Western Health and Social Care Trust

POLICY AND PROCEDURES FOR MANAGEMENT OF COMPLAINTS AND COMPLIMENTS/SERVICE USER FEEDBACK

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Western Health & Social Care Trust

Title:	**Policy and Procedures for Management of Complaints and Compliments/Service User Feedback**		
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Management of Complaints and Compliments/Service User Feedback

POLICY

PART 1

1. Introduction and Context

1.1 The Western Health & Social Care Trust's (hereafter referred to as the "Trust") Complaints and Service User Feedback Policy and Procedures has been based on and complies with the legislative principles contained in the Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009, Department of Health's (DoH) 'Complaints in Health & Social Care - Standards and Guidelines for Resolution & Learning' published in April 2009, updated in October 2013 and more recently updated, renamed and published in April 2019 as the 'Guidance in relation to the Health and Social Care Complaints Procedure'.

1.2 A separate specific policy and procedure is in place for the management of representations and complaints under Part IV and paragraph 4, Schedule 5 of the Children (Northern Ireland) Order 1995.

1.3 This policy should be read in conjunction with the Complaints Procedures set out in **Part 2** of this document and other associated documentation as detailed in the various Appendices. Relevant documents will be available on the Trust's Internet and Intranet sites.

1.4 Feedback from service users is an important aspect of the Trust's governance arrangements, and helps the Trust to improve the quality of the services we offer and safeguard high standards of care and treatment. All complaints, enquiries, comments/ suggestions and compliments are encouraged, and will be taken seriously as they are viewed as a positive opportunity for learning and improving services and service user experiences.

2. Purpose

This policy details the Trust's arrangements for dealing with verbal and written complaints, enquiries, comments/suggestions and compliments received about care or treatment, or about issues relating to the provision of health and social care services provided by or on behalf of the Trust.

The policy is designed to provide ease of access, and a consistent, open and supportive process which results in prompt and fair resolution of complaints.

3. Policy Aims and Objectives

- To provide ease of access to those wishing to make a complaint about health and social care services provided;
- To ensure the process for dealing with complaints is simple and straightforward;
- To ensure responses to complaints are timely whilst being comprehensive, accurate and open with an emphasis on early resolution of the complaint;
- To ensure staff and complainants are treated with the same open and fair approach;
- To promote and provide a unified approach for the receipt, investigation and response to all complaints;
- To ensure that complaints are used positively to support learning, continuously improve the services we provide and where possible prevent a recurrence.

4. Scope of the Policy

This policy applies to all staff working in the Trust. It is the responsibility of all staff to familiarise themselves with and adhere to the contents of this policy.

5. Policy Principles

The HSC Complaints Procedure has been developed around 4 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 distress for all;
Learning and development – ensuring complaints are viewed as a positive opportunity to learn and to improve services.

6. Definitions

The definitions used in this policy are taken from the Department of Health's "Guidance in Relation to the Health and Social Care Complaints Procedure" revised in April 2019.

Complaint - "an expression of dissatisfaction that requires a response." This could be about any matter connected with the provision of care by the Trust. The Trust recognises that problems can and will occur and welcomes complaints as an opportunity to review and improve services.

Enquiry – "to ask a question." Service users or their representatives formally seek an explanation or clarification regarding services received or awaited. Enquiries are distinct from requests for information which are managed under Information Governance policies and procedures

Complainant – An existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint).

Service User – For consistency the term service user is used throughout this document to mean a patient, client, resident, carer, visitor or any other person accessing Health & Social Care services.

Compliment – "an expression of regard or praise." Compliments from service users are to be encouraged as these have a positive effect on staff morale and highlight the high quality care and services which are provided across our organisation. Compliments help us identify areas of best practice which can be shared with other services/teams within the Trust, as well as promote confidence in services provided by the Trust.

7. Roles and Responsibilities

7.1 **All Staff** are responsible for:

- Discussing and attempting to resolve complaints, as they arise, in an informal, sensitive and confidential manner;
- Ensuring that the Trust's complaints posters and leaflets are available and accessible to service users to encourage all types of user feedback;
- Referring the matter as soon as possible to their line manager if unable to deal with complaints raised directly with them or seeking advice from Complaints Department staff on how to proceed;
- Completing the Trust's Informal Complaints Form on a timely basis in conjunction with their Manager;
- Keeping their line manager updated on complaints and enquiries they are currently dealing with and outcomes including improvements made;
- Contributing to the investigation of complaints and enquiries within the service/team and returning statements, reports and other information to Investigating Officers within requested timescales;
- Informing their line manager and other team members (if appropriate) when they receive a written compliment from service users so that it can be recorded on the Compliments database available here
- Availing of training and refresher training provided to enable understanding of the Trust's arrangements for managing and dealing with complaints.

7.2 **Managers** are responsible for:

- Seeking informal resolution of complaints raised at service level within identified timescales, if possible, as a rapid response and personal contact often results in effective complaints resolution;
- Ensuring informal complaints are recorded on the Trust's Informal Complaints Form and retained on file;
- Ensuring that the Trust's Complaints Policy and Procedures are included in the induction of their staff, and that staff are released to attend appropriate training;
- Supporting, advising and assisting staff to resolve the issues giving rise to the complaint or enquiry, when possible;
- Ensuring all formal complaint letters received by staff are forwarded immediately to the Complaints Manager on receipt;
- Contributing to the investigation of complaints and enquiries and making sure statements and reports address all of the issues raised;
- Ensuring that statements/reports are returned to the Investigating Officer within the required timescales;
- Identifying learning and implementation of action plans to prevent the problem recurring;
- Introducing service improvements and making sure that all relevant information is disseminated throughout the service/team and Directorate Governance Groups as necessary;
- Making sure a 'fair and just' organisational culture is maintained. Ensuring that staff members are:
    - informed if a complaint is made against them;
    - receive a copy of the complaint;
    - given the opportunity to provide their version of events; and

- made aware of the process and timescales for responding to complaints.

- Such staff should receive feedback on the outcome of the complaint and appropriate support from their line manager before, during and after the investigation into the complaint;

- Ensuring regular update of the Compliments database with details of any written compliments received;
- Making sure that information relating to complaints and compliments is displayed in facilities accessed by service users and made available for inspections/audits etc.

7.3 **Nominated Investigating Officer(s)** are responsible for:

- Reviewing the complaint and highlighting the issues to be addressed;
- If appropriate, making early contact with the complainant to introduce themselves and establish outcome the complainant is hoping for;
- Liaising as necessary with identified Service Managers/Professional staff/Investigating Officers in other service areas to ensure all of the issues raised are investigated;
- Identifying staff members to be interviewed or statements required as applicable;
- Checking records/documents as required;
- Considering the value of an independent experts review;
- Analysing the information obtained from the investigation and making sure information is available to respond to all of the issues raised in the complaint or enquiry;
- Taking account of any corroborative evidence available relating to the complaint;
- Determining if a meeting is required with the complainant before or after the final response is issued;
- Ensuring investigations are concluded promptly and where applicable, learning identified;
- Informing Complaints Department staff at the earliest opportunity if it is known or anticipated that there will be a delay in the preparation of the draft response and likely timescales for provision of same;
- Contacting the complainant directly if the delay reaches 3 months from the date the complaint has been received, to explain reasons for delay and agree a new response time.
- Keeping Complaints Department staff informed of the outcome of any direct discussions with the complainant;
- Preparing the draft response and Complaints Closure Form and sending them to the Assistant Director for review and approval;
- Forwarding the approved draft response to the Complaints Department promptly for quality assurance and completion of the approval process;
- Ensuring that legible records are kept of the complaints investigation and readily available in the event that the Northern Ireland Ombudsman requests these as part of an investigation;
- Identifying a deputy to deal with complaints or enquiries in his/her absence.

