLAINT

What is a complaint?

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

Promoting access

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

Who can complain?

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

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient’s or client’s consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

Consent

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

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

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

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance¹².

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

¹² <https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care>

Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the UK General Data Protection Regulations (GDPR) and Data Protection Act 2018 which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. More detailed information can be found in the DoH guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information* ¹³published January 2012.

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

Third Party Confidence

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

¹³ DoH Code of Practice:

<https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information>

connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

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

Use of Anonymised Information

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

How can complaints be made?

2.13 Complaints may be made in a variety of formats including verbally, written or electronic. Should a verbal complaint be made the complainant should be asked to formalise their complaint in writing. If the complainant is unable to put their complaint in writing then Trust staff or the Patient Client Council can provide assistance. It is helpful to establish at the outset what the complainant wants to achieve in order to avoid confusion or dissatisfaction and subsequent complaints. HSC organisations should be mindful of technological advances specifically in regard to email communications and must adhere to their relevant Information Technology (IT) policies and procedures. Complaints Managers should also consider local arrangements to ensure there is no breach of patient/client confidentiality in the management of information surrounding complaints.

2.14 Complaints may be made to any member of staff, for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint “on the spot” or pass it to the Complaints Manager.

It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery¹⁴. (See Flowchart page 45)

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, to the Chief Executive. All HSC organisations have named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services;
- Regulated Establishments and Agencies; and
- Independent Sector Providers.

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

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

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the SPPG Complaints Team¹⁵, if he/she does not feel able to approach immediate staff (see flowchart page 46).

¹⁴ Section 75 of the Northern Ireland Act 1998 <https://www.legislation.gov.uk/ukpga/1998/47/section/75>

¹⁵ SPPG Complaints Team acting on behalf of the DoH.

2.18 Where requested, the SPPG Complaints Team will act impartially as [“honest broker”](#) to the complainant and Practice/Practitioner in either the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the SPPG Complaints Team should be, wherever possible, to restore the trust between the patient and the Practice/Practitioner staff. This will involve an element of mediation on the part of the SPPG Complaints Team or the offer of conciliation services where they are appropriate. The SPPG Complaints Team should seek with the complainant’s agreement to involve the FPS Complaints Manager as much as possible in resolving the issues. The SPPG Complaints Team is also available to Practice/Practitioner staff for support and advice.

2.19 The SPPG Complaints Team has a responsibility to record and monitor the outcome of complaints lodged with them.

2.20 The SPPG Complaints Team will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint Independent Experts, Lay Persons or Conciliation Services, where appropriate.

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

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies¹⁶ must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

- Effectively publicising the arrangements for dealing with complaints and ensuring service users, clients and families are aware of such arrangements;
- Ensuring that any complaint made under the complaints procedure is investigated;
- Ensuring that time limits for investigations are adhered to;

¹⁶ Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.

- Advising complainants regarding the outcomes of the investigation; and
- Maintaining a record of learning from complaints that is available for inspection.

2.23 Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure. It is for the Ombudsman to determine whether or not a case falls within that office's jurisdiction.

2.24 Complaints may be made by service users or persons acting on their behalf providing they have obtained the service user's consent. Complaints relating to contracted services provided by the registered provider or agency may be received directly by the service provider or by the contracting Trust. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider or agency. The registered provider is required by legislation to ensure the complaint is fully investigated. The general principle in the first instance would be that the registered provider or agency investigates and responds directly to the complainant.

2.25 However, individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that commissioned the care on their behalf (see flowchart on page 47) as the commissioning Trust has a continuing duty of care to the service user and should participate in local resolution as necessary.

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

providers, other professionals and the RQIA to enable appropriate decisions to be made.

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

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

2.29 Voluntary Adoption Agencies became regulated by the RQIA in 2010 and in due course, these arrangements will extend to Fostering Agencies services which will also be regulated by the RQIA.

Independent Sector Providers

2.30 This section of the guidance has been developed for use in complaints against Independent Service Providers (ISP) in contract with HSC Trusts. Complaints against regulated establishments and agencies, such as, residential and nursing homes should be handled in accordance with paragraphs 2.22 to 2.28 above. On occasions HSC organisations contract with ISPs to provide services for patients/clients. An example where this may be the case is in the maintenance of waiting lists for elective forms of treatment.

2.31 Such contracts are agreed and managed by HSC Trusts and procured in accordance with public procurement law. ISPs may have their own premises or may be permitted to use Trust premises, equipment and facilities.

2.32 Trusts must be assured that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints. This should include the appointment of designated

officers of suitable seniority to take responsibility for the management of the in-house complaints handling procedures, the investigation of complaints and the production of leaflets, or other literature (available and accessible to patients/clients) that outline the provider's complaints procedure.

2.33 Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated (see flowchart on page 48).

2.34 Where complaints are raised directly with the Trust, it must establish the nature of the complaint and consider how best to proceed. The Trust may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where it raises serious concerns or where the Trust deems it in the public interest to do so. This may also be considered preferable should the Trust premises and/or staff have been involved (see flowchart on page 48).

2.35 In all cases, appropriate communication should be made with the complainant to inform them which organisation is leading the investigation into their complaint.

2.36 In complaints investigated by the ISP:

- A written response will be provided by the ISP to the complainant and copied to the Trust;
- Where there is a delay in responding within the target timescales the complainant will be informed and where possible provided with a revised date for conclusion of the investigation; and
- The letter of response must advise the complainant that they may progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and, if so, will confirm who should be responsible for conducting it. The Trust will work closely with the ISP to enable appropriate decisions to be made.

2.37 The complainant must also be informed of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

2.38 It is possible that referrals to the Ombudsman, where complaints are dealt with directly by the ISP without Trust participation in local resolution, will be referred to the Trust by the Ombudsman for action.

2.39 Trusts should have agreed arrangements in place to ensure that ISPs regularly provide information relating to all complaints received and responded to directly by them. This information should be made available to the Trust for monitoring purposes. The ISP must keep a record of complaints, the subsequent investigation and its outcome and any action taken as a result. This record must be submitted to the Trust no longer than 10 working days after the end of each quarter for complaints closed in the period. This should include details of the number, source and type(s) of complaint, action taken and outcome of investigation.

2.40 The ISP should also indicate if the learning from complaints has been disseminated to all relevant staff. The ISP must review their complaints procedure on an annual basis and in this annual review shall include a review of the outcome of any complaints investigations during the preceding year to ensure that where necessary any changes to practice and procedure are implemented. This annual review must be available for inspection by Trust staff on request.

What information should be included in the complaint?

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

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

Supporting complainants and staff

2.42 Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate ([Annex 1](#) refers). Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (detailed in Section 5 – Roles and responsibilities). Independent advocacy and specialist advocacy services are also available ([Annex 7](#) refers).

What are the timescales for making a complaint?

2.43 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh and the relevant evidence such as records of treatment will be easier to source.

2.44 If a complainant was not aware that there was potential cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

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

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

2.47 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety

and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

SECTION 3 – HANDLING COMPLAINTS

Accountability

3.1 Standard 1: *Accountability* provides the criteria by which organisations should operate ([Annex 1](#) refers). Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation:

- to take responsibility for the local complaints procedure;
- to ensure compliance with the regulations; and
- to ensure that action is taken in light of the outcome of any investigation.

In the case of HSC Trusts, a Director (or a Clinical Governance Lead in FPS setting) should be designated. All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements.

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

Performance Management

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

3.4 Complaints should be used to inform and improve the standard of service provision. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a

recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

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

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DoH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

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

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions¹⁷ and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

3.8 The Complaints Manager or whoever is designated on their behalf must be readily accessible to both the public and members of staff. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;

¹⁷ DoH Complaints Directions: <https://www.health-ni.gov.uk/publications/hsc-complaints-directions>

- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)¹⁸ to assist staff requiring professional indemnity¹⁹;
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.9 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager should

¹⁸ There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).

¹⁹ Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

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

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

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

3.12 Local information should:

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

Training

3.13 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. HSC staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function

effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.14 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate ([Annex 1](#) refers).

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

3.16 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation especially if it is likely to exceed the 20 working day target for any reason. Early provision of information and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to accordingly. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.17 Where possible, all complaints should be registered and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that require formal investigation, or those that should be investigated and managed outside of the HSC Complaints Procedure by other means. Front-line staff will often find the information they gain from complaints useful in improving service quality. This

is particularly so for complaints that have been resolved “on the spot” and have not progressed through the formal HSC Complaints procedure. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

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

3.19 There should be a statement expressing sympathy or concern regarding the issue that led to a complaint being made. This is a statement of common courtesy, not an admission of responsibility.

3.20 It is good practice for the acknowledgement letter to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within **10 working days**. As soon as the HSC organisation becomes aware that the relevant response timescale is not achievable they must provide the complainant with an explanation. The complainant must be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

3.21 The acknowledgement should:

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

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

Joint Complaints

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

Out of Area Complaints

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

Investigation

3.25 Standard 5: *Investigation* provides the criteria by which organisations must operate ([Annex 1](#) refers). HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only "resolution" but also to:

- ascertain what happened or what was perceived to have happened;
- establish the facts;
- learn lessons;

- detect misconduct or poor practice; and
- improve services and performance.

3.26 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/senior person, wherever necessary, about the conduct or findings of the investigation.

3.27 Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout. Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

Assessment of the complaint

3.28 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence.

Investigation and resolution

3.29 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those

responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

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

- senior managers/professionals at an early stage;
- [honest broker](#);
- [independent experts](#);
- [lay persons](#); and
- [conciliators](#).

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

Completion of Investigation

3.32 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*²⁰ will assist HSC organisations in ensuring the completeness and readability of such reports.

3.33 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual

²⁰ https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2034-07_0.pdf

accuracy and to ensure clinicians/ professionals agree with and support the draft response.

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

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

Circumstances that might cause delay

3.36 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.14).

Periods of acute mental illness

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

Physical Injury

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

3.39 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements. The complainant must also be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

Responding to a complaint

3.40 Standard 6: *Responding to complaints* provides the criteria by which organisations must operate ([Annex 1](#) refers). A response must be sent to the complainant within **20 working days of receipt** of the complaint (**10 working days within FPS**) or, where that is not possible, the complainant must be advised of the delay (as per paragraph 3.39 above).

3.41 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC may reply electronically whilst ensuring they adhere to the relevant Information Technology (IT) policies and procedures and maintain appropriate levels of confidentiality according to Trust policies and procedures

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

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

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

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

Concluding Local Resolution

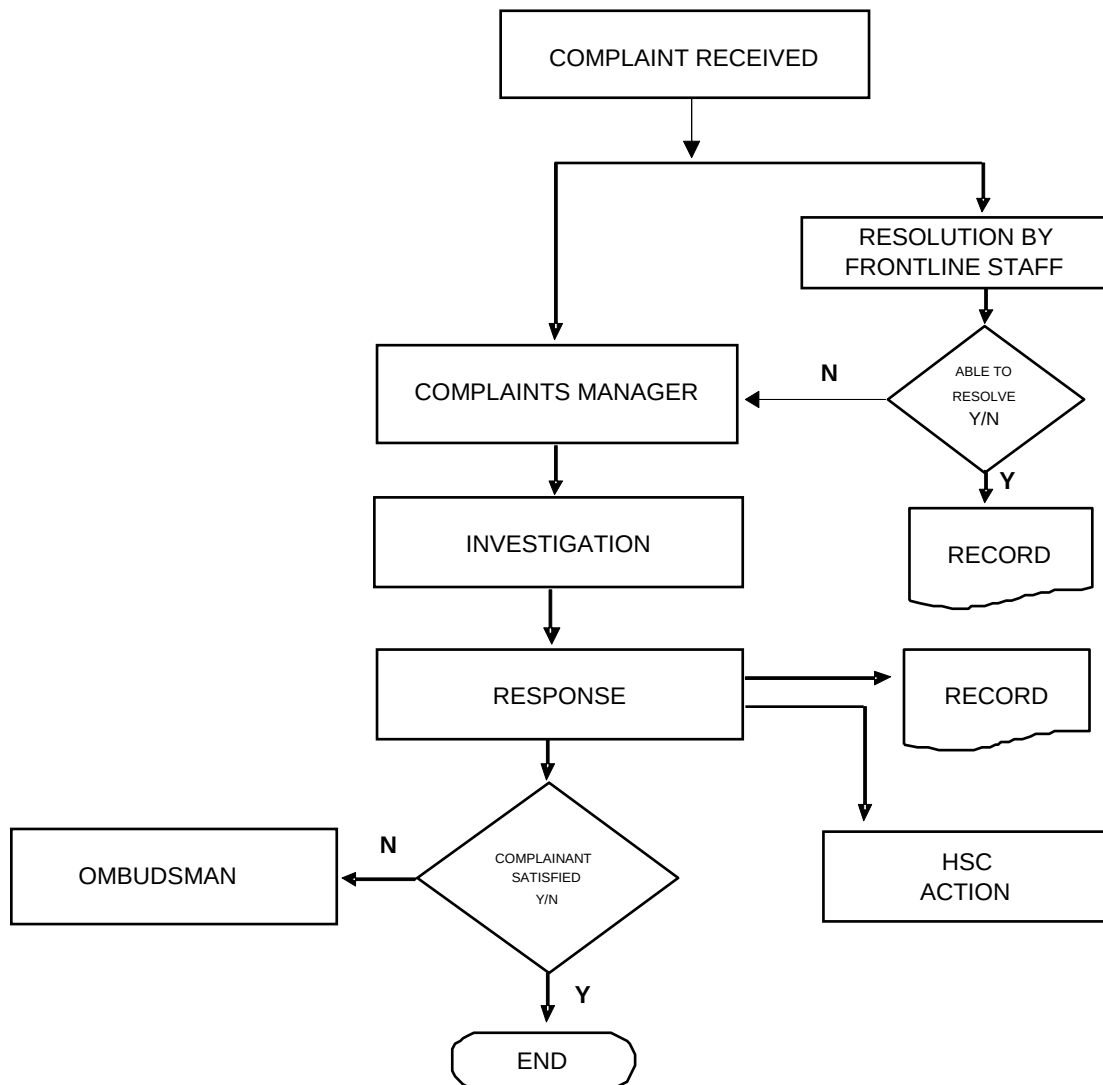
3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying “closure”. Complainants should contact the organisation within one month of the organisation’s response if they are dissatisfied with the response or require further clarity²¹. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

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

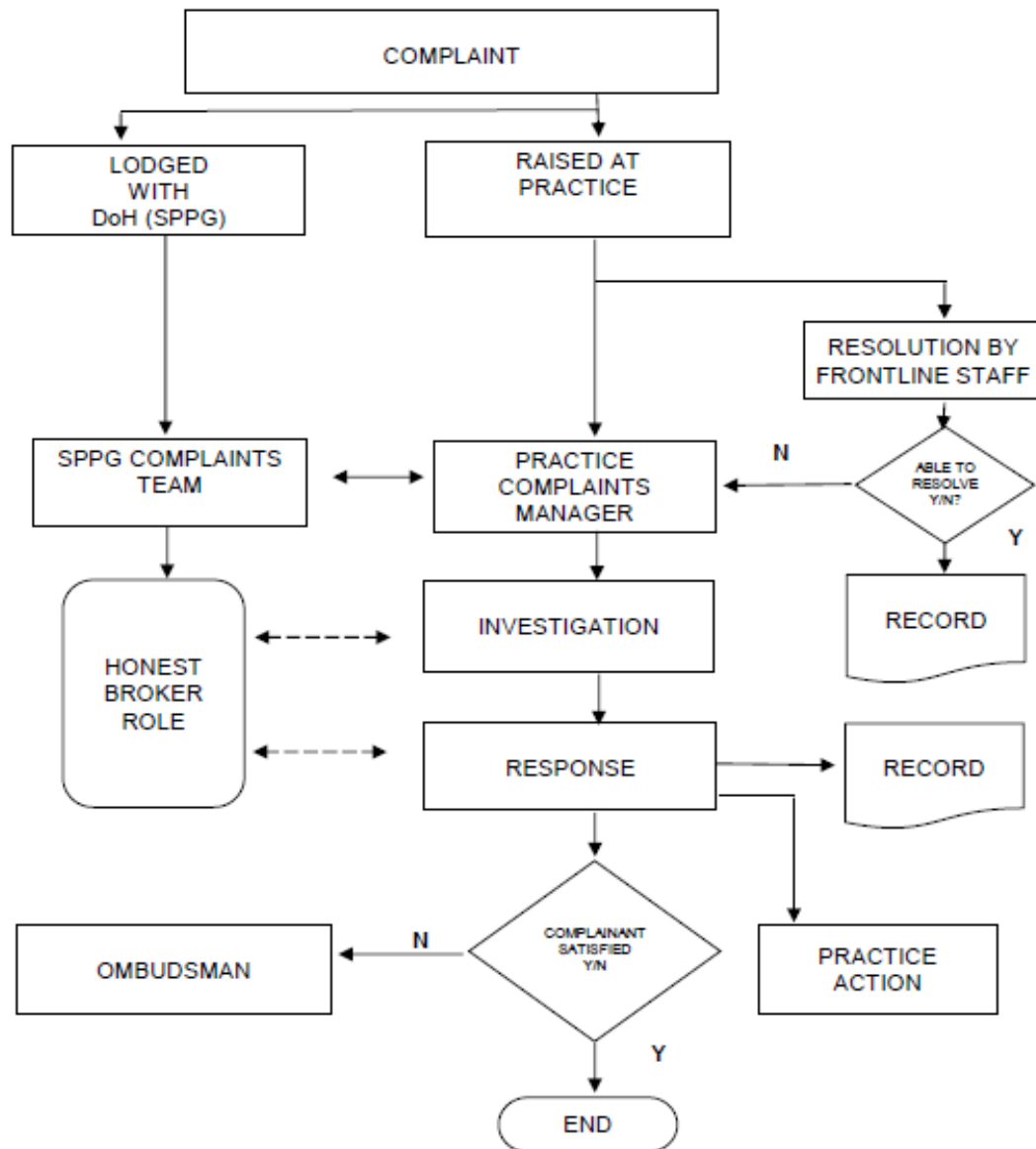
3.47 This completes the HSC Complaints Procedure. There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

²¹Inserted 5th June 2013 per letter from Director of Safety, Quality & Standards Directorate

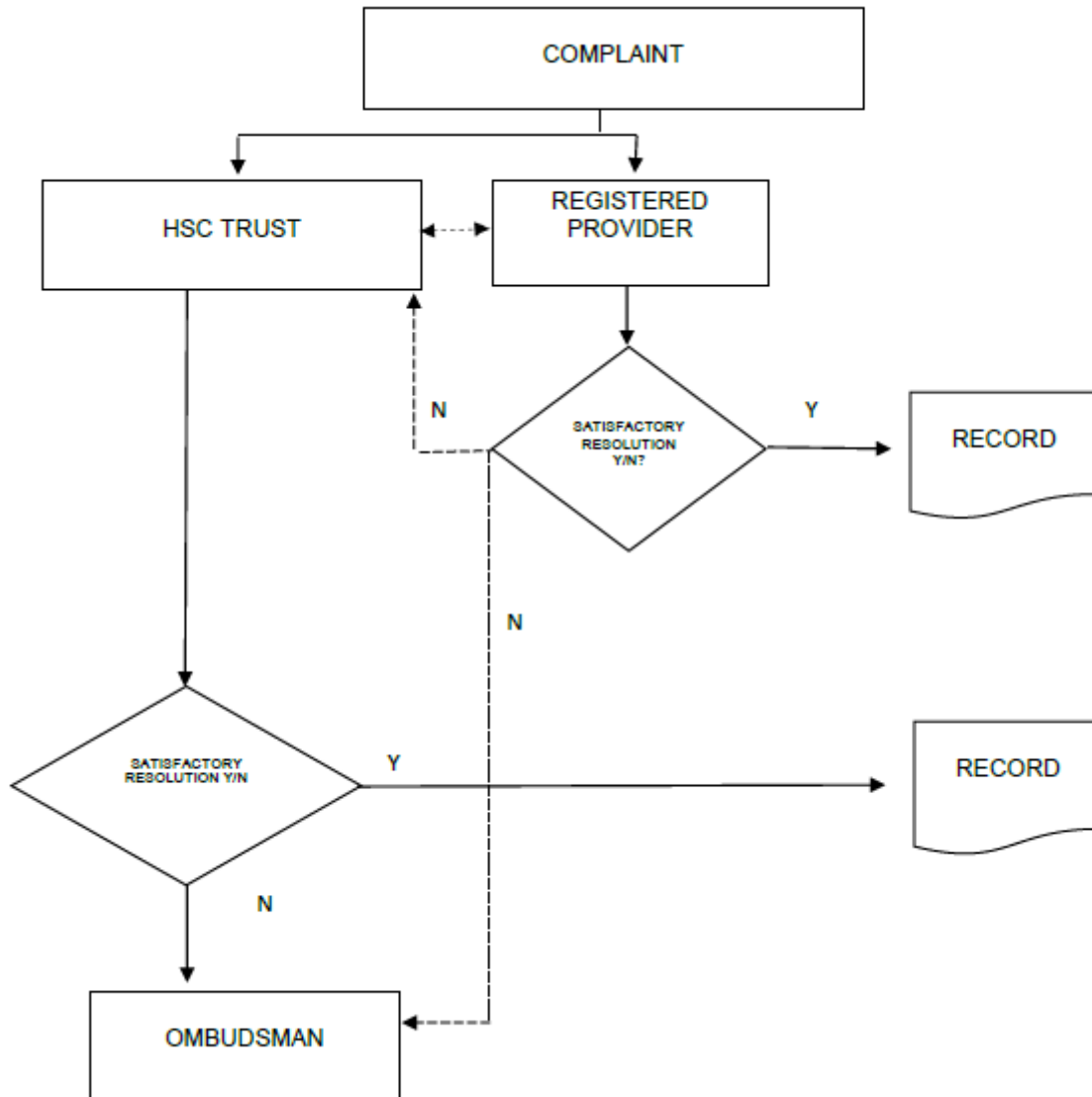
HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



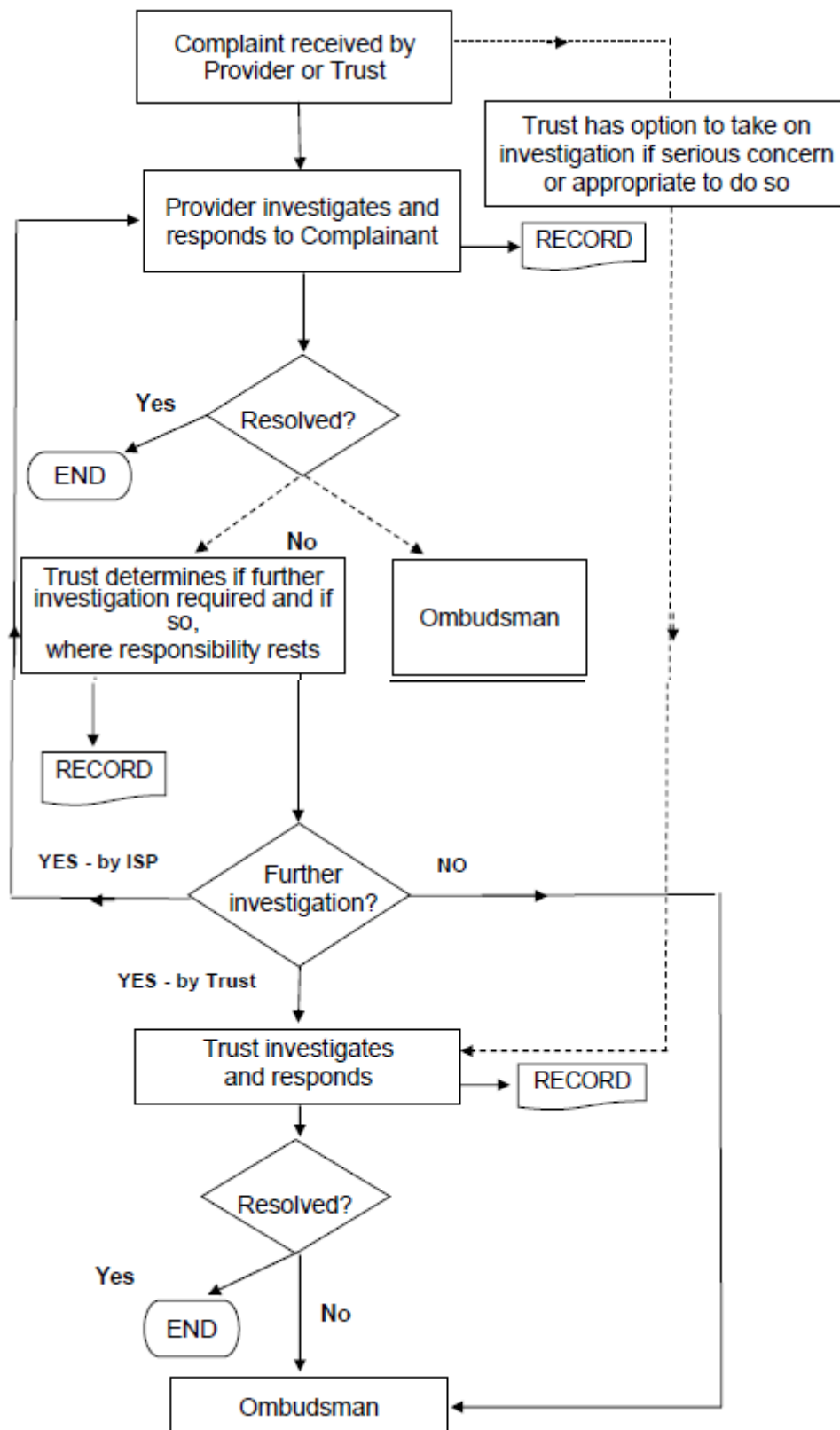
FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



REGULATED ESTABLISHMENTS & AGENCIES FLOWCHART
(Services commissioned by HSC - Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.)



INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement	within 2 working days* of receipt
Family Practitioner Services	within 3 working days
Response	within 20 working days
Family Practitioner Services	within 10 working days (20 working days if lodged with the SPPG Complaints Team)
Should complainant wish to seek clarity in relation to response or express continued dissatisfaction	within 1 months of the organisation's response

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

SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

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

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

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

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

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

DoH

4.5 The SPPG Complaints Team on behalf of DoH will maintain an oversight of all FPS and HSC Trust complaints received (including HSC prison healthcare) and be prepared to analyse any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

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

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

HSC Trusts

4.8 All HSC Trusts must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide their Management Boards and the DoH with quarterly complaints reports outlining the number and types of complaints received, the investigation undertaken and actions as a result including those relating to regulated establishments and agencies, and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare. The reports must summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

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

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

Quarterly reports

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

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

4.12 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.13 Family Practitioner Services must provide the SPPG Complaints Team with anonymised copies of all written complaints received and responses provided by the Practice within 3 working days of the response being issued.