7.4 **Complaints Manager** is responsible for:

- Day to day management of the Complaints Department and ensuring that the complaint process complies with relevant standards and timeliness in respect of complaint management;
- Providing information as requested by the Northern Ireland Public Services Ombudsman (NIPSO)
- Providing regular complaints and compliments related analyses, trends and lessons learned reports to Committees, Sub-Committees and Groups within the Governance Accountability Framework;
- Co-ordinating and managing all formal complaints received by the Trust;
- Maintaining comprehensive databases of all complaints and compliments received;
- Providing support and advice to staff responding to complaints;
- Reviewing draft responses received from Investigating Officers, ensuring all issues raised in the formal complaint have been addressed, taking into account ease of understanding and co-ordinating the process to final approval;
- Having access to all relevant records (including personal medical records) which are essential to any complaint referred to him/her;
- Identifying training needs of staff and ensuring that appropriate programmes are organised in conjunction with line managers;
- Ensuring that the Complaints Officers apply the Complaints Handling Flowchart **(Appendix 3)** when processing formal complaints;
- Regularly raise awareness of the Complaints Handling Flowchart to Investigating Officers, Managers, Assistant Directors and Directors;
- Being aware of the availability of, and advising complainants about:-
    - the support available from the Patient and Client Council
    - the Ombudsman/Commissioner for Complaints; and
    - the role and availability of conciliation or advocacy services.

7.5 **Complaints Officers (in Complaints Department)** are responsible for:

- Assisting the Complaints Manager in administrating the complaints process;
- Processing all documentation relating to complaints and providing specialist advice, including contact with service users and their representatives, health and social care staff, Nominated Investigating Officers, Assistant Directors, Directors and the Chief Executive;
- Informing complainants of any delays, reasons and expected timescale for written response to their complaint in line with HSC Complaints Procedure Guidance;
- Assisting in the delivery of complaints/compliments related training to various staff groups across the Trust;
- Ensuring that records relating to complaints are maintained and kept up to date;
- Quality assuring responses received from Investigating Officers pertaining to complaints;
- Assisting with the provision of documentation as and when required for Ombudsman (NIPSO) cases;

- Collating information on complaints and compliments and provision of analyses and reports to services, committees as and when required and in line with statutory requirements.

7.6 **Assistant Directors** are responsible for ensuring that:

- Managers and staff within their Directorate are aware of, and comply with the requirements of this Policy and Procedures;
- Investigating Officers undertake thorough investigation of issues identified in complaints;
- Staff are appropriately trained in receiving and responding to complaints**;**
- There is timely and robust processes in place for approval of draft responses to complaints;
- Complaints are dealt with promptly, appropriately and quality assured before submission to the Complaints Officer (in Complaints Department);
- Learning and service improvement occurs and is shared across the Trust;
- Complaints are integrated into Directorate governance arrangements;
- A deputy is designated to deal with complaints or enquires in his/her absence.

7.7 **Head of Clinical Quality & Safety / Governance Manager** are responsible for:

- Ensuring that the complaints process is managed in accordance with all relevant guidelines, legislation and standards and for ensuring that processes are in place to identify and disseminate learning on a Trust wide/regional basis;
- Ensuring arrangements are in place to consider formal complaints and determine level of investigation / action required;
- Ensuring arrangements are in place for quality assuring all responses received from Investigating Officers pertaining to complaints or enquiries;
- Providing information to relevant departments and groups/committees within the Trust as well as to Department of Health, HSCB/PHA, Ombudsman and other external agencies as appropriate.

7.8 **Executive and Other Directors** are responsible for ensuring that:

- Managers and staff within their area of responsibility are aware of and comply with the requirements of this Policy and Procedure;
- Ensuring that appropriate systems and processes are embedded to ensure effective complaints arrangements are in place;
- Complaints are dealt with promptly and appropriately and that learning is shared so that service improvement occurs;
- Management of complaints is integrated into Directorate/ Division governance arrangements.

7.9 **Medical Director** is responsible for:

- Implementing the Trust's Statutory Duty of Quality;
- Taking a strategic viewpoint on behalf of the Trust in relation to complaints;
- Effective implementation of the policy and will report to Trust Board on performance in managing complaints;

- Delivering the organisation's complaints process and ensuring processes are in place, in conjunction with all Directors so that all necessary learning takes place;
- Designating a Senior Manager to manage the Trust's Complaints Procedure;

7.10 **Chief Executive**:

- Has overall accountability/responsibility for complaints management within the Trust;
- Will respond in writing to all formal complaints (or delegate when appropriate);
- Has overall responsibility to ensure that complaints are integrated into Trust Clinical and Social Care Governance and Risk Management arrangements.

7.11 **Rapid Review Group** are responsible for:

- Weekly review of formal complaints received the preceding week and considering action to be taken with high risk complaints;
- Identifying trends, emerging issues and potential risks;
- Monitoring the Trust's performance against the Department of Health's and Northern Ireland Public Services Ombudsman's timescales for responding to complaints
- Reviewing recommendations from the Northern Ireland Public Services Ombudsman
- Identifying learning for sharing corporately and/or regionally.

7.12 **The Trust's Improvement through Involvement Committee** reports to the Trust Board and is chaired by a Non-Executive Director. The duties of the Committee are associated with providing assurance to the Board on the effectiveness of the Trust's arrangements for co-production and learning from experience. In relation to complaints and compliments the Committee will

- Use the experiences people tell us about to understand how our services work and to promote learning and improvement when they fall below expectations;
- Receive regular progress reports from relevant service or project leads on the implementation of prioritised co-production initiatives;
- Evaluate the impact and outcomes of service improvements, evidence what works and demonstrate the value of effective involvement activity across the Trust;
- Build capacity and nurture capability by promoting improved methods for engaging people who use and deliver services, and by sharing learning and information across the Trust and beyond;
- Produce an annual work programme, secure necessary resources and report regularly to the Board on progress measured against agreed goals and targets.

8. Implementation of Policy

It is the responsibility of all staff to familiarise themselves with and adhere to this policy. This policy will be brought to the attention of all Line Managers within the Trust who will ensure that all staff who do not have internet/intranet access are made aware of the provisions of this policy.

9. Training and Education

The Trust will ensure that training and information on the management of complaints and compliments is available for staff at the appropriate level. This must be included within:

- Corporate induction for all new staff;
- Departmental induction for all new staff;
- Departmental training days and workshops; and

- Corporate training programmes/courses encompassing general training on complaints management for all staff likely to come into contact with service users to enable them to respond appropriately to complaints, enquiries, comments/suggestions and compliments; and
- Specialist complaints management training for Investigating Officers, complaints staff and others, as required.

10. Information for Service Users

10.1 The Trust will produce information for service users on how to provide feedback on services which will be well publicised, simple and clear and available in all service areas across the Trust.

10.2 Information on how to make a complaint will be provided free of charge and will be available in various formats and languages. Other arrangements will be made as necessary to meet the specific needs of those wishing to comment on our services, including the provision of interpreting services and translation of information into additional languages, as required.

10.3 All service users will be made aware of the independent service provided by the Patient and Client Council.

10.4 Other independent advocacy and specialist advocacy services are available for service users who wish to provide feedback. Further information is available from Complaints Department staff by telephoning 028 7161 1226 or via email at Complaints.Department@westerntrust.hscni.net or Compliments@westerntrust.hscni.net.

10.5 When acknowledging formal complaints, complaints staff will enclose information about the Complaints Procedure. If service users require additional information or have a query about their complaint they will be advised to contact complaints staff.

11. Recording, Monitoring, Audit and Review

11.1 Complaints, compliments and MLA enquiries received are recorded on electronic databases. The Datix system is used for recording and management of complaints. Staff members connected to complaints (including staff named within the complaint or subsequently connected to the cause/issues of the complaint will be linked as “Contacts” on the Datix system.