4.14 Arrangements should be in place to ensure that the complainant is aware and agrees to his/her complaint being forwarded to the SPPG Complaints Team.

4.15 The SPPG Complaints Team will record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.16 All other HSC organisations must publish an annual report on complaints handling. Copies should be sent to the PCC and the DoH. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

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

Learning

4.18 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place²².

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

4.20 The SPPG Complaints Team on behalf of the DoH will have in place regional-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints and must ensure they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

²² The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf>

SECTION 5 - ROLES AND RESPONSIBILITIES

DoH

5.1 The SPPG on behalf of DoH is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The *Standards for Complaints Handling* provides a level against which HSC service performance can be measured ([Annex1](#) refers).

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

5.3 The SPPG Complaints Team on behalf of the DoH will have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The SPPG Complaints Team will provide a vital role in supporting FPS complaints that includes:

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

HSC Organisations

5.5 HSC organisations must:

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

The Patient and Client Council (PCC)

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

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

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

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

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

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

WHO CAN HELP ME RAISE MY COMPLAINT?

You can get practical help to raise your complaint from the Patient and Client Council (PCC).

You can contact a PCC Officer at:

Phone: 0800 917 0222

Email: complaints.pcc@hscni.net



For more information, visit PCC's website:

www.patientclientcouncil.hscni.net

The PCC Complaints Support Service is there to:

- Give you information on how to complain and who to complain to
- Help you write letters of complaint
- Make telephone calls for you about your complaint
- Go with you to meetings about your complaint and make sure your concerns are responded to
- Work with health and social care organisations to improve services as a result of your complaint

WHAT CAN I DO IF I AM NOT SATISFIED WITH THE TRUST'S RESPONSE?

If you are not happy with the trust's response to your complaint, you can contact the Northern Ireland Public Service Ombudsman (NIPSO) at:

Phone: 0800 343 424

Email: nipso@nipso.org.uk

For more information, visit NIPSO's website:

www.nipso.org.uk

ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

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

[Standard 1: Accountability](#)

[Standard 2: Accessibility](#)

[Standard 3: Receiving complaints](#)

[Standard 4: Supporting complainants and staff](#)

[Standard 5: Investigation of complaints](#)

[Standard 6: Responding to complaints](#)

[Standard 7: Monitoring](#)

[Standard 8: Learning](#)

STANDARD 1: ACCOUNTABILITY

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

Rationale:

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

Criteria:

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

STANDARD 2: ACCESSIBILITY

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

Rationale:

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

Criteria:

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

STANDARD 3: RECEIVING COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

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

Rationale:

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

Criteria:

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

STANDARD 5: INVESTIGATION OF COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 6: RESPONDING TO COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 7: MONITORING

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

Rationale:

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

Criteria:

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

STANDARD 8: LEARNING

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

Rationale:

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

Criteria:

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

ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- Health and Personal Social Services General Dental Services (Amendment) Regulations (NI) 2008;
- The General Ophthalmic Services (Amendment) Regulations
- (Northern Ireland) 2014The Pharmaceutical Services Regulations (NI) 1997.

The Children (NI) Order 1995:

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

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) 2009;
Amendment Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009);
- Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009) (Honest Broker Timescales) (Amended 2013)
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010).

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

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

ANNEX 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: 020 7713 5155 www.gcc-uk.org	Nursing and Midwifery Council (NMC) Nurses, midwives and specialist community public health nurses Phone: 020 76377181 www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: 020 71676000 www.gdc-uk.org	Royal Pharmaceutical Society of Great Britain (RPSGB) Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 08452572570 https://www.rpharms.com
General Medical Council (GMC) Doctors Phone: 01619236602 www.gmc-uk.org	Pharmaceutical Society of Northern Ireland Pharmacists and pharmacy premises in Northern Ireland Phone: 02890 326927 www.psni.org.uk
General Optical Council (GOC) Opticians Phone: 020 7580 3898 www.optical.org General Osteopathic Council (GOsC) Osteopaths Phone: 020 7357 6655 www.osteopathy.org.uk	Professional Standards Authority for Health and Social Care (the Authority) aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. Phone: 020 73898030 http://www.professionalstandards.org.uk
Health and Care Professions Council (HCPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 03005006184 www.hpc-uk.org	Northern Ireland Social Care Council (NISCC) Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: 028 95362600 www.niscc.info

ANNEX 4: HSC PRISON HEALTHCARE

1. HSC prison healthcare is commissioned by the DoH. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

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

ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman²³ can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

All listed authorities within the Ombudsman's jurisdiction have a statutory obligation to signpost complainants to the Ombudsman's office where the listed authority's complaints handling procedure is exhausted.

Section 25 of the Public Services Ombudsman Act (Northern Ireland) 2016 states:

25. (1) This section applies where a listed authority's complaints handling procedure is exhausted.
- (2) The authority must, within 2 weeks of the day on which the complaint handling procedure is exhausted give the person aggrieved a written notice stating –
- (a) that the complaints handling procedure is exhausted, and
- (b) that the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman.
- (3) A notice under subsection (2) must –
- (a) inform the person aggrieved of the time limit for referring the complaint to the Ombudsman; and
- (b) provide details of how to contact the Ombudsman.

²³ With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation.

2. The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Freepost: Freepost NIPSO
Telephone: (028) 9023 3821
Freephone: (0800) 34 34 24
Email: nipso@nipso.org.uk

3. Additional information on the jurisdiction and powers under the Public Services Ombudsman Act (NI) 2016 can be accessed at:
www.nipso.org.uk

ANNEX 6: THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

1. The RQIA is an independent non-departmental public body. The RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.
2. The RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DoH. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.
3. The RQIA has a duty to encourage improvement in the delivery of services and to keep the DoH informed on matters concerning the provision, availability and quality of services.
4. The RQIA may be contacted at:

9th Floor, Riverside Tower
Lanyon Place
Belfast
BT1 3BT
Tel: 028 90 517500

<http://www.rqia.org.uk/>

ANNEX 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.
2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.
3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

ANNEX 8: CONCILIATION

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

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

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

3. Where a complainant is considered unreasonable or abusive under the *Unacceptable Action Policy* ([Annex 13 refers](#)) then conciliation would NOT be an appropriate option.

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

5. Conciliation may be requested by the complainant, the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH. In FPS complaints it may be suggested by the SPPG Complaints Team.

FPS arrangements

6. The Practitioner/Practice/Pharmacy Manager (respondent) should approach the SPPG Complaints Team for advice.

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

Agreement by parties involved

8. The FPS Practice/Practitioner/HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

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

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

10. The conciliator must advise the Practice/Practitioner/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The Practice/Practitioner must then notify the SPPG Complaints Team of the outcome.

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

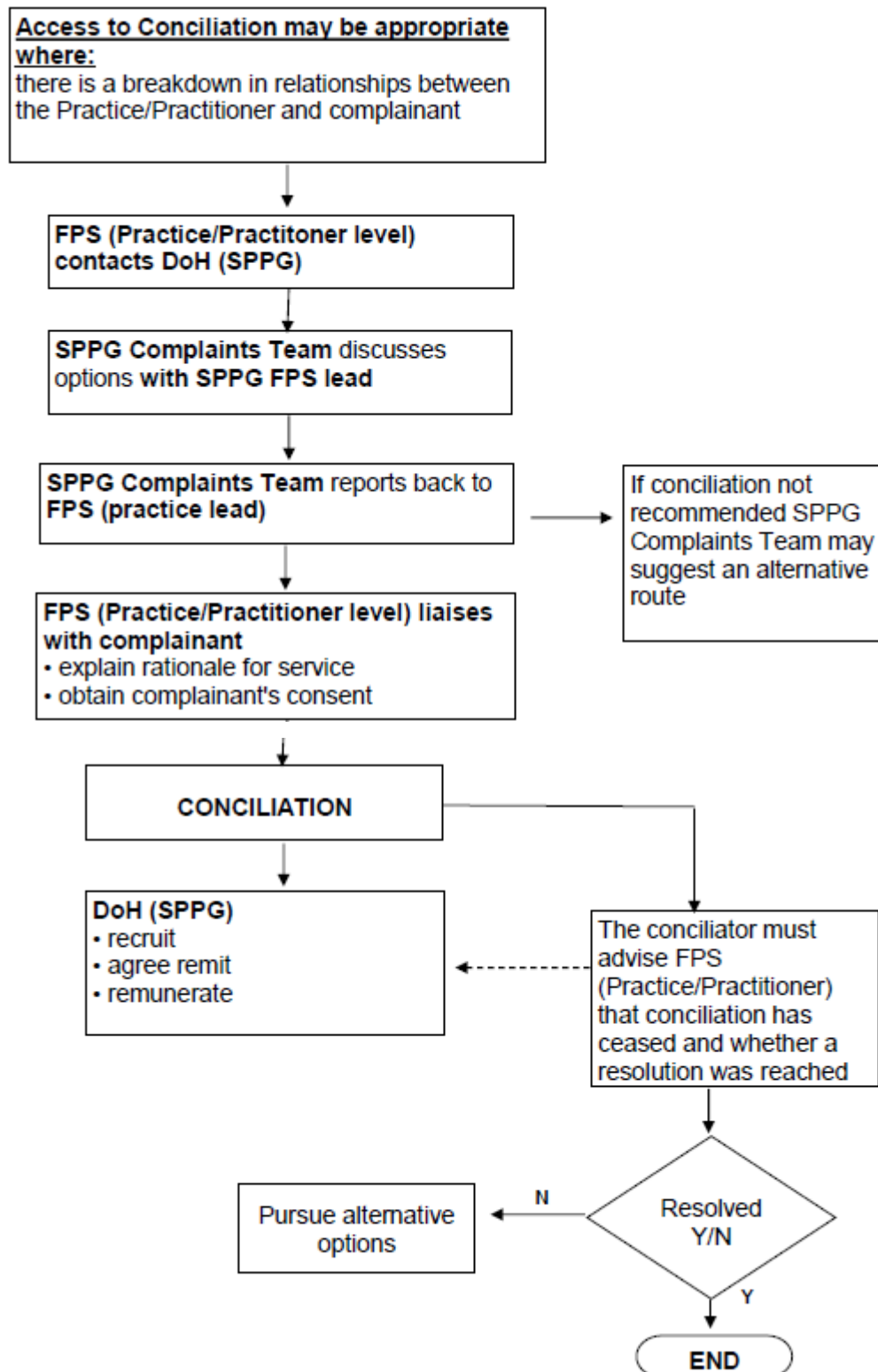
Appointment of conciliators

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

Monitoring

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

Conciliation – FPS



ANNEX 9: INDEPENDENT EXPERTS

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

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

FPS arrangements

2. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

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

Agreement and consent

4. The FPS Practice/Practitioner/HSC organisation/SPPG Complaints Team must contact the complainant and discuss the rationale for involving an Independent Expert and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

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

6. Where it has been agreed that an Independent Expert will be involved the Practice/Practitioner/HSC organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

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

7. The Independent Expert's findings/report will be forwarded to the Practice/Practitioner/HSC organisation/SPPG Complaints Team (if acting as contact point). A full report of the findings should be made available by the practice/pharmacy/HSC organisation to:

- the complainant; and
- the SPPG Complaints Team (for FPS only).

8. The letter of response to the complainant is the responsibility of the Practice/Practitioner/ HSC organisation.

Appointment of Independent Experts

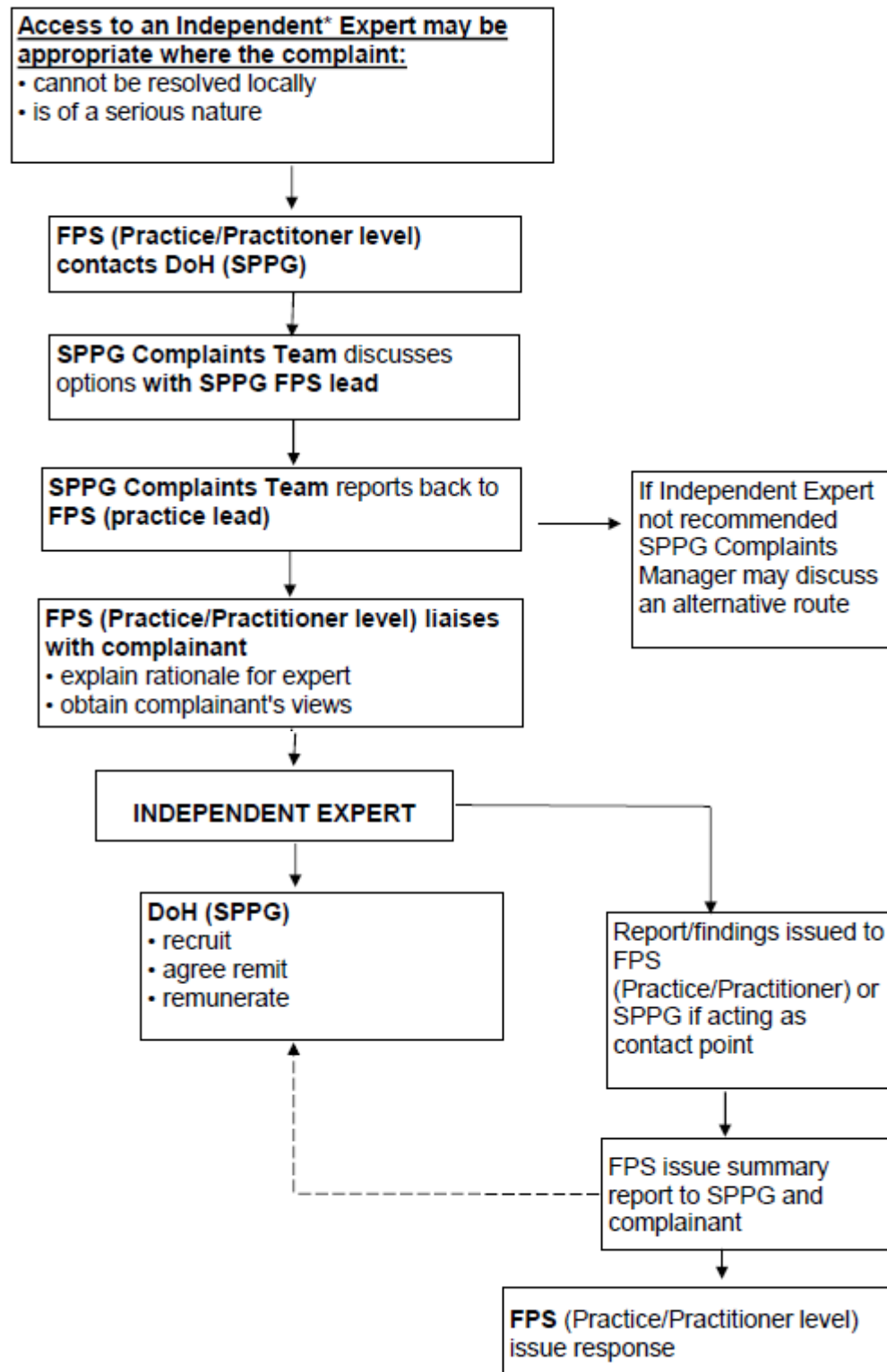
9. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

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

Monitoring

11. The SPPG Complaints Team will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.
12. A flowchart outlining the process for FPS is shown overleaf.