11.2 Reports monitoring the nature, volume, trends and learning associated with complaints and compliments will be provided regularly to various groups/committees within the Trust’s governance arrangements. Reports will also be provided to Department of Health (DoH) Health & Social Care Board (HSCB) in line with their requirements. An annual complaints report will also be published on the Trust’s website.

11.3 Compliance against relevant complaints handling standards will be regularly monitored by the Complaints Department.

11.4 Implementation of actions following audit and/or recommendations from NIPSO reports will be monitored by the Complaints Department.

11.5 The Policy will be reviewed as necessary due to developments and initiatives as driven by external and internal influences.

12. Evidence Base/References

Guidance in Relation to the Health and Social Care Complaints Procedure, DoH (2019)
The Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009 (Amendment 2013 & Amendment No. 2, 2019)
The Children (NI) Order (1995) Policy and Procedures – Representation and Complaints, Volume 5, EHSSB (1996)
General Data Protection General Data Protection Regulation (GDPR) and Data Protection Act 2018
Access to Health Records (NI) Order (1993)
Freedom of Information Act (2000)
Human Rights Act (1998)
Adult Safeguarding Policy for Northern Ireland 'Adult Safeguarding: Prevention and Protection in Partnership', DoH & DoJ (2015)
Regional Core Child Protection Policy & Procedures, SBNI (2017)
Code of Practice on Protecting the Confidentiality of Service User Information Policy, DHSSPS (2016)
Data Protection and Confidentiality Policy, Western Health & Social Care Trust (November 2018)
Good Practice Standards for NHS Complaints Handling, The Patients Association (2013)
Guidance & Template for Developing or Reviewing Policies, Procedures, Guidelines & Protocols, Western Health & Social Care Trust (April 2018).

13. Consultation Process

13.1 This is an update of an extant policy using the Western Health & Social Care Trust's template for policies. It was previously issued for consultation to the Trust's extant policy consultation list. There are no significant changes to the policy therefore further consideration is not required.

14. Equality and Human Rights Considerations

14.1 This policy has been screened for equality implications as required by Section 75 and Schedule 9, of the Northern Ireland Act, 1998.

The Trust aims to handle all complaints fairly and honestly regardless of who makes a complaint. The Trust treats all members of the community equitably and will not show bias to any particular individual or group.

15. Signatories

Signature …… Date: ……
(Responsible Officer)

Signature …… Date: ……
(Responsible Director)

COMPLAINTS, COMPLIMENTS AND USER VIEWS PROCEDURES

PART 2

Part 2: PROCEDURES for the Management of Complaints, Compliments and User Views

16. Introduction

16.1 This Procedure details the Trust's processes following the receipt of complaints, enquiries, comments/suggestions and compliments about care or treatment, or about issues relating to the provision of health and social care. Guidance is also provided for front line staff in relation to dealing with complaints, which have been raised directly by service users or their representatives. It is separate from, but complimentary to, the procedure for dealing with complaints contained in the Children (NI) Order Representation and Complaints Procedure.

17. Complaints /Informal Complaints/MLA Enquiries/ User Views and Associated Action

17.1 Complaints

17.1.1 A complaint or concern may be made in person, by telephone or in writing, including email or via the Trust's website. With regard to a verbal complaint or concern, Complaints staff will assist service users to formulate their complaint if necessary. Once the details have been typed up these will be forwarded to the complainant to view and sign as a factual description of the complaint and returned to the Complaints Department for the investigation to commence. Care should be taken to include:

- contact details for the person making the complaint or enquiry (including details regarding the service user if the complaint or enquiry has been made by a third party);
- who or what is being complained or enquired 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, an explanation or changes to services.

17.1.2 Where views are provided in person or by telephone, complaints staff will clarify whether the person concerned wishes to make a formal or informal complaint.

17.1.3 The person making a formal complaint will receive an acknowledgement letter normally within 2 working days from the Complaints Department confirming receipt. An information leaflet will be included regarding the Trust's Complaints Procedure.

17.1.4 **Informal complaints** and concerns are subject to the same actions and responsibilities within the Trust's Complaints Procedure, which apply to the formal complaints process. Whilst informal complaints are not subject to the timescales for responding to complaints set by the Department of Health, it is good practice that these are investigated and responded to as soon as practically possible.

17.2 **MLA Enquiries**

Written correspondence received from elected representatives including Local Councillors, MEPs, MLAs, Committees within the Northern Ireland Assembly and Government Offices/Departments will be assessed by the Chief Executive and, on considering the detail presented, who will make a judgement in terms of how the correspondence should be processed. If the matter is to be dealt with as a formal complaint, she will forward correspondence to the Complaints Department for action. In the case of all other matters/issues these will be processed as Enquiries. Depending on the nature of the Enquiry it may be necessary for staff within the Chief Executive's Office to seek consent prior to taking any further action.

17.3 User Views (i.e. Comments, Suggestions and Compliments)

17.3.1 For the purposes of this procedure, user views are those made by, or on behalf of patients/clients/visitors about the service which they have experienced.

17.3.2 Comments/suggestions made by service users or their representatives directly to the Trust should be considered and acted on where possible. If it is felt by the service that a written response to the person's comment or suggestion is required, the service will respond directly in writing to the service user

17.3.3 We acknowledge that staff involved in the delivery of health or social care will receive compliments from service users in various formats such as Thank You cards and letters on a regular basis. We use the compliments we receive to highlight and evidence good practice.

17.3.4 All written compliments received directly by the Ward/Department should be shared with relevant staff as soon as possible and recorded on the Trust's Compliments database available here

17.3.5 Where compliments are received via the Trust's website or to the Complaints Department, they will be forwarded by the Complaints Department to the Manager of the Ward/Department concerned for sharing with relevant staff and recording on the Trust's Compliments database available here

17.3.6 The Public Health Agency launched an online user feedback platform (Care Opinion) in August 2020 to complement and enhance existing feedback systems within the Trust by providing a technological approach for users to share their experience of health and social care services.

18. Time Limit for Making Complaints

18.1 A complaint, written or verbal, should be made as soon as possible, normally within 6 months of the event which caused the problem, or within 6 months of the person making the complaint realising he/she had something to complain about, provided that this is within 12 months of the event.

18.2.1 There is discretion to extend this time limit where it would be unreasonable, in the circumstances of a particular case, for the complaint or enquiry to have been made earlier and where it is still possible to investigate the facts of the case.

18.2.2 This discretion will be used with sensitivity, and the Complaints Manager will discuss any such complaints and enquiries as they arise with the appropriate Director and the Head of Clinical Quality & Safety/Governance Manager. Contact will then be made with the Chief Executive who will decide what action is necessary.

19. Who Can Complain?

19.1 A complaint may be made by:

- a service user;
- a former service user; or
- a member of the public or visitor using HSC services and facilities.

19.2 A complaint may be made by a representative acting on behalf of a person mentioned above in any case where that person:

- has died;
- is a child;
- is unable to make the complaint him/herself; or
- has requested the representative to act on his/her behalf.

In such cases consent will be sought by complaints staff, where necessary.

19.3 Where a complaint relates to the actions of the Western Health and Social Care Trust and one or more Health and Social Care (HSC) organisations for example, another Health and Social Care Trust, there should be full co-operation between complaints staff in the organisations involved to ensure the complaint is appropriately investigated and responded to. The consent of the person making the complaint will be sought before sharing details of the complaint across HSC organisations and complaints staff will keep him/her informed regarding how each aspect of the complaint will be dealt with and by whom.

19.4 Where a complaint is received relating to services from another HSC organisation, the complaint will be forwarded to the relevant complaints office/department for investigation and issuing of a response directly to the person concerned. Complaints staff will notify the person making the complaint that his/her complaint has been re-directed and will provide information on the process to be followed including the name and contact details of complaints staff in the organisation concerned.

20. Consent

20.1 If a complainant is making a formal complaint about his/her own care, it is not necessary to obtain their express consent to use personal information when

investigating their complaint as he/she has implied their consent by asking the Trust to investigate the matter.

The Trust's formal acknowledgement letter does state that information from health and/or social care records may need to be disclosed to those involved in investigating the complaint and to contact the Complaints Department, if for any reason, the complainant does not wish this to happen.

20.2 Third party complaints may be made by a service user's relatives, friends, carers or other representatives such as their solicitor or elected representative. Third party complaints are acceptable provided the service user has given his/her written consent. However, in such circumstances we will judge each complaint on its own merits and the Trust will reserve the right to seek written consent from the service user prior to releasing information, i.e. of a sensitive or personal nature, beyond general issues.

20.3 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.

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

20.5 Where consent is required but not provided, Complaints Department will seek consent before any further action is taken. The timescale to respond starts after receipt of the completed consent form.

20.6 Where consent cannot be obtained, advice should be sought from the Complaints Manager who may liaise with relevant professional staff and will consider whether the person representing the service user 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 before confidential information can be released.

20.7 To enable a determination, the service user's records may need to be checked and questions such as the following should be considered:

- Who is the service user's documented next of kin or main carer or significant person?
- Are there additional contacts documented?
- What is the complainant's relationship to the service user?
- Does or did the complainant have significant relationship/ contact/ involvement with the service user to enable him/her to make the complaint in his/her own right?

- Has the complainant been involved directly with the issues complained about?
- Is there anything documented in the service user's records regarding the sharing of information with others?
- Would sharing the information with the complainant breach the Trust's duty of confidentiality to the service user?

The list above is not exhaustive.

20.8 If it is determined that a person is not suitable to act as a representative, the reasons should be documented. The Chief Executive (or designated senior person/nominee) will inform the complainant in writing outlining the reasons for the decision having been taken and advising them of their right to appeal the decision. Where a complainant challenges the Trust's decision, an appeal will be considered by Director/s (or nominee/s) not involved in the original decision. The complainant will be advised in writing of the decision.

20.9 Those wishing to make third party complaints who want to pursue their own concerns can bring these to the attention of the organisation without compromising the identity of the service user. Any identified concerns will be considered, investigated and addressed as fully as possible. A response will be provided to the third party on any issues it is possible to address without breaching the service user's confidentiality.

21. Confidentiality

21.1 All Trust staff have a legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in General Data Protection Regulation (GDPR) and Data Protection Act 2018 and the Human Rights Act 1998. Ethical guidance is available from the respective professional bodies and from the Department of Health 'Code of Practice on Protecting the Confidentiality of Service User Information' published in January 2012 and updated in April 2019. The common law duty of confidence must also be observed.

21.2 Care must be taken at all times to make sure that any information disclosed about the service user is confined to that which is relevant to the investigation of the complaint and is only disclosed to those people who have a demonstrable need to know for the purpose of investigating the complaint.

21.3 It is good practice to inform the service user that in order to investigate and fully answer their complaint it may be necessary to examine information within their health or social care notes and records relevant to the investigation of their complaint or enquiry. Service users should be advised to contact complaints staff immediately if they do not agree to their notes and records being examined. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

21.4 As indicated at Section 20 above explicit consent must be obtained before identifiable information is given to any third party. In addition, the following principles also apply to all complaints:

i. records relating to complaints must be stored securely;
ii. information pertaining to the investigation of the complaint including statements or reports, notes of meetings and copies of relevant sections from health and social care records and the written response must be filed separately to the service user's health or social care records;
iii. the reference number provided by complaints staff, not the person's name, should be used wherever possible during investigations to maintain confidentiality;
iv. information and reports produced to identify trends and inform future good practice from lessons learned should safeguard the confidentiality of service users and staff; and
v. when forwarding information electronically all identifiable information pertaining to the person making the complaint or enquiry should be enclosed as attachments and password protected.

21.5 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 that information which is relevant to the complaint should be considered for disclosure, and then only to those within the HSC organisation who have a demonstrable need to know in connection with the investigation into the complaint or enquiry.

21.6 Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure. If the third party objects, then it can only be disclosed where there is an overriding public interest in doing so.

21.7 All letters regarding the complaint will be marked 'strictly private and confidential'.

22. Anonymous Complaints or Concerns

22.1 Anonymous complaints or concerns (verbal or written) will be investigated in the same manner as those from identified persons, provided that sufficient information is supplied suggesting that there is some validity in the complaint or concern made. An investigation will be undertaken, findings recorded, and remedial action taken as necessary. If possible a response will be provided to the writer.

23. Trust Complaints Procedures - Local resolution

23.1.1 The purpose of local resolution (i.e. resolution of a complaint within the Trust) is to provide an opportunity for the person making the complaint and the organisation to attempt a prompt and fair resolution of the complaint.

23.1.2 We are committed to promoting active approaches to resolving complaints informally at local level, sensitively and in a timely manner. (see Section 23.2 below).

23.1.3 Staff must view complaints investigation and management as a central component of the delivery of a holistic package of care to service users. Therefore, all complaints received should be treated with equal importance and every effort should be made to resolve such complaints. Staff must make sure that the service user's immediate care needs are being met before matters relating to the complaint are addressed. If staff are unsure about how to deal with any complaint they should seek advice from their line manager on what should be the appropriate approach. Advice and assistance can also be sought at any time from complaints staff.

23.2 Informal Complaints Process

23.2.1 Informal complaints are usually made verbally to frontline staff or directly into the service area. Occasionally, a written complaint may be considered under the informal process but only if it is clear that it can be resolved simply and quickly, and after discussion with the Complaints Manager.

23.2.2 Many matters that give rise to concern should be dealt with as and when they arise, e.g. minor criticisms about waiting times, meals or transport arrangements, can often be cleared up at the time they occur.

23.2.3 Staff are encouraged to resolve informal complaints as soon as reasonably practical to do so. Any action needing to be taken should be agreed verbally with the person making the complaint and the need for further contact clarified, as appropriate. Once the necessary action has been taken, and only when it is felt to be appropriate/necessary, a written response should be issued.

23.2.4 Information regarding these informal complaints should be recorded on the Trust's Informal Complaints form and kept on file within the Manager's office.

23.2.5 If the person making the complaint remains dissatisfied with the outcome, the procedure for making a more formal complaint via the Complaints Department should be explained.

23.2.6 On no account should a service user feel discriminated against because he/she has raised a complaint.

23.2.7 Issues/concerns raised which may be suitable for resolution as informal complaints are suggested in **Appendix 1**. A flowchart is provided in **Appendix 2** detailing the process for managing informal complaints.

23.3 Formal Complaints Process

23.3.1 Verbal and written complaints received via the Complaints Manager or the Chief Executive's Office are usually dealt with under the formal complaints process. Occasionally complaints received via these channels may be dealt with under the informal process but only if it is clear that it can be resolved simply and quickly, and after discussion with the Complaints Manager.

23.3.2 Where a formal complaint is made verbally, the complainant will be asked to put the complaint in writing or will be assisted to do so by a member of Complaints Department staff.

23.3.3 A formal complaint should be responded to within 20 working days. The timescales, process, staff responsibilities, accountability and the quality assuring process are outlined in the Formal Complaints Process flowchart in **Appendix 3.**

23.3.4 Where a complaint raises issues across more than one Trust, the Complaints Manager will

- Gain consent from the complainant before sharing any details of any complaint across other HSC organisations
- Notify the other organisation(s) involved, to discuss and agree one of the following options:
    - Each Trust will deal with the issues relevant to their Trust;
    - One Trust will take the lead in investigating and co-ordinating the response
- Advise the complainant about how each aspect of their complaint is being dealt with and by whom.
- For those aspects of the complaint that are being dealt with by Western Trust, keep the complainant informed in line with the Trust's processes for managing complaints.