Independent Experts – FPS Access



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

ANNEX 10: LAY PERSONS

1. Lay persons may be beneficial in providing an independent perspective of non-clinical/ technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay persons involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the investigator during the investigation process where the complainant is considered unreasonable ([Annex 13 refers](#)).

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

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

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

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

FPS arrangements

5. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

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

Agreement and consent

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

8. Where it has been agreed that a lay person will be involved the Practice/Practitioner/HSC Organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

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

9. The layperson's findings/report will be forwarded to the Practice/Practitioner/HSC Organisation/SPPG Complaints Team. The full report will be made available by the Practice/ Practitioner/HSC Organisation/SPPG Complaints Team (for FPS only) and to the complainant.

10. The letter of response to the complainant is the responsibility of the Practice/Practitioner/HSC Organisation/SPPG Complaints Team.

Appointment of lay persons

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

Monitoring

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

ANNEX 11: HONEST BROKER ROLE

1. “Honest broker” is the term used to describe the role of the SPPG Complaints Team in supporting and advising FPS on the handling of complaints. The complainant or the Practice/Practitioner can ask the SPPG Complaints Team to act in this role at any point in the complaints process. It is expected that the SPPG Complaints Team will not carry out the investigation but it is also expected that it will add value to the process by providing support and advice to FPS.

2. It is not an alternative to local resolution. Neither is it an opportunity for the SPPG Complaints Team to take over an investigation. Rather it is about facilitating communications and building relationships between the Practice/Practitioner and the complainant or reaching positions of understanding. The honest broker will act as an intermediary and is available to both, the complainant or Practice/Practitioner staff throughout the complaints process. For example, the honest broker may:

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

3. Paragraphs 2.16 to 2.21 outline the options available to complainants when pursuing FPS complaints. This includes an option to lodge their complaint directly with the SPPG Complaints Team. Where the complainant contacts the SPPG Complaints Team the options available to resolve the complaint will be explained:

- that the complaint can be copied to the relevant practice/pharmacy for investigation, resolution and response; or
- that the SPPG Complaints Team can act as honest broker between the complainant and the Practice/Practitioner.

4. FPS co-operation in complaints of this type is essential for the role of honest broker to effectively assist in the successful local resolution of complaints. FPS will be asked for their agreement should the complainant prefer the SPPG Complaints Team's involvement.

5. Where the SPPG Complaints Team has been asked to act as honest broker they will:

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate;
- provide advice to the complainant and the Practice/Practitioner on target timescales²⁴; and
- where there is a delay, ensure the complainant is advised as set out in paragraph 3.39.

6. Whichever process is used it is important to note that the Practice/Practitioner are responsible for the investigation and the response. The SPPG Complaints Team, however, must ensure that:

- a written response is provided by the Practice/Practitioner to the complainant and any other person subject to the complaint (whether this is direct from the Practice/Practitioner or from the SPPG Complaints Team after receiving a report from the Practice/Practitioner;
- the response is of sufficient quality and addresses the complainant's concerns;
- the written response is provided within target timescales and where this is not possible that the complainant is informed; and
- the response notifies the complainant of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure.

7. The complainant may contact the SPPG Complaints Team for further advice and support.

²⁴ For 'honest broker' this is 20 working days from receipt of the complaint: for FPS, this is 10 working days from receipt of the complaint.

ANNEX 12: ADULT SAFEGUARDING

Definition of vulnerable adult

1. The regional policy 'Adult Safeguarding – Prevention and Protection in Partnership' defines the terms 'adult at risk of harm' and 'adult in need of protection'²⁵.
2. The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.
3. An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:
 - a) **personal characteristics**
 - AND/OR**
 - b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain.

Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

²⁵ 'Adult Safeguarding – Prevention and Protection in Partnership' (July 2015) (<https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents>), p10

4. An **'adult in need of protection'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

AND

d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

5. In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).

6. The decision as to whether the definition of an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Reportable offences and allegations of abuse

7. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk then the regional *'Adult Safeguarding Operational Procedures'* (September 2016) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016) should be activated (see paragraph 1.26).

ANNEX 13: UNREASONABLE OR ABUSIVE COMPLAINANTS

1. HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.
2. In determining arrangements for handling such complainants, staff need to:
 - ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
 - appreciate that even habitual complainants may have grievances which contain some substance;
 - ensure a fair approach; and
 - be able to identify the stage at which a complainant has become habitual.
3. The following *Unacceptable Actions Policy*²⁶ should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Actions Policy

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

²⁶ Unacceptable Actions Policy based on best practice guidelines issued by the [Scottish Public Services Ombudsman](#)-Updated 18 January 2017

Aggressive or abusive behaviour

5. HSC organisations understand that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards HSC staff, it will consider that unacceptable. Any violence or abuse towards staff will not be accepted.

6. Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations will judge each situation individually and appreciate individuals who come may be upset. Language which is designed to insult or degrade, is racist, sexist or homophobic or which makes serious allegations that individuals have committed criminal, corrupt or perverse conduct without any evidence is unacceptable. HSC organisations may decide that comments aimed at third parties are unacceptable because of the effect that listening or reading them may have on staff. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

7. HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and staff should refer to the Zero Tolerance campaign launched in 2007 to clarify the HSC position in relation to attacks on the workforce. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

8. HSC organisations consider these demands become unacceptable when they start to (or when complying with the demand would) impact substantially on the work of the organisation.

9. Examples of actions grouped under this heading include:
- repeatedly demanding responses within an unreasonable timescale;
 - insisting on seeing or speaking to a particular member of staff when that is not possible; and
 - repeatedly changing the substance of a complaint or raising unrelated concerns.
10. An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

11. Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the organisation or inundates the organisation with copies of information that has been sent already or that is irrelevant to the complaint.
12. The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

Unreasonable use of the complaints process

13. Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about an organisation with which they have a continuing relationship, if subsequent incidents occur.
14. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a complaints system to be important and it will only be in exceptional circumstances that

it would consider such repeated use is unacceptable, however it reserves the right to do so in those exceptional circumstances.

Unreasonable refusal to co-operate

15. When the HSC organisation is looking at a complaint, it will need to ask the individual who has complained to work with them. This can include agreeing with the HSC organisation the complaint it will look at; providing it with further information, evidence or comments on request; or the individual summarising the concerns or completing a form for the HSC organisation.

16. Sometimes, an individual repeatedly refuses to cooperate and this makes it difficult for the HSC organisation to proceed. The HSC organisation will always seek to assist someone if they have a specific, genuine difficulty complying with a request. However, the HSC organisation consider it is unreasonable to bring a complaint to it and then not respond to reasonable requests.

Examples of how the HSC manage aggressive or abusive behaviour

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

18. HSC organisations will not accept any correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. The HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful and ask them to stop using such language. It will state that it will not respond to their correspondence if the action or behaviour continues.

19. HSC staff will end telephone calls if they consider the caller aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that their behaviour is unacceptable and end the call if the behaviour persists. In extreme situations, the HSC organisation will tell the complainant in writing that their name is on a “no personal contact” list. This means that it will limit contact with them to either written communication or through a third party.

Examples of how the HSC deal with other categories of unreasonable behaviour

20. The HSC organisation has to take action when unreasonable behaviour impairs the functioning of its office. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

21. Where a complainant repeatedly phones, visits the organisation, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the HSC organisation may decide to:

- limit contact to telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of staff who will deal with the future calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact from the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; and
- take any other action that the HSC organisation considers appropriate.

22. Where the HSC organisation considers correspondence on a wide range of issues to be excessive, it may tell the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly.

23. In exceptional cases, the HSC organisation will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further.

24. The HSC organisation will always tell the complainant what action it is taking and why.

The process the HSC follows to make decisions about unreasonable behaviour

25. HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to change their behaviour or action before a decision is taken.

How the HSC lets people know it has made this decision

26. When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing²⁸ why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

27. It is important that a decision can be reconsidered. A complainant can appeal a decision to restrict contact. If they do this, the HSC organisation will only consider arguments that relate to the restriction and not to either the complaint made to the organisation or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable, the restrictions were disproportionate; or that they will adversely impact on the individual because of personal circumstances.

28. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They

must advise the complainant in writing²⁷ that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

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

²⁷ Unacceptable Actions Policy based on best practice guidelines issued by the [Scottish Public Services Ombudsman](#)-Updated 18 January 2017

ANNEX 14: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995²⁸ (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) 1987²⁹.
2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996³⁰.
3. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 (a flowchart to aid decision making is attached).
4. The HSC Trusts should familiarise themselves with these requirements.

²⁸ Children (NI) Order 1995: <http://www.legislation.gov.uk/nisi/1995/755/contents>

²⁹ Adoption Order (NI) 1987: <http://www.legislation.gov.uk/nisi/1987/2203/contents>

³⁰ Representations Procedure (Children) Regulations (NI) 1996:
<http://www.legislation.gov.uk/nisr/1996/451/contents/made>

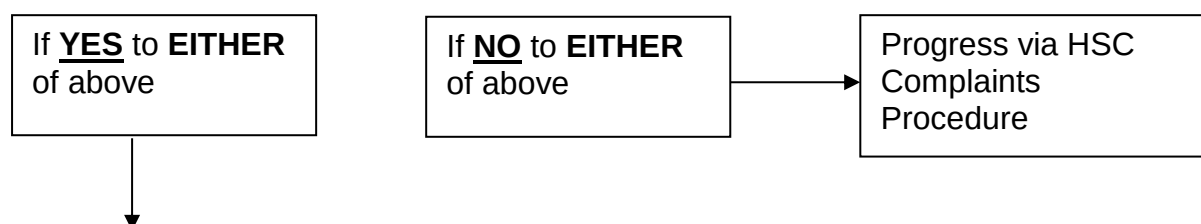
CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE



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

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

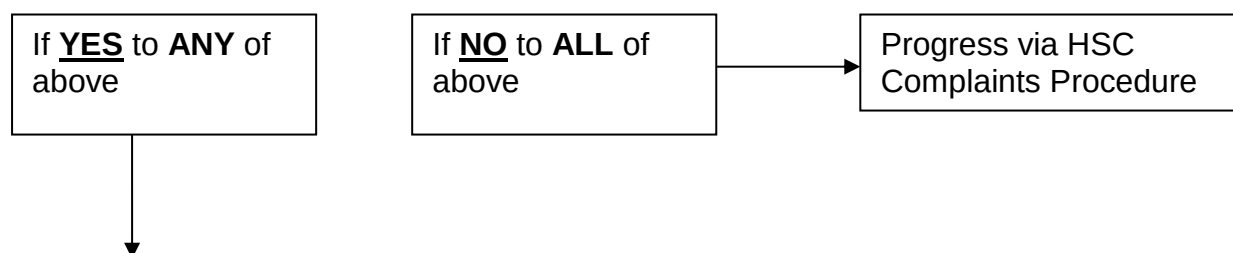
“A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust’s exercise of its functions under Part IV of, and para 6 of Schedule 5 to, the Children Order.”
(Guidance & Regulations – Vol. 4, Para 12.5 – DHSS)



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

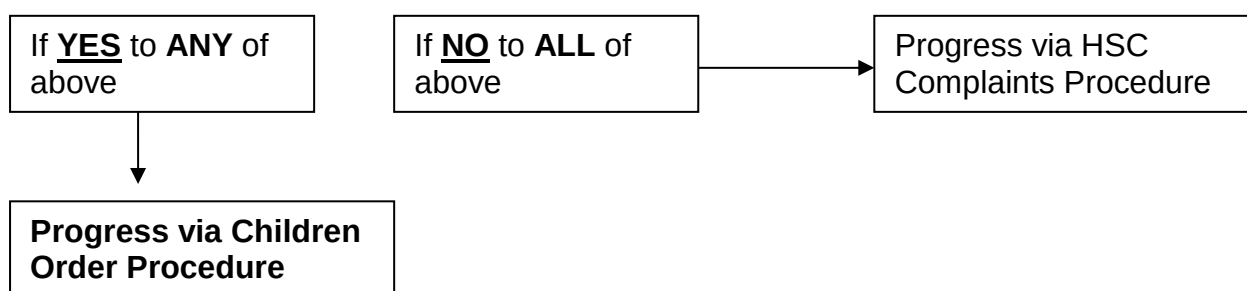
“... about Trust support for families and their children under Part IV of the Order.”
(Vol. 4, Para 12.8)

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



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

- a. **Any child** who is being looked after by the Trust;
- b. **Any child** who is not being looked after by the Trust, but is in need;
- c. A parent **of his**;
- d. Any person who is not a parent of his but who has **parental responsibility for him**;
- e. Any Trust foster parent;
- f. Such other person as the Trust considers has a sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.
 - the person who had the day to day care of the child within the past two years;
 - the child's Guardian ad Litem;
 - the person is a relative of the child (as defined by Children Order, Article 2(2));
 - The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
 - a friend;
 - a teacher;
 - a general practitioner.(Children (NI) Order 1995 Article 45(3))



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

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

Definitions of Key Terms

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

Complaint	“an expression of dissatisfaction that requires a response”
Complainant	an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	the Chief Executive of the HSC organisation
Complaints Manager	the person nominated by an HSC organisation to handle complaints
DoH ³¹	Department of Health in Northern Ireland
Family Practitioner Service (FPS)	family doctors, dentists, pharmacists and opticians
Honest Broker	this is the term used to describe the role of the SPPG on behalf of DoH in FPS complaints
HSC Organisation	an organisation which commissions or provides health and social care services and for the purpose of this guidance includes HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the Business Services Organisation (BSO), the Public Health Agency (PHA), Family Practitioner Services (FPS), Out-of-Hours Services, and pilot scheme providers
Local Resolution	the resolution of a complaint by the organisation, working closely with the service user

³¹ Formally the Department for Health, Social Services and Public Safety (DHSSPS)

NIBTS	Northern Ireland Blood Transfusion Service
NIPSO	Northern Ireland Public Services Ombudsman (NIPSO, known as ‘the Ombudsman’)
Out of-Hours services	refers to immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
PCC	Patient and Client Council
Pilot Scheme	a small-scale experiment or set of observations undertaken to decide how and whether to launch a full-scale project (refers to personal dental services provided by an HSC Trust in this case)
Pilot Scheme Complaints Procedure	is a complaints procedure established by the pilot scheme
Practice based complaints procedure	is an FPS complaints procedure established within the terms of the relevant regulations
Registered Provider	person carrying on or managing the establishment or agency
RQIA	Regulation, Quality and Improvement Authority which is the organisation responsible for regulating, inspecting and monitoring the standard and quality of health and social care services provision by independent and statutory bodies in Northern Ireland
Registered Establishments and Agencies	for example, residential care homes, nursing homes, children’s homes, nursing agencies, independent clinics/hospitals, etc. registered with
Regulated Sector	and regulated by the RQIA

Senior Person	refers to registered establishments and agencies
Service User	means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC Trust means a patient, client, resident, carer, visitor or any other person accessing HSC services
Special Agency	For example the NI Blood Transfusion Service (NIBTS)
SPPG	Strategic Planning and Performance Group, DoH (formerly HSC Board)

Title:	Belfast Health and Social Care Trust Disciplinary Policy		
Author(s)	Damian McAlister, Cynthia Crutchley, Regional HR Policy Group		
Ownership:	Human Resources & Organisational Development Directorate		
Approval by:	Regional Joint Negotiating Forum Workforce Governance and Policy Review Sub-Committee Trust Policy committee Executive Team Meeting	Approval date:	09/03/2015 01/07/2015 05/08/2015 19/08/2015
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Version No.	V2	Supersedes	V1 – September 2007- August 2010
Key words:	Disciplinary		
Links to other policies	HSS (TC8) 6/15 Maintaining High Professional Standards in the Modern HPSS – a framework for the handling of concerns about doctors and dentists employed in the HPSS http://www.belfasttrust.hscni.net/pdf/BHSCT_Maintaining_High_Professional_Standards.pdf		

Date	Version	Author	Comments
01/04/2015	1.1	D McAlister C Crutchley Regional Employment Law Team	Appendix 2 - Change in relation to level of panels for hearings and appeals as agreed regionally. Other minor changes which were agreed regionally.
20/09/2019	1.2		Awaiting regional input – review extended 1 year



Director of Human Resources & OD



Chief Executive

DISCIPLINARY PROCEDURE

Author	Regional HR Policy Group
Directorate responsible	Human Resources & Organisational Development
Date	1 st April 2015
Review date	1 st April 2017

1. INTRODUCTION

This procedure is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behaviour. The aim of the procedure is to ensure:

- The Trust can operate effectively as an organisation.
- Disciplinary action taken is fair, appropriate and consistent and all who are involved in the process are treated with dignity and respect
- Managers, employees and their representatives are aware of their rights and obligations in matters relating to disciplinary and appeals procedure.

This Procedure applies to all Trust staff. It should be noted that in relation to Medical and Dental staff issues of general/professional misconduct are dealt with under this procedure. Further relevant procedures are contained in circular HSS (TC8) 6/2005 "Maintaining High Professional Standards in the Modern HPSS – a framework for the handling of concerns about doctors and dentists employed in the HPSS".

This disciplinary procedure should be read in conjunction with the Trust's Disciplinary Rules, which are set out in Appendix 1 of this Procedure.

Issues of competence and job performance will be dealt with under the Trust's Capability Procedure.

2. GUIDANCE AND DEFINITIONS

"Trust Employee" is anyone employed by the Trust.

"Investigating Officer" is any person authorised to carry out an investigation into alleged breaches of discipline to establish the facts of the case.

"Presenting Officer" is usually the investigating officer and presents the evidence to the Disciplinary Panel

"Employee Representative" is any employee of the Trust who is an accredited representative of a trade union, professional organisation or staff organisation or a full time official of any of the above organisations or a fellow Trust employee. Legal Representation will not be permitted at any stage of this Disciplinary Procedure.

"Disciplinary Panel" is the person or persons authorised to take disciplinary action.

"Misconduct" is a breach of discipline which is considered potentially serious enough to warrant recourse to formal disciplinary action (please refer to Disciplinary Rules).

"Gross Misconduct" is a serious breach of discipline which effectively destroys the employment relationship, and/or confidence which the Trust must have in an employee or brings the Trust into disrepute (please refer to Disciplinary Rules).

3. PRINCIPLES

The following general principles are applicable to all disciplinary cases:

- a. Employees are directed by their contract of employment to ensure they familiarise themselves with these procedures and the consequences of breaching the Trust's Disciplinary Rules
- b. In cases where an investigation is necessary, disciplinary action will not be taken against an employee until such an investigation is completed. However, the Trust reserves the right to proceed with disciplinary action where an employee fails to co-operate with an investigation.
- c. Where a case is being investigated under this Disciplinary Procedure, the employee will be provided with a copy of this procedure as soon as possible. At every stage in the procedure the employee will be advised of the nature of the complaint, and will be given the opportunity to state their case before any decision is made.
- d. At all stages during the disciplinary procedure, the employee will have the right to be accompanied and/or represented by an employee representative.
- e. No employee will be dismissed for a first breach of discipline except in the case of gross misconduct where the disciplinary action may be summary dismissal.
- f. An employee will have the right to appeal against any disciplinary action imposed.
- g. In deciding upon appropriate disciplinary action, consideration will be given to the nature of the offence, any mitigating circumstances and previous good conduct.
- h. The Trust will collect information from relevant witnesses. Trust employees who are witnesses to alleged misconduct will be required to give evidence and may be required to attend disciplinary meetings and/or hearings.
- i. At all stages disciplinary proceedings will be completed as quickly as practicable.

- j. Any disciplinary action will be appropriate to the nature of the proven misconduct.

4. ARRANGEMENTS FOR MEETINGS/HEARINGS

Employees are expected to participate fully with the disciplinary process. If a Trust employee cannot attend a meeting/hearing through circumstances outside her/his control and unforeseeable at the time the meeting/hearing was arranged they must notify the HR Department and provide reasons. The Trust will arrange one further meeting/hearing. Failure to attend this rearranged meeting/hearing may result in the disciplinary process continuing in their absence based on the information available.

5. ACTION IN PARTICULAR CASES

- a. **Disciplinary action in the case of an employee representative, who is an accredited representative of a Trade Union, Professional Organisation or Staff Organisation.**

Although normal disciplinary standards apply to the conduct of an employee representative, no disciplinary action beyond the informal stage should be taken until the matter has been discussed with a full-time official of the employee's trade union, professional organisation or staff association.

- b. **Police enquiries, legal proceedings, cautions and criminal convictions not related to employment**

Police enquiries, legal proceedings, caution or a conviction relating to a criminal charge shall not be regarded as necessarily constituting either a reason for disciplinary action or a reason for not pursuing disciplinary action. Consideration must be given as to the extent to which the offence alleged or committed is connected with or is likely to adversely affect the employee's performance of duties, calls into question the ability or fitness of the employee to perform his or her duties or where it is considered that it could bring the Trust into disrepute. In situations where a criminal case is pending or completed the Trust reserves its right to take internal disciplinary action.

- c. **Trust's duty to make referrals**

The Trust is required, where appropriate under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, to make a referral if a person working with children or vulnerable adults has been dismissed, would have been dismissed, or considered for dismissal had he/she not resigned, or has been suspended, or transferred from a Child Care or vulnerable adults position.

Further, the Trust has a duty to make referrals to relevant professional bodies e.g. NMC, GMC, NI Social Care Council, HPC and also to the Police Service of Northern Ireland (PSNI) in appropriate cases and share relevant information.

In cases of alleged theft, fraud or misappropriation of funds, action should include consultation with the Director of Finance, DHSSPS and the PSNI as appropriate.

d. **Suspension from Work**

Management reserves the right to immediately suspend an employee with pay. Precautionary suspension must be authorised by the appropriate senior manager or suitable deputy.

The reason for suspension should be made clear to the employee and confirmed in writing. When the reason for suspension is being conveyed to the employee, where possible, he or she should be accompanied by an employee/trade union representative. Suspension is not disciplinary action, and as a consequence carries no right of appeal. The appropriate senior manager should consider other alternatives, for example transfer of employee, restricted or alternative duties if considered feasible and appropriate.

Any decision to precautionary suspend from work, restrict practice, or transfer temporarily to other duties must be for the minimum necessary period of time. The decision must be reviewed, by the appropriate senior manager, every 4 weeks.

6. **DISCIPLINARY PROCEDURE**

This section sets out the steps which may be taken following a breach of the Trust's Disciplinary Rules

6.1 **COUNSELLING AND INFORMAL WARNINGS**

- a. The manager has the discretion to address minor issues through either counselling or the issue of an informal warning. At this informal stage matters are best resolved directly by the employee and line manager concerned.
- b. Counselling does not constitute formal disciplinary action. Counselling should be conducted in a fair and reasonable manner and the line manager should ensure that confidentiality is maintained. This should take the form of pointing out any shortcomings of conduct or performance and encouraging improvement and may include an agreed training or development plan. It is the line manager's responsibility to ensure that notes of the counselling meeting are shared with the employee, are stored securely and that the situation is monitored. This counselling does not in any way prevent the line manager from instigating formal disciplinary

action if appropriate. If the faults are repeated, or the conduct does not improve, the formal disciplinary procedure may be instigated

- c. The line manager has the discretion to issue an informal warning. If this is applicable, the manager will follow these steps:
 - Manager investigates matter
 - Manager meets with employee
 - Manager issues informal warning
 - Informal warning is confirmed to employee in writing and is deleted from their record after 6 months
 - Employee has right to appeal to the next line manager
 - Appeal request should be submitted within 7 working days
- d. The right to be accompanied by an employee representative will apply throughout the informal process.
- e. In the event that issues cannot be resolved with counselling or informal warnings the Formal Disciplinary Procedure should be invoked.

FORMAL DISCIPLINARY PROCEDURE

6.2 INVESTIGATION

- a. The Investigating Officer is responsible for establishing the facts of the case. The investigation will be conducted as quickly as is reasonable taking account of the extent and seriousness of the allegations. The Investigating Officer should meet with the employee who may be accompanied and/or represented by an employee representative and ensure that they are given a copy of the procedure. The Investigating Officer should explain the alleged misconduct to the employee. The Investigating Officer should ensure that any witnesses are interviewed and that all relevant documentation is examined before a decision is made on the appropriate course of action.
- b. It should be noted that, if an issue has already been investigated under another agreed investigatory procedure and disciplinary action has been recommended, then there is no requirement to reinvestigate under this Disciplinary Procedure.

6.3 HEARING

- a. If it is considered that there is a case to be answered, the employee should be called to attend a disciplinary hearing before the appropriate Disciplinary Panel. A copy of this Disciplinary Procedure should accompany the letter advising of the hearing. The

employee should be informed in writing of the allegation and the right to be represented. Any documentation intended for use by either party at the Disciplinary Hearing should be exchanged no later than five working days prior to the hearing.