All parties involved have individual responsibility for ensuring their part of the complaint is appropriately investigated and ratified by their Trust.

23.3.5 For those complaints dealt with under the formal complaints process, a written acknowledgement letter will be sent to the person making the complaint on behalf of the Chief Executive within two working days of receipt of the complaint.

Included with each acknowledgement letter will be the Trust's Complaints Leaflet which states:

- information on how the Complaints Procedure works;
- reference to the supportive role offered by the Patient and Client Council;
- guidance on further action which can be taken if the person making the complaint is not satisfied with the final written response; and
- contact details for complaints staff should the person making the complaint have any queries.

23.3.6 Staff in the Complaints Department will ensure all formal complaints are graded in line with the HSC Regional Risk Evaluation Matrix and Impact Assessment Table - see **Appendix 4**.

23.3.7 The complaint will be forwarded to the Nominated Investigating Officer as per each Directorate's governance arrangements with a copy to the relevant Director and Assistant Director.

23.3.8 It is important that the Nominated Investigating Officer ensures there is independence to the investigation of complaints and in particular where the complaint refers to a specific member of staff. Staff within the Complaints Department will provide advice to the Nominated Investigating Officer regarding appropriate investigation of complaints involving staff.

23.3.9 The Investigating Officer should, where appropriate, make early contact with the complainant to clarify issues, to help inform area(s) for investigation and/or understand expectations for outcome. An Investigation Template for Investigating Officers is provided in **Appendix 5**.

23.3.10 Staff guidance notes on writing statements and reports have been produced and are attached as **Appendix 6**.

23.3.11 Were the complaint involves more than one Directorate the relevant Director/s will be asked to identify which Investigating Officer will be responsible for taking the lead, co-ordinating the investigation and drafting the response. The Complaints Officer (in the Complaints Department) will assist in gathering reports from other Directorate areas to support the Lead Investigating Officer to draft the response.

23.3.12 The Investigating Officer, either during or on completion of his/her investigation, should consider whether there is a need to contact or meet with the person making the complaint before the written response is issued.

This decision should be reached through consultation with the relevant Assistant Director and/or Director and include identification of those staff members requiring to be present at the meeting**.** Guidance notes developed with regard to complaints-related meetings are attached at **Appendix 7**.

23.3.13 Consideration will also need to be given, as appropriate to involving:

- conciliators / mediators;
- independent advocates;
- independent experts; or
- lay persons.

The Investigating Officer must liaise with staff from the Complaints Department to make arrangements for engaging with any of the aforementioned experts.

Further information about conciliation and the use of independent experts or lay persons is detailed at **Appendix 8**.

23.3.14 It is the responsibility of the relevant Investigating Officer to prepare the draft response from the information obtained from the investigation. The response should be clear, accurate, balanced, simple and easy to understand. The draft response should aim to answer all the issues raised in the complaint, be open and honest explaining the situation, why it occurred and reporting the action taken or proposed. The draft response should also include an apology where things have gone wrong with the eaim of assuring the person making the complaint, that we have taken their concerns seriously.

23.3.15 The draft response must then be sent through the line management structure to the Assistant Director for consideration and approval. Following approval at Assistant Director level, the Investigating Office must send the draft response to the Complaints Handler in the Complaints Department for quality assurance checks. Should any outstanding issues be identified, the Complaints Handler will continue to follow up with the Investigating Officer until resolved. The Complaints Handler will then forward the updated draft response to the relevant Director for approval.

23.3.16 Complaints staff will, if required during the approval process, make minor amendments to the draft response, and forward it to the Chief Executive for approval and signature.

23.3.17 If it has been identified that there will be a delay in the draft response being prepared or forwarded it is important that the relevant Investigating Officer, or Assistant Director notify Complaints Department staff of the likely length of any delay and the reason/s for this. This will allow complaints staff to issue a holding letter to the person making the complaint at the earliest possible opportunity.

23.3.18 As required by the Department of Health, complaints must be investigated and the person making the complaint issued with a written response from the Trust **within 20 working days**. A holding letter will be issued by Complaints Department, if necessary explaining that the response will be delayed and providing a reason for the delay.

Any additional delays should be notified to complaints staff to allow them to keep the person making the complaint informed of progress. Any delay in issuing the written response **should not normally exceed an additional 20 working days**.

23.3.19 Should the delay in issuing a written response reach 3 months from the date the complaint is received, the Investigating Officer must make direct contact with the complainant to explain the reasons and agree a new response date. The Investigating Officer must update the Complaints Handler on the outcome(s) of discussions with the complainant including any revised response date.

The Complaints Handler will also escalate delays that have reached this point (3 months) to the Director and the Chief Executive.

23.3.20 An offer to meet with the person making the complaint may be included in the written response, if this is felt to be appropriate. In advance of the response being issued, contact details for a member of staff should be identified with whom complaints staff can liaise if the person making the complaint wishes to take up the offer of a meeting, requires additional information or feels there are outstanding issues requiring to be resolved.

23.3.21 A copy of the final response will be sent to the relevant Investigating Officer, Assistant Director and Director for appropriate action, learning and service improvement. Staff should be informed of any changes in system or practice that resulted from complaints.

23.3.22 If the person making the complaint is not satisfied with the written response and has outstanding issues/concerns, action should be taken as appropriate in an

attempt to review and resolve the complaint. The person making the complaint should also be advised of their right to take their complaint to the Northern Ireland Public Services Ombudsman (NIPSO).

23.3.23 Documentation associated with the investigation and action taken in relation to each formal complaint should be stored securely by the Investigating Officer at local level, should this information be requested by the Northern Ireland Public Services Ombudsman or another statutory body.

23.3.24 Complaints staff can be contacted for advice by Investigating Officers, Assistant Directors and Directors if necessary during the investigation of complaints and when draft responses are being prepared.

24. Learning from Complaints

24.1 The Trust supports the ethos of learning from complaints. They provide a rich source of service user information and opportunity for service improvement. Many complainants indicate their rationale for making a complaint is that they do not want other patients to go through a similar experience.

24.2 To assist with this, the Trust has developed a Complaints Closure Form **(Appendix 9)** which must be completed by the Investigating Officer in conjunction with the relevant manager for all complaints where learning has been identified. The use of this form is important as it contributes to the process of learning from complaints, implementation and sharing of that learning.

24.3 It is important that staff and teams reflect on complaints received, to know where things went wrong and why, and to identify how the matter could be handled better in the future. Managers should encourage and enable this to take place in a safe and supportive environment. Learning and improvements made from complaints should be a standard agenda item for discussion at team meetings and/or briefings.

24.4 Directors, Assistant Directors, managers and staff are responsible for ensuring that actions/learning identified on the Complaints Closure Form are implemented.

24.5 Regular reports are provided to Directors and management staff to ensure that they are made aware of any learning arising from complaints. In addition reports provided to the Trust's Improvement Through Involvement Committee (or in its absence to the Clinical & Social Care Governance Sub-Committee and Governance Committee) include examples of learning identified in service Directorates.

25 Unreasonable, Vexatious or Abusive Persons

25.1 Whilst recognising the right of every individual to make a complaint and to be treated equitably in having these thoroughly investigated and fully responded to, there will be times when nothing further can be done to assist them.

25.2 The difficulty in handling such persons making complaints can cause undue stress for staff and place pressures on time and resources. However, someone should only be categorised as unreasonable, vexatious or abusive as a last resort after all reasonable measures have been taken to resolve the complaint using the Trust's Complaints Procedure. Unacceptable actions are outlined at **Appendix 10**.