- b. The Disciplinary Panel is made up of 2 managers at an appropriate level - Appendix 2 outlines the minimum level.
- c. Where an employee's professional competence/conduct is in question the Disciplinary Panel may, if needed, invite a suitably qualified experienced person from the same profession to attend the Hearing as an expert adviser. The adviser does not have a decision-making role.
- d. In cases of professional misconduct involving medical or dental staff, the Disciplinary Panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) who is not currently employed by the Trust (see Maintaining High Professional Standards in the Modern HPSS (Nov 2005) Section III Para 1). The advice of the appropriate local representative body should be sought.
- e. The employee shall normally be present during the hearing of all the evidence put before the Panel; however the employee may choose not to attend the hearing. It should be made clear that the hearing will proceed in his or her absence. Any submission by the employee in writing or by his or her representative will be considered. The Trust reserves the right to proceed to hear a disciplinary case in the absence of the employee where no adequate explanation is provided for the employee's absence.
- f. Any witnesses required to attend the hearing should be granted the appropriate time off from their work. The employee representative cannot be a witness or potential witness to the disciplinary process.
- g. At the Hearing, the case against the employee and the evidence should be detailed by the presenting officer and the employee should set out his/her case and answer the allegations.
- h. Witnesses may be called by either party and can be questioned by the other party and/or by the Disciplinary Panel. The presenting officer and the employee/representative will have the opportunity to make a final submission to the Disciplinary Panel at the end of the Hearing with the presenting officer going first. The Disciplinary Panel has the right to recall any witnesses but both sides and their representatives have the right to be present.

6.4 DISCIPLINARY DECISION

- a. The Disciplinary Panel will review all the evidence presented before taking its decision. The Disciplinary Panel will determine on a balance of probability whether the allegations were or were not proven. Before deciding on the appropriate disciplinary action, the Disciplinary Panel should consider any mitigating circumstances put forward at the hearing and take account of the employee's record.
- b. The decision should be communicated in writing to the employee normally within 7 working days of the date of the hearing or as soon as reasonably practicable. In the case of formal or final written warnings, the timescale of any sanction should be specified. The employee should be advised of the consequences of further breaches of discipline and informed of the right and method of appealing the decision.
- c. In the case of dismissal, the employee should be advised that the decision of the Disciplinary Panel will be fully implemented pending appeal.
- d. The appeal hearing should be organised in a timescale which allows proper representation to occur, consistent with principles of natural justice. In all circumstances an appeal hearing shall be organised within 12 weeks of the original hearing.
- e. Pay pending appeal will only be paid in circumstances where management alone have failed to convene an appeal hearing within the aforementioned timescale. In this circumstance payment will be recommenced from the point in time that the notice period ends.
- f. Pay pending appeal will not apply in circumstances where the employee was summarily dismissed.

6.5 DISCIPLINARY ACTION

The Disciplinary Panel may impose one or more of the following disciplinary sanctions / actions

- a. **Formal Warning** - a formal warning may be given following misconduct or where misconduct is repeated after informal action has been taken. A formal warning will remain on the employee's record for a period of one year. The warning should be accompanied by advice to the employee on the consequence of any repetition or continuance of the misconduct that has given rise to the disciplinary sanction / action.
- b. **Final Warning** - a final warning may be given when the misconduct is considered more serious or where there is a continuation of misconduct which has led to previous warnings and/or informal action. A final warning will remain on the

employee's record for a period of 2 years. The warning should be accompanied by advice to the employee on the consequence of any repetition or continuance of the misconduct that has given rise to the disciplinary sanction/action.

- c. **Transfer and/or Downgrading** - the Disciplinary Panel may decide that the most appropriate course of action should be either transfer, downgrading or both. These disciplinary actions may be imposed in addition to either a formal warning or a final warning as appropriate.
- d. **Dismissal** – Dismissal will apply in situations where previous warnings issued have not produced the required improvement in standards or in some cases of Gross Misconduct.
- e. **Summary Dismissal** – in some cases where Gross Misconduct has been established, an employee may be summarily dismissed i.e. without payment of contractual or statutory notice.

NOTE: If the misconduct is proven the Disciplinary Panel may recommend that any associated financial loss should be recouped from the employee. This should be referred to the Director of Finance for further consideration.

7. **DISCIPLINARY APPEALS**

- a. An employee wishing to appeal disciplinary action should write to the Director of Human Resources stating the grounds of their appeal within 7 working days of receipt of the letter containing the disciplinary decision. The appeal hearing will be arranged as early as practicable and the employee will have the right to be represented. The employee will normally receive 7 working days notice of the date of the appeal hearing.
- b. The Appeal Panel, will comprise 2 managers from the Trust who have had no previous involvement in the case and who are normally at a more senior level than the Disciplinary Panel. In professional misconduct appeals involving medical staff and/or dentists, the Appeal Panel will comprise one additional medically/dentally qualified panel member who is not employed by the Trust or has not been previously involved in the disciplinary case. Where the employee's professional competence/conduct is in question, the Appeal Panel may invite a suitably qualified and experienced senior officer in the same profession from the trust or outside the Trust to attend the hearing as an assessor. The assessor has no decision making role. The Appeal Panel will permit additional evidence not available or provided at the Disciplinary Hearing to be considered only if it is considered relevant to the original allegation.
- c. The Appeal hearing will be a full rehearing of the case.

- d. The Appeal Panel will have the authority to confirm, set aside, or reduce the decision of the Disciplinary Panel. It will not have the right to increase the decision of the Disciplinary Panel. Where the decision of the Appeal Panel involves a variation of the original disciplinary decision, it should state the reasons and any operative date. The decision of the Appeal Panel is final and will be conveyed in writing to the appellant within seven working after the hearing. In the event of delay a written explanation will be provided.
- e. In the event of reinstatement following an appeal the appropriate back payment will be made.

8. REVIEW OF THE PROCEDURE

This procedure should be reviewed periodically in consultation with recognised staff side representatives via the HSC (NI) Joint Negotiation Forum.

Signed on behalf of Trade Union Side

Signed on behalf of Management



Anne Speed
Joint Secretary

Damian McAlister
Director of Human Resources & OD

This procedure is effective from 1st April 2015

APPENDIX 1 TRUST DISCIPLINARY RULES

In accordance with paragraph 1 of the Trust's Disciplinary Procedure, Disciplinary Rules are set out below. Conduct is categorised under the headings of "**Misconduct**" and "**Gross Misconduct**". This list should not be regarded as exhaustive or exclusive but used simply as a guide.

In determining the appropriate heading, managers are required to carefully consider the circumstances and seriousness of the case.

MISCONDUCT

Listed below are examples of offences of misconduct, other than gross misconduct, which may result in disciplinary action and/or counselling/informal warning in the light of the circumstances of each case. Where misconduct **is** repeated this may lead to dismissal.

- **Inappropriate or unacceptable conduct or behaviour towards employees, patients, residents, clients, relatives or members of the public.**
- **Abuse of employment position and/or authority.**
- **Absenteeism**
- **Unauthorised Absence**
- **Insubordination.**
- **Poor Time-keeping.**
- **Dishonesty.**
- **Unsatisfactory Performance and Conduct.**
- **Failure to adhere to contract of employment.**
- **Failure to comply with the responsibilities and duties of employment position.**
- **Failure to comply with Trust Rules and Procedures, Policies and Practices.**
- **Failure to declare outside Employment/Activities** – Failure to declare any outside activity which would impact on the full performance of contract of employment.
- **Failure to conform with safety, hygiene, security rules and regulations**
- **Misuse of Trust Resources-** internet, e-mail, telephone etc (see Trust policies)
- **Misuse of Trust Property-**neglect, damage, or loss of property, equipment or records belonging to the Trust, clients, patients, residents or employees
- **Use of foul language.**
- **Gambling on Trust Premises**
- **Dangerous horseplay.**
- **Discrimination, victimisation, harassment or bullying on any grounds**
- **Breach of confidentiality.**
- **Alcohol/Drugs misuse.**
- **Being an accessory to a disciplinary offence**

GROSS MISCONDUCT

The following are examples of Gross Misconduct offences which are serious breaches of contractual terms which effectively destroy the employment relationship, and/or the confidence which the Trust must have in an employee. Gross misconduct may warrant summary dismissal without previous warnings.

- **Theft** - Theft from the Trust, its employees, patients, clients, residents or the public including other offences of dishonesty.
- **Fraud** - Falsification of documentation or records pertaining to patients, clients, staff, or other persons. Misrepresentation which results, or could result in financial gain (e.g. applications for posts, pre-employment medical forms, time-sheets, clock- cards, subsistence and expenses claims etc.)
- **Being under the influence or misuse of Alcohol or Drugs** – Being under the influence of alcohol, unauthorised consumption while on duty or during working hours. Reporting for duty smelling of alcohol. Misuse of drugs e.g. through misappropriation or being under the influence of drugs.
- **Breaches of safety, hygiene, security rules and regulations endangering one's own or another's physical well-being or safety.**
- **Issues of probity.**
- **Physical violence / assault or other exceptionally offensive behaviour.**
- **Criminal Conduct**- including failure to notify the Trust of a criminal offence either at work or outside of work. Consideration will be taken of criminal conduct/convictions and relevance to the employee's position.
- **Breaches of Confidentiality.**
- **Discrimination, victimisation, harassment or bullying on any grounds**
- **Serious Breaches of Trust Rules, Policies, Procedures and Practices**
- **Malicious or vexatious allegations or intimidation against another employee.**
- **Serious Insubordination.**
- **Ill-treatment or wilful neglect of patients, clients, residents.**
- **Negligence.**
- **Breaches of contract of employment and/or Professional Codes of Conduct.**
- **Some outside Employment/Activities**-Engaging in outside employment/activities that would prevent the efficient performance of duties, adversely affect health, bring into question loyalty and reliability or in any way weaken confidence in the Trust's business. Engaging in outside employment when contracted to work for the Trust unless otherwise agreed or where outside work is undertaken in competition with the Trust.
- **Abuse of sick pay provisions.**
- **Bringing the Trust into Disrepute.**
- **Misuse or unauthorised use of Property.** - Unauthorised use or removal of Trust property. Damage caused maliciously or recklessly to property, equipment or records belonging to the Trust, clients, patients, residents or employees
- **Misuse of Trust resources, including IT resources (see IT policies), or misuse of Trust name.**
- **Serious professional misconduct or negligence**
- **Unauthorised sleeping on duty**

APPENDIX 2 – PANELS FOR HEARINGS AND APPEALS

Misconduct		
	Hearing	Appeal
Staff below 5 th level	Level 5	Level 4
Staff at 5 th Level	Level 4	Level 3
Staff at 4 th Level	Level 3	Level 2
Staff at 3 rd Level	Level 2	Level 2
Staff at 2 nd Level	Level 1 / Level 2	Chair / Level 1 / Level 2
Gross Misconduct		
	Hearing	Appeal
Staff below 5 th level	Level 5	Level 4
Staff at 5 th Level	Level 4	Level 3
Staff at 4 th Level	Level 3	Level 2
Staff at 3 rd Level	Level 2	Level 2
Staff at 2 nd Level	Level 1 / Level 2	Chair / Level 1 / Level 2

Level 1 – Chief Executive

Level 2 – Director

Level 3 – Assistant / Co-Director

Level 4 – Senior Manager

Level 5 – Service Manager

Maintaining High Professional Standards in the Modern **HPSS**

*A framework for the handling of concerns about doctors and
dentists in the HPSS*

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN HPSS

*A framework for the handling of concerns about doctors and dentists in the
HPSS*

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INTRODUCTION

1. This document introduces the new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.
2. Throughout this framework where the term "performance" is used, it should be interpreted as referring to all aspects of a practitioner's work, including conduct, health and clinical performance. Where the term "clinical performance" is used, it should be interpreted as referring only to those aspects of a practitioner's work that require the exercise of clinical judgement or skill.
3. Under the Directions on Disciplinary Procedures 2005, HPSS organisations must notify the Department of the action they have taken to comply with the framework by 31 January 2006.
4. The framework is in six sections and covers:
 - I. Action when a concern first arises
 - II. Restriction of practice and exclusion from work
 - III. Conduct hearings and disciplinary procedures
 - IV. Procedures for dealing with issues of clinical performance
 - V. Handling concerns about a practitioner's health
 - VI. Formal procedures – general principles
5. Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist.

Background

6. There has been some concern in the past about the way in which complaints about doctors and dentists have been handled. Developing new arrangements for dealing with medical and dental staff performance has become increasingly important in order to address these concerns and to reflect the new systems for quality assurance, quality improvement and patient safety being introduced in the HPSS.
7. The National Clinical Assessment Authority (NCAA) was established to improve arrangements for dealing with poor clinical performance of doctors. The Department entered into a service level agreement with the NCAA in October 2004 to provide advice and guidance to the HPSS. Since April 2005,

the NCAA has become a division of the National Patient Safety Agency, and is now known as the National Clinical Assessment Service (NCAS).

8. The new approach set out in the framework builds on four key elements:
 - appraisal¹ and revalidation – processes which require practitioners to maintain the skills and knowledge needed for their work through Continuing Professional Development (CPD);
 - the advisory and assessment services of the NCAS – aimed at enabling HSS Bodies² to handle cases quickly and fairly - reducing the need to use disciplinary procedures to resolve problems;
 - tackling the blame culture – recognising that most failures in standards of care are caused by systems' weaknesses, not individuals per se;
 - new arrangements for handling exclusion from work as set out in Sections I and II of this framework.
9. To work effectively these need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists maintaining their competence; and which support an open approach to reporting and addressing concerns about doctors' and dentists' practice. The new approach recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through disciplinary action. However, it is not intended to weaken accountability or avoid disciplinary action where the situation warrants this approach.

The new framework

10. At the heart of the new arrangements is a co-ordinated process for handling concerns about the safety of patients posed by the performance of doctors and dentists when this comes to the attention of the HPSS. Whatever the source of this information the response must be the same –
 - to ascertain quickly what has happened and establish the facts;
 - to determine whether there is a continuing risk;
 - to decide whether immediate action is needed to manage the risk to ensure the protection of patients;
 - to put in place action to address any underlying problem.

¹ Appraisal is a structured process which gives doctors an opportunity to reflect on their practice and discuss, with a suitably trained and qualified appraiser, any issues arising from their work, and their development needs.

² In the Direction and Framework "HSS bodies" means: HSS Trusts, HSS Boards and Special Agencies

Under these new mechanisms, exclusion from work must be used only in the most exceptional circumstances.

11. All HSS bodies must have procedures for handling concerns about an individual's performance. These procedures must reflect the framework in this document and allow for informal resolution of problems where deemed appropriate. Concerns about the performance of doctors and dentists in training should be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset. The onus still rests with the employer for the conduct of the investigation and any necessary action.

SECTION I. ACTION WHEN A CONCERN FIRST ARISES

INTRODUCTION

1. The management of performance is a continuous process to ensure both quality of service and to protect clinicians. Numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures.
2. Concerns about a doctor or dentist's performance can come to light in a wide variety of ways, for example:
 - concerns expressed by other HPSS staff;
 - review of performance against job plans and annual appraisal;
 - monitoring of data on clinical performance and quality of care;
 - clinical governance, clinical audit and other quality improvement activities;
 - complaints about care by patients or relatives of patients;
 - information from the regulatory bodies;
 - litigation following allegations of negligence;
 - information from the police or coroner;
 - court judgements; or
 - following the report of one or more critical clinical incidents or near misses.
3. All allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to establish the facts and the substance of any allegations. Unfounded or malicious allegations can cause lasting damage to a doctor's reputation and career. Where allegations raised by a fellow HPSS employee are shown to be malicious, that employee should be subject to the relevant disciplinary procedures.

SUMMARY OF KEY ACTIONS NEEDED

4. The key actions needed at the outset can be summarised as follows:
 - clarify what has happened and the nature of the problem or concern;
 - consider discussing case with NCAS on the way forward;
 - consider if urgent action needs to be taken to protect the patient/s;
 - consider whether restriction of practice or exclusion is required;

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
 - arranging supervision of normal contractual clinical duties;
 - restricting the practitioner to certain forms of clinical duties;
 - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
 - sick leave for the investigation of specific health problems.
6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member*" should be involved to any significant degree in the management of individual cases.
8. The key individuals that may have a role in the process are summarised below:-
 - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
 - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

representations from the practitioner about his or her exclusion or any representations about the investigation;

- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- the Director of HR 's role will be to support the Chief Executive and the Medical Director.

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
 - immediate telephone advice, available 24 hours;
 - advice, then detailed supported local case management;
 - advice, then detailed NCAS performance assessment;
 - support with implementation of recommendations arising from assessment.
10. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.
11. The first stage of the NCAS's involvement in a case is exploratory – an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem, and possibly recognize the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.
12. The focus of the NCAS's work on assessment is likely to involve performance difficulties which are serious and/or repetitive. That means:

- clinical performance falling well short of recognized standards and clinical practice which, if repeated, would put patients seriously at risk;
 - alternatively, or additionally, issues which are ongoing or recurrent.
13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.
14. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.
16. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.
17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

IMMEDIATE EXCLUSION

18. When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.
19. An immediate time limited exclusion may be necessary
 - to protect the interests of patients or other staff;
 - where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.
20. The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources.
21. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.
22. The clinical manager having obtained the authority to exclude must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting
23. Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.
24. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.
25. The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

26. At any point in the process where the Medical Director has reached a judgment that a practitioner is to be the subject of an exclusion, the regulatory body should be notified. Guidance on the process for issuing alert letters can be found in circular HSS (TC8) (6)/98. This framework also sets out additional circumstances when the issue of an alert letter may be considered.
27. Section II of this framework sets out the procedures to be followed should a formal investigation indicate that a longer period of formal exclusion is required.

FORMAL APPROACH

28. Where it is decided that a formal approach needs to be followed (perhaps leading to conduct or clinical performance proceedings) the CE must, after discussion between the Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member as outlined in paragraph 8. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.
29. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action.
30. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied to any interview or hearing by a companion. The companion may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but he or she will not, however, be acting in a legal capacity.

The Case Investigator's role

31. The Case Investigator:
 - must formally, on the advice of the Medical Director, involve a senior member of the medical or dental staff³ with relevant clinical experience in cases where a question of clinical judgment is raised during the investigation process;
 - must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It is the responsibility of the Case Investigator

³ Where no other suitable senior doctor or dentist is employed by the HSS body a senior doctor or dentist from another HSS body should be involved.

to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered;

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
 - must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
 - must assist the designated Board member in reviewing the progress of the case.
32. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work. They may not be a member of any disciplinary or appeal panel relating to the case.
33. The Case Investigator has wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

The Case Manager's role

34. The Case Manager is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority
35. The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.
36. If during the course of the investigation, it transpires that the case involves more complex clinical issues (which cannot be addressed in the Trust), the Case Manager should consider whether an independent practitioner from another HSS body or elsewhere be invited to assist.

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.
38. The report should give the Case Manager sufficient information to make a decision on whether:
- no further action is needed;
 - restrictions on practice or exclusion from work should be considered;
 - there is a case of misconduct that should be put to a conduct panel;
 - there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
 - there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
 - there are serious concerns that fall into the criteria for referral to the GMC or GDC;
 - there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.
40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

41. On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.

SECTION II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

INTRODUCTION

1. This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions). Under the Directions on Disciplinary Procedures 2005, HPSS employers must incorporate these principles and procedures within their local procedures. The guiding principles of Article 6 of the Human Rights Act must be strictly adhered to.
2. In this part of the framework, the phrase “exclusion from work” has been used to replace the word “suspension” which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.
3. The Directions require that HSS bodies must ensure that:
 - exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
 - where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
 - all extensions of exclusion are reviewed and a brief report provided to the CE and the board;
 - a detailed report is provided when requested to the designated Board member who will be responsible for monitoring the situation until the exclusion has been lifted.

MANAGING THE RISK TO PATIENTS

4. Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.
5. The purpose of exclusion is:
 - to protect the interests of patients or other staff; and/or
 - to assist the investigative process when there is a clear risk that the practitioner’s presence would impede the gathering of evidence.
6. It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

THE EXCLUSION PROCESS

7. **Under the Directions, an HSS body cannot require the exclusion of a practitioner for more than four weeks at a time.** The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

Key aspects of exclusion from work

8. Key aspects include:
- an initial “immediate” exclusion of no more than four weeks if warranted as set out in Section I;
 - notification of the NCAS before immediate and formal exclusion;
 - formal exclusion (if necessary) for periods up to four weeks;
 - ongoing advice on the case management plan from the NCAS;
 - appointment of a designated Board member to monitor the exclusion and subsequent action;
 - referral to NCAS for formal assessment, if part of case management plan;
 - active review by clinical and case managers to decide renewal or cessation of exclusion;
 - a right to return to work if review not carried out;
 - performance reporting on the management of the case;
 - programme for return to work if not referred to disciplinary procedures or clinical performance assessment;
 - a right for the doctor to make representation to the designated Board member
9. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director.

Exclusion other than immediate exclusion

10. A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), whether there is reasonable and proper cause to exclude. **The NCAS must be consulted where formal exclusion is being considered.** If a Case Investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.
11. The report should provide sufficient information for a decision to be made as to whether:
 - (i) the allegation appears unfounded; or
 - (ii) there is a misconduct issue; or
 - (iii) there is a concern about the practitioner's clinical performance; or
 - (iv) the complexity of the case warrants further detailed investigation before advice can be given.
12. Formal exclusion of one or more clinicians must only be used where:
 - a. there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of:
 - allegations of misconduct;
 - concerns around the functioning of a clinical team which are likely to adversely affect patients;
 - concerns about poor clinical performance; or
 - b. the presence of the practitioner in the workplace is likely to hinder the investigation.
13. Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.
14. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion

(paragraph 30 of Section I defines companion). All discussions should be minuted, recorded and documented and a copy given to the practitioner.

15. The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 19, and the need to remain available for work paragraph 20) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.
16. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable periods until the completion of disciplinary procedures, if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review (see paras 26 – 31 relating to the review process). The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.
17. If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.
18. If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

Exclusion from premises

19. Practitioners should not be automatically barred from the premises upon exclusion from work. Case Managers must always consider whether a bar is absolutely necessary. The practitioner may want to retain contact with colleagues, take part in clinical audit, to remain up to date with developments in their specialty or to undertake research or training. There are certain circumstances, however, where the practitioner should be excluded from the premises. There may be a danger of tampering with evidence, or where the practitioner may present a serious potential danger to patients or other staff

Keeping in contact and availability for work

20. Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the HPSS employer. This caveat does not refer to time for which they are not being paid by the HPSS employer. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).
21. The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in CPD and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

Informing other organisations

22. Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HPSS and non-HPSS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer⁴.
23. Where the Case Manager has good grounds to believe that the practitioner is practicing in other parts of the HPSS, or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the CMO of the Department to consider the issue of an alert letter.
24. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' have been

⁴ HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointments.

commonly used in the recent past. **No HSS body may use "gardening leave" as a means of resolving a problem covered by this framework.**

Existing suspensions & transitional arrangements

25. On implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

26. The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:
- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended. A copy must be sent to the Department (Director of Human Resources).
 - receive an assurance from the CE and designated board member that the agreed mechanisms are being followed. Details of individual exclusions should not be discussed at Board level.

Regular review

27. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive⁵. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.
28. The HSS body must take review action before the end of each 4-week period. The table below outlines the various activities that must be undertaken at different stages of exclusion.

⁵ It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. • The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. • Case Manager submits advisory report of outcome to CE and Medical Director. • Each review is a formal matter and must be documented as such. • The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: • A report must be made by the Medical Director to the CE: - outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; - and if the investigation has not been completed - a timetable for completion of the investigation. • The CE must report to the Director of Human Resources at the Department, who will involve the CMO if appropriate. • The case must be formally referred back to the NCAS explaining: - why continued exclusion is thought to be appropriate; - what steps are being taken to complete the investigation at the earliest opportunity. • The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, • A further position report must be made by the CE to

	the Department indicating: - the reason for continuing the exclusion; - anticipated time scale for completing the process; - actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.
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29. Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

The role of the Department in monitoring exclusions

30. When the Department is notified of an exclusion, it should confirm with the NCAS that they have been notified.
31. When an exclusion decision has been extended twice (third review), the CE of the employing organisation (or a nominated officer) must inform the Department of what action is proposed to resolve the situation.

RETURN TO WORK

32. If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged, what duties and restrictions apply, and any monitoring arrangements to ensure patient safety.

SECTION III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there is a case of misconduct that must be put to a conduct panel (paragraph 38 of section 1). Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.
2. It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraph 5 of Section IV refers).
3. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.⁶
4. Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.
5. HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

CODES OF CONDUCT

6. Every HPSS employer will have a Code of Conduct or staff rules, which should set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories:
 - a refusal to comply with the requirements of the employer where these are shown to be reasonable;
 - an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of

⁶ Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee

doctors and dentists by their regulatory body⁷;

- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

7. The employer's Code of Conduct should set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct, and could lead to summary dismissal. The code cannot cover every eventuality. Similarly the Labour Relations Agency (LRA) Code of Practice provides a non-exhaustive list of examples. Acts of misconduct may be simple and readily recognised or more complex and involved. Examples may include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and/or discrimination in the exercise of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.
8. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.
9. It is for the employer to decide upon the most appropriate way forward, including the need to consult the NCAS and their own sources of expertise on employment law. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively, or in addition, he or she may make representations to the designated Board member.
10. In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC.

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

11. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters

⁷ In case of doctors, *Good Medical Practice*. In the case of dentists, *Maintaining Standards*.

would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.

Cases where criminal charges are brought not connected with an investigation by an HPSS employer

12. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made. Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should, as a matter of good practice, explain the reasons for taking such action.

Dropping of charges or no court conviction

13. If the practitioner is acquitted following legal proceedings, but the employer feels there is enough evidence to suggest a potential danger to patients, the Trust has a public duty to take action to ensure that the practitioner does not pose a risk to patient safety. Where the charges are dropped or the court case is withdrawn, there may be grounds to consider allegations which if proved would constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned.

SECTION IV. PROCEDURES FOR DEALING WITH ISSUES OF CLINICAL PERFORMANCE

INTRODUCTION & GENERAL PRINCIPLES

1. There will be occasions following an adequate investigation where an employer considers that there has been a clear failure by an individual to deliver an acceptable standard of care, or standard of clinical management, through lack of knowledge, ability or consistently poor performance. These are described as clinical performance issues.
2. Concerns about the clinical performance of a doctor or dentist may arise as outlined in Section I. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through local informal processes set out in Section I (paragraphs 15 – 17) **the matter must be referred to the NCAS before consideration by a performance panel** (unless the practitioner refuses to have his or her case referred).
3. Matters which may fall under the performance procedures include:
 - out moded clinical practice;
 - inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
 - incompetent clinical practice;
 - inappropriate delegation of clinical responsibility;
 - inadequate supervision of delegated clinical tasks;
 - ineffective clinical team working skills.

Wherever possible such issues should be dealt with informally, seeking support and advice from the NCAS where appropriate. The vast majority of cases should be adequately dealt with through a plan of action agreed between the practitioner and the employer.

4. Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in Section V of this framework.

How to proceed where conduct and clinical performance issues are involved

5. It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If

a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

6. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question⁸.
7. As set out in Section I (paras 9 - 14), the NCAS can assist the employer to draw up an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.
8. If the practitioner does not agree to the case being referred to NCAS, a panel hearing will normally be necessary.