25.3 If the person making the complaint is felt to be unreasonable, vexatious or abusive staff should raise the matter as soon as possible with the relevant Investigating Officer within their Directorate who will inform the relevant Director. Complaints staff experiencing similar difficulties can raise concerns with the Governance Manager and/or Head of Clinical Quality and Safety initially.

25.4 Staff should complete an incident form to record all incidents of unacceptable actions by complainants.

25.5 Consideration needs to be given as to whether the Complaints Procedure has been correctly applied as far as possible and that no issue within the complaint or enquiry has been overlooked or inadequately addressed. It also needs to be determined whether a fair approach has been taken and that we can identify the stage at which the person has become unreasonable, vexatious or abusive.

25.6 If agreed that the person has become unreasonable, vexatious or abusive, the Director must contact the Chief Executive and advise the Complaints Manager that he/she has done so. Various possible actions should be considered:

- it may be appropriate to inform the individual in writing that they are at risk of being classified as being unreasonable, vexatious or abusive and providing an explanation as to the reason for this. The individual should then be allowed the opportunity to modify their behaviour or action before a decision is taken;
- try to resolve matters before categorising someone as unreasonable, vexatious or abusive, by drawing up a signed agreement with the individual setting out a code of behaviour for the parties involved if the Trust is to continue dealing with them. If the agreement is breached consideration would then be given to implementing other actions as outlined below:
  - affected staff should be consulted and involved in drawing up and agreeing a management plan for future communication with the individual and shared with all relevant professionals;
  - restrict further contact with the individual either in person, by telephone, letter or email - or any combination of these provided that one form of contact is maintained. It may be deemed appropriate to only take telephone calls from the individual at set times or on set days. In extreme situations further contact may be restricted to liaison through an identified third party;
  - notify the individual in writing that previous responses have answered the issues raised with a view to resolving the complaint, that there is nothing more to add and continuing contact on the matter will serve no useful purpose. The individual should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered;
  - notify the individual that only a certain number of issues will be considered in any given period and ask him/her to limit or focus their requests accordingly;
  - return irrelevant documents to the individual or, in extreme cases advise the individual that further irrelevant documents will be destroyed;

- temporarily suspend all contact with the individual, or investigation of the complaint, whilst seeking legal advice from the Directorate of Legal Services (DLS);
- or take other action considered to be appropriate.

25.7 Further actions may need to be considered in addition to the above measures, and advice sought from the Head of Clinical Quality and Safety, the Governance Manager, the Police Service of Northern Ireland (PSNI) or the Directorate of Legal Services (DLS) if the unreasonable, vexatious or abusive behaviour persists.

25.8 The individual must be informed in writing what action is being taken and reasons why and if relevant, the length of time any restrictions will be in place.

A copy of any correspondence forwarded to unreasonable, vexatious or abusive individuals will be copied promptly and forwarded to the relevant Assistant Director or Director and the relevant Investigating Officer for information and onward dissemination to staff. A record will be kept by the Complaints Manager, for future reference, of the reasons why an individual has been classified as unreasonable, vexatious or abusive, actions taken and review arrangements.

25.9 A decision to restrict contact with the person making the complaint may be re-considered if the individual demonstrates a more acceptable approach. The Complaints Manager will contact Directors to ensure review of the status of all individuals with restricted contact arrangements.

25.10 The decision to restrict contact can be appealed by the individual concerned. A Director who was not involved in the original decision should consider the appeal. The individual will then be notified in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

25.11 With regard to telephone calls taken from aggressive, abusive or offensive individuals the staff member taking the call has the right to make the decision to tell the caller that his/her behaviour is unacceptable and end the call if the behaviour does not stop. Similarly, with regard to other aggressive or abusive behaviours staff directly experiencing this may take the decision to deal immediately with that behaviour in a manner they consider appropriate to the situation and in accordance with the Trust's Zero Tolerance Policy.

With the exception of these immediate decisions taken at the time of an incident, decisions to restrict contact made by such individuals with the Trust should only be taken after careful consideration of the situation by the relevant Director.

26 Support for Staff

26.1 Service Managers should bear in mind that staff will often require support if a complaint is received. Support is available from line management, Occupational Health, 'Inspire Workplaces' (employee assistance scheme) as well as support regarding the complaints process from the respective Complaints Handler or the Complaints Manager.

26.2 In addition, staff who are the subject of a complaint, should be informed of the complaint by their manager, be kept informed throughout the process and have the opportunity to see the relevant information contained in the final response letter. They may also receive help and/or support from their professional bodies and trade unions during this process.

27 Assurance of Service

27.1 Service Users have an absolute assurance that the submission of a Complaint will not in any way lead to the withdrawal of the services they are assessed as being in need of. Staff should therefore ensure that there is no suspension of contact with a service user when a complaint is made or intimated, and their actions should in no way construe this as being the case.

28 Regulated Establishments & Agencies and other Independent Service Providers

28.1 When a complaint or enquiry is received which relates to a regulated establishment or agency registered with the Regulation and Quality Improvement Authority (RQIA) or other independent service provider (e.g. private hospital) the person making the complaint or enquiry should be encouraged to raise their concerns, at the outset, with the registered provider.

28.2 All registered providers that hold a contract with the Trust to provide services must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards, relevant legislative requirements and the HSC Complaints Procedure. They are required by legislation to ensure the complaint is fully investigated.

28.3 If a complainant prefers to raise their concerns through the Trust, the Complaints Manager will forward the complaint to the relevant Head of Service who will establish the nature of the complaint and consider how best to proceed. The Head of Service, with the agreement of the Assistant Director, may refer it to the registered provider for investigation, resolution and response. If it is a matter that can only be dealt with by the Trust, if it raises serious concerns or the Trust deems it in the public interest, it will investigate. The person making the complaint or enquiry will be informed regarding the action being taken.

In the event that the matter has not been resolved to the satisfaction of the person making the complaint or enquiry, the Trust will then investigate the complaint if it has commissioned the service user's care.

If the issue being complained or enquired about relates to the registered establishment or agency's failure to comply with regulations or associated standards, the complaint will be shared with the relevant Service Manager and Assistant Director who will consider if a referral to RQIA is appropriate for further action.

28.4 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 the HSC Trust participation in local resolution, will be referred to the HSC Trust by the Ombudsman for action.

29 Matters Excluded from the Trust Complaints Procedure

29.1 Some matters are excluded from investigation through the Trust HSC Complaints Procedure. Exclusions are as follows:

- Legal Action;
- Disciplinary action;
- Children Order representations and complaints;
- Child Protection Procedures;
- Staff grievances;
- Investigation by professional regulatory bodies;
- Independent enquiry and criminal investigation;
- Complaints about services commissioned by Health & Social Care Boards;
- Issues related to General Data Protection Regulations or Freedom of Information;
- Coroner's Cases;
- Protection of Vulnerable Adults/adult safeguarding;
- Serious Adverse Incidents (SAIs)**;
- Whistleblowing;
- Private care and treatment or service which includes private dental or privately supplied spectacles;
- Services which are not provided by or funded by the HSC, e.g. provision of private medical reports

**Any aspects of a complaint which fall outside the SAI process will continue to be investigated under the HSC Complaints Procedure. The complainant should be advised accordingly.

30 The Northern Ireland Public Services Ombudsman (NIPSO)

30.1 Complaints may be made to the Ombudsman where:

- the Trust has refused to investigate a complaint where it felt the complaint fell outside the time limits set by HSC Board;
- a service user or their representative is dissatisfied following receipt of the Trust's written response and have exhausted the local resolution process.

30.2 There may be circumstances where the Ombudsman is prepared to accept a complaint directly without the person having first put their complaint to the organisation concerned.

30.3 The Ombudsman is completely independent of Health & Social Care organisations and the Government and can be contacted by completing a complaint form (available from the Ombudsman's Office) or if preferred individuals may write a letter of complaint. So that complaints can be dealt with as quickly as possible, information should be provided regarding the organisation being complained about, what is being complained about and how the person has suffered as a result. Any relevant correspondence or documentation should be enclosed along with the complaint and sent to:

Northern Ireland Ombudsman
Progressive House
33 Wellington Place
BELFAST
BT1 6HN

Freepost: Freepost NIPSO

Telephone: 02890 233821
Freephone: 0800 34 34 24
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk

30.4 Once the Ombudsman has received the complaint, it will be examined to determine whether it is within the Ombudsman's power to investigate, and if so, whether it should be investigated.

30.5 If the Ombudsman decides not to proceed with an investigation of the complaint, the person concerned will be informed and the reasons for the decision explained. However, if there are a lot of papers involved, or new or difficult issues are raised, the decision whether to investigate may take slightly longer.

30.6 As a first step in their investigation the Ombudsman's Office will generally send a summary of the complaint to the Trust, asking them for their comments and outlining the information required. Once this has been completed a response will be sent to the person making the complaint informing them whether or not the Ombudsman will continue with the investigation and explaining the reasons for the decision.

30.7 If the Ombudsman decides to continue with the investigation, this will involve thorough consideration of each aspect of the complaint. This is a rigorous process, may involve Independent Professional Advice experts and at its conclusion, a detailed report will be produced. This report is issued in draft format to the Trust for feedback as to factual accuracy, recommendations made etc. A final report will then be issued by the Ombudsman to the Trust and may require final action. Action may be in the form of a letter of apology to the person making the complaint, issue of a consolatory payment and/or identification of actions/improvements which are planned or implemented, where appropriate.

30.8 A flowchart has been developed which outlines the Trust processes for dealing with Ombudsman complaints. This is detailed at **Appendix 11**

31 Performance Management

31.1 The Governance Manager will ensure that regular reports are produced which include information on complaints management and compliments received. Reports are considered monthly at Chief Executive Assurance and Rapid Review Group meetings. Quarterly reports are provided to Directorate Governance meetings, Clinical & Social Care Governance sub-Committee & Governance Committee within the Trust's Governance Accountability Framework.

31.2 Directors are responsible for onward dissemination of these reports to senior managers and services/teams within their Directorate. These reports can be used to consider emerging issues/trends, potential risks and actions taken.

31.3 The Complaints Manager is responsible for ensuring that appropriate monitoring reports are returned to the Department of Health and other organisations as required.

Appendix 1

Issues/concerns raised which may be suitable for resolution as **informal** complaints are suggested below:

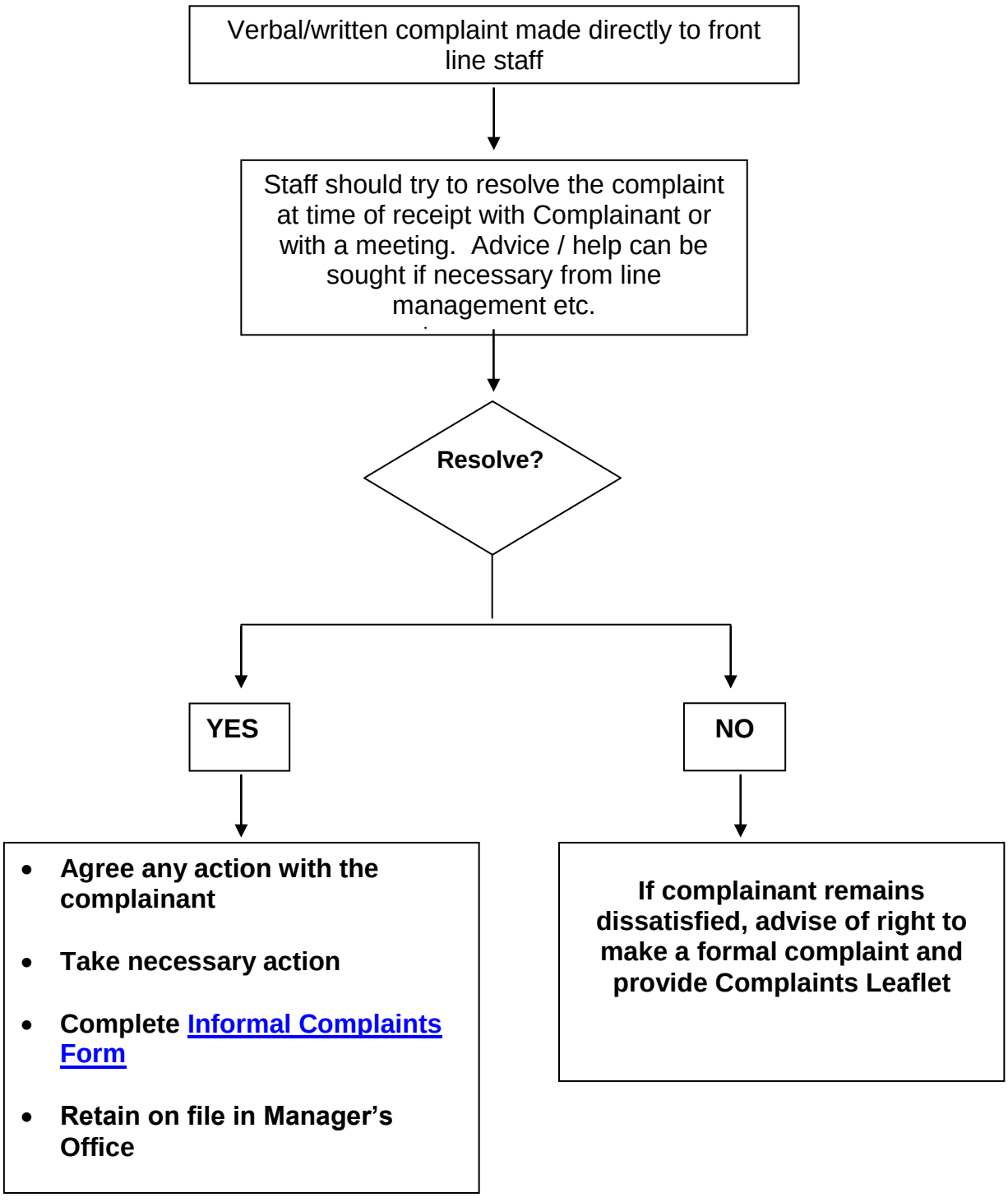
- Communication/information issues;
- Staff attitude/behaviour (excluding negligence/misconduct issues);
- Alleged breaches of confidentiality or issues regarding patient/client privacy or dignity;
- Waiting times for outpatient appointment, community services or at Accident and Emergency Departments;
- Appointment delay or cancellation (outpatients);
- Delay or cancellation of admission, operation or procedure;
- Transport issues – late or non-arrival of transport, journey time and suitability of vehicle/equipment;
- Quality of treatment and care;
- Access to premises/facilities;
- Records/record keeping issues;
- Assessment of need;
- Patients' status/discrimination issues;
- Consent to treatment;
- General/minor infection control issue;
- Complaints about the environment, hotel or support services, security.

Complaints which should be dealt with through the formal complaints process:

- Complex complaints involving more than two service areas;
- Complaints made in relation to someone who has died whilst in receipt of services or where it is felt the Trust contributed in some way to the person's death;
- Complaints which indicate possible medical/clinical negligence;
- Complaints likely to attract significant media attention;
- Complaints where possible future legal action has been indicated;
- Complaints which relate to an area where an external or independent review is planned or underway;
- Complaints where the person making the complaint has clearly indicated that they had initially raised their concern/issues with front line staff and that resolution had not been possible;
- Complaints relating to misdiagnosis;
- Policy or commercial decisions;
- Patients' property/expenses/finance;
- Complaints about waiting lists for services (where explanation from service has not been accepted);
- Complaints about quantity of treatment and care;
- Complaints about waiting for aids, adaptations and appliances;
- Complaints relating to contracted regulated establishments and agencies or other contracted services;
- Discharge/transfer arrangements.