HEARING PROCEDURE

The pre-hearing process

9. The following procedure should be followed before the hearing:
 - the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;
 - all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date

⁸ see paragraphs 5 and 6 in section 6I on arrangements for small organisations

should be set for the hearing;

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;
- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;
- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.
- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

10. The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately experienced medical or dental practitioner who is not employed by the Trust.⁹ No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.
11. Arrangements must be made for the panel to be advised by:
 - a senior member of staff from Human Resources;
 - an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HPSS employer;

⁹ Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee.

- a representative of a university if provided for in any protocol agreed between the employer and the university.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS/NHS employer, in the same grade as the practitioner in question, should be asked to provide advice. In the case of doctors in training the postgraduate dean's advice should be sought.

12. It is for the employer to decide on the membership of the panel. A practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The employer should review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The employer must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

Representation at clinical performance hearings

13. The hearing is not a court of law. Whilst the practitioner should be given every reasonable opportunity to present his or her case, the hearing should not be conducted in a legalistic or excessively formal manner.
14. The practitioner may be represented in the process by a companion who may be another employee of the HSS body: an official or lay representative of the BMA, BDA, defence organisation or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

Conduct of the clinical performance hearing

15. The hearing should be conducted as follows:
 - the panel and its advisers, the practitioner, his or her representative and the Case Manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
 - the Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing;
 - the procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;
- the side calling the witness can question the witness;
- the other side can then question the witness;
- the panel may question the witness;
- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

The order of presentation shall be:

- the Case Manager presents the management case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification;
- the practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification;
- the Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case;
- the Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation;
- the panel shall then retire to consider its decision.

Decisions

16. The panel will have the power to make a range of decisions including the following:

Possible decisions made by the clinical performance panel

- a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;
- a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:

- the clinical performance problem(s) identified;
- the improvement that is required;
- the timescale for achieving this improvement;
- a review date;
- measures of support the employer will provide; and
- the consequences of the practitioner not meeting these requirements.

In addition, dependent on the extent or severity of the problem, the panel may:

- issue a written warning or final written warning that there must be an improvement in clinical performance within a specified time scale together with the duration that these warnings will be considered for disciplinary purposes (up to a maximum of two years depending on severity);
- decide on termination of contract.

In all cases where there is a finding of unsatisfactory clinical performance, consideration must be given to referral to the GMC/GDC.

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. The panel may wish to comment on the systems and procedures operated by the employer.

17. A record of all findings, decisions and written warnings should be kept on the practitioner's personnel file. Written warnings should be disregarded for disciplinary purposes following the specified period.
18. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Given the possible complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.
19. The decision must be confirmed in writing to the practitioner within 10 working days. This notification must include reasons for the decision, clarification of the practitioner's right of appeal (specifying to whom the appeal should be addressed) and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

Introduction

20. Given the significance of the decision of a clinical performance panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place. Every Trust must therefore establish an internal appeal process.
21. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel, in arriving at their decision, acted fairly and reasonably based on:
 - a fair and thorough investigation of the issue;
 - sufficient evidence arising from the investigation or assessment on which to base the decision;
 - whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re-hear the entire case but may direct that the case is re-heard if it considers it appropriate (see paragraph 24 below).

22. A dismissed practitioner will, in all cases, be potentially able to take their case to an Industrial Tribunal where the fairness of the Trust's actions will be tested.

The appeal process

23. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.
24. Where the appeal is against dismissal, the practitioner should not be paid, from the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to re-hear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

The appeal panel

25. The panel should consist of three members. The members of the appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the designated board member. These members will be:

Membership of the appeal panel

- an independent member (trained in legal aspects of appeals) from an approved pool.¹⁰ This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust¹¹ who must also have the appropriate training for hearing an appeal.

In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university

26. The panel should call on others to provide specialist advice. This should normally include:
- a consultant from the same specialty or subspecialty as the appellant, but from another HPSS/NHS employer¹²;
 - a senior Human Resources specialist.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS employer in the same grade as the practitioner in question should be asked to provide advice. Where the case involves a doctor in training, the postgraduate dean should be consulted.

27. The Trust should convene the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 29. Every effort should be made to ensure that the panel members are acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant's objections should be noted carefully. Trusts are reminded of the need to act reasonably at all stages of the process.

¹⁰ See Annex A.

¹¹ Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.

¹² Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

28. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original performance hearing. The following timetable should apply in all cases:
- appeal by written statement to be submitted to the designated appeal point (normally the Director of HR) within 25 working days of the date of the written confirmation of the original decision;
 - hearing to take place within 25 working days of date of lodging appeal;
 - decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.
29. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

Powers of the appeal panel

30. The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.
31. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.
32. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a clinical performance hearing panel.

Conduct of appeal hearing

33. All parties should have all documents, including witness statements, from the previous performance hearing together with any new evidence.
34. The practitioner may be represented in the process by a companion who may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative

will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

35. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.
36. The panel, after receiving the views of both parties, shall consider and make its decision in private.

Decision

37. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's Case Manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision of the panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

Action following hearing

38. Records must be kept, including a report detailing the performance issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the clinical performance procedure and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Industrial Tribunal.

Annex A

APPEAL PANELS IN CLINICAL PERFORMANCE CASES

Introduction

1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.
2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held Northern Ireland wide list rather than through local selection. The benefits include:
 - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
 - the ability to monitor performance and assure the quality of panellists.
3. The following provides an outline of how it is envisaged the process will work.

Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with the Department, who will be responsible for administration of the list
5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the BMA, BDA, defence organisations, and the NCAS. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.
6. The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competencies featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.
7. Panel members will be subject to appraisal against the core competencies and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.
8. The level of fees payable to panel members will be set by the Department and paid locally by the employer responsible for establishing the panel.

9. List members will be expected to take part in and contribute to local training events from time to time. For example, training based on generic tribunal skills along the lines of the Judicial Studies Board competencies and /or seminars designed to provide background on the specific context of HPSS disciplinary procedures.

SECTION V. HANDLING CONCERNS ABOUT PERFORMANCE ARISING FROM A PRACTITIONER'S HEALTH

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there are concerns about the practitioner's health that should be considered by the HSS body's Occupational Health Service (OHS) and the findings reported to the employer.
2. In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. Employers should be aware that the practitioner may also self refer to OHS.
3. The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the HPSS.

HANDLING HEALTH ISSUES

4. On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of HR, the Medical Director or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)¹³. The practitioner may be accompanied to these meetings (as defined in Section I, para 30). Confidentiality must be maintained by all parties at all times.
5. The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.
6. In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary procedures (as outlined in Section IV), or misconduct procedures (as outlined in Section III) would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer

¹³ In the absence of a Medical Director organisations should put in place appropriate measures as part of agreed arrangements for small organisations to ensure the appropriate level of input to the process. See section vi.

to resolve the underlying situation e.g. by refusing a referral to the OHS or NCAS.

7. A practitioner who is subject to the procedures in Sections III and IV may put forward a case on ill health grounds that proceedings should be delayed, modified or terminated. In those cases the employer should refer the practitioner to OHS for assessment as soon as possible and suspend proceedings pending the OHS report. Unreasonable refusal to accept a referral to, or to co-operate with OHS, may give separate grounds for pursuing disciplinary action.

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

8. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk. The following are examples of actions a Trust might take in these circumstances, in consultation with OHS and having taken advice from NCAS and/or NIMDTA if appropriate.

Examples of action to take

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);
- remove the practitioner from certain duties;
- make adjustments to the practitioner's working environment;
- reassign them to a different area of work;
- arrange re-training for the practitioner;
- consider whether the Disability Discrimination Act (DDA) applies (see below), and, if so, what other reasonable adjustments might be made to their working environment.

DISABILITY DISCRIMINATION ACT (DDA)

9. Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.
10. Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non-disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

Examples of reasonable adjustment

- make adjustments to the premises;
- re-allocate some of the disabled person's duties to another;
- transfer employee to an existing vacancy;
- alter employee's working hours or pattern of work;
- assign employee to a different workplace;
- allow absence for rehabilitation, assessment or treatment;
- provide additional training or retraining;
- acquire/modify equipment;
- modifying procedures for testing or assessment;
- provide a reader or interpreter;
- establish mentoring arrangements.

11. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in consultation with the practitioner, OHS, and HPSS Superannuation Branch.

Note. Special Professional Panels (generally referred to as the "three wise men") were set up under circular TC8 1/84. This part of the framework replaces those arrangements and any existing panels should be disbanded.

SECTION VI. FORMAL PROCEDURES – GENERAL PRINCIPLES

TRAINING

1. Employers must ensure that managers and Case Investigators receive appropriate training in the operation of formal performance procedures. Those undertaking investigations or sitting on disciplinary or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members have completed before they can take a part in these proceedings.

HANDLING OF ILLNESS ARISING DURING FORMAL PROCEEDINGS

2. If an excluded employee or an employee facing formal proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside formal procedures and the employer should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.
3. If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the practitioner should have the opportunity to provide written submissions and/or have a representative attend in his absence.
4. Where a case involves allegations of abuse against a child or a vulnerable adult, the guidance issued to the HPSS in 2005, "Choosing to Protect – A Guide to Using the Protection of Children Northern Ireland (POCNI) Service", gives more detailed information.

PROCESS FOR SMALLER ORGANISATIONS

5. Many smaller organisations may not have all the necessary personnel in place to follow the procedures outlined in this document. For example, some smaller organisations may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.
6. Such organisations should consider working in collaboration with other local HPSS organisations (eg other Trusts) in order to provide sufficient personnel

to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the HPSS organisation should contact the Department to take its advice on the process followed and ensure that it is in accordance with the policy and procedures set out in this document.

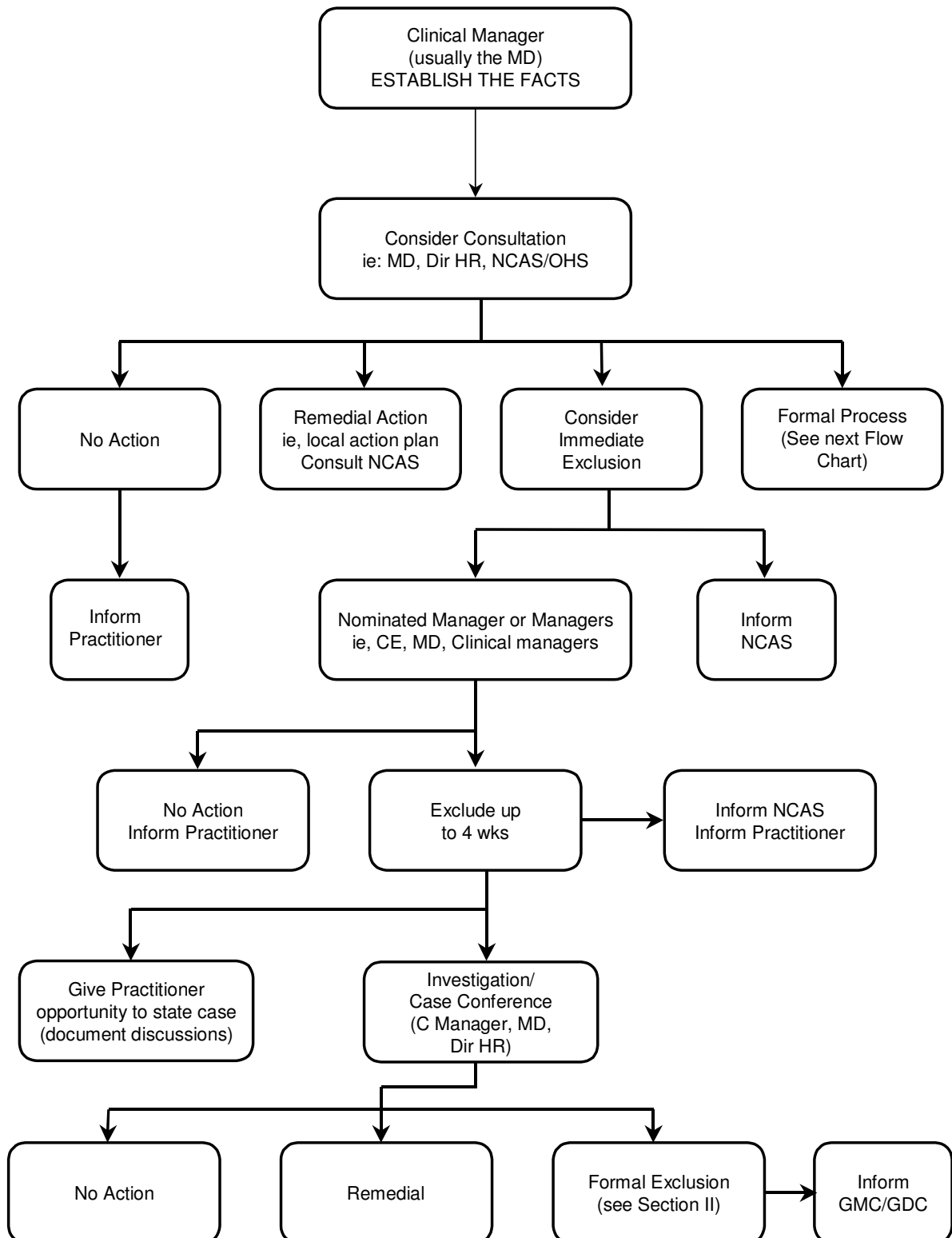
TERMINATION OF EMPLOYMENT WITH PROCEDURES UNFINISHED

7. Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.
8. There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.
9. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children and Vulnerable Adults List (held by the Department of Employment and Learning).

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

10. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:
 - settlement agreements must not be to the detriment of patient safety;
 - it is not acceptable to agree any settlement that precludes involvement of either party in any further legitimate investigations or referral to the appropriate regulatory body.

INFORMAL PROCESS



FORMAL PROCESS