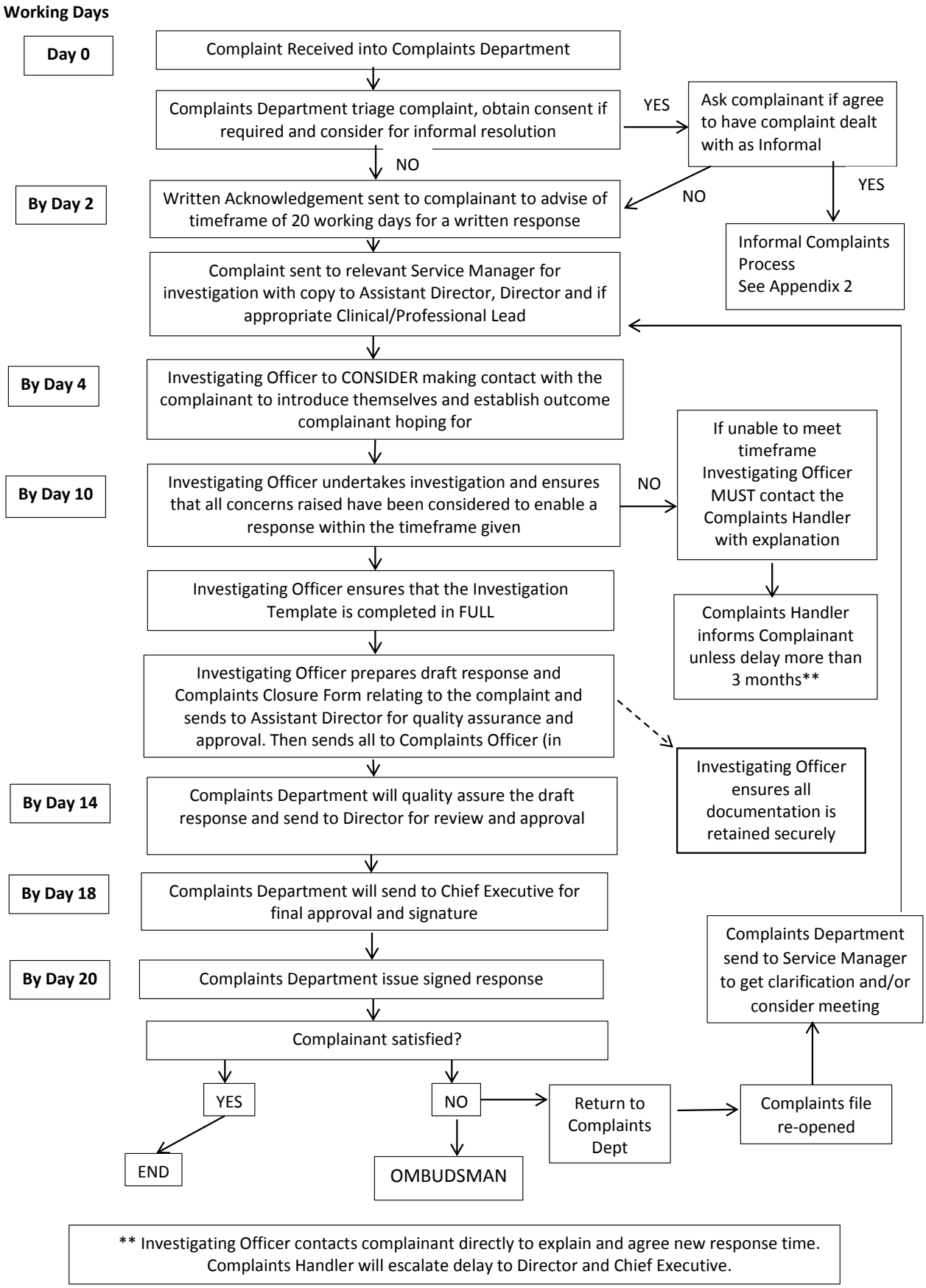
Appendix 2

Informal Complaints Process Flowchart



Appendix 3

Complaints Process Flow Chart



** Investigating Officer contacts complainant directly to explain and agree new response time. Complaints Handler will escalate delay to Director and Chief Executive.

Appendix 4

HSC REGIONAL 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**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

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

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]

	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)I
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g. Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016)

Appendix 5

Investigation template for Investigation Officers

If more than one service involved, service managers to liaise and agree lead Investigating Officer

Complainant Name (person making complaint)		**Complainant's Contact Details** (e.g. phone, email)	
Service User Name (if different from above)		**Service User's Details** (Address, DOB, Record No.)	
Draft Response due (to Complaints from Directorate)		**Service User Consent Received?**	
Complaints Office Initial Grading		**Service Area's Initial Triage** (issues to consider before proceeding with formal complaints process)	**1. Confirm Grading:** _____ **2. Can this be resolved informally by immediate contact with complainant?** ☐YES ☐NO _____ **3. Who will Investigating Officer/s be?** _____ _____ **4. Does it meet criteria for SAI?** ☐YES ☐NO
Any delay in draft response? (from Directorate to Complaints)	☐YES ☐NO **If yes, give reason:** **(inform Complaints Department asap of delay & reason)**		

Key Issues of Complaint for Investigation (list below or reference other document where you have these as applicable)
Where appropriate, you should contact complainant (phone / meet) to clarify issues / nature of complaint / their expectations / outcome they would like, before commencing investigation – *getting your investigation right first time*

	Complainant's expectations for outcome?

Investigation Methodology Details of how you carried out your investigation (list not exhaustive) (tick box as applicable)
Attach all documentation to support your investigation, e.g. service user records (inc. electronic), staff rotas, policy/procedure/guidance, reports, interviews, record of phone calls, emails, timeline, etc – *you need to evidence a thorough, robust & proportionate investigation*

☐ Records reviewed (inc. electronic records)? Details:
☐ Reports received? Details:
☐ Trust policy/procedure/protocol/standard etc? Details:
☐ Regional or National policy/procedure/guidelines/guidance etc? Details:
☐ Staff/witnesses interviewed? Details:
☐ Complainant/other external witnesses interviewed? Details:
☐ Chronology or timeline of events? Details:
☐ Independent advice internal? Details:
☐ Independent expert advice external? Details:
☐ Use of Lay Person? Details:
☐ Root Cause Analysis? Details:
☐ Other? Details:

Investigation Details / Analysis / Findings – Review each key issue identified above (detail below or reference other document where you have recorded these, as applicable) Example: What happened? What should have happened? If something went wrong, what? Why, when & how did it happen? Facts v disputed events? What is the root cause? Any contributory factors? Mitigating circumstances? Any good practice?

Conclusion/s

Remedy for Complainant / Put Things Right

See Ombudsman's 'Principles for Remedy' i.e. if possible, returning the person to the position they would have been in if the poor service had not occurred, e.g. apology, reviewing/changing a decision, remedial action, reimbursement for costs incurred, etc.

Action Plan to Prevent Recurrence / Lessons Learnt (SMART Objectives)

NB: If no action has been identified, please indicate this below

Issue Identified		Action Taken / Planned	Person Responsible	Completion Date	
				Target	Completed
1					
2					
3					
4					

Sharing the Learning

What has been learned?

How will you share the Learning?	☐ **Directorate(s)** (specify)		☐ **Trustwide**	
	☐ **Other** (specify)		☐ **Regional**	

Providing Outcome of Investigation to Complainant – How will you provide the outcome of your investigation?

Meeting? – ☐**YES** ☐**NO**
(arrangements can be made via the Complaints Department; a minute/note of the meeting will be required)

Written Response? – ☐**YES** ☐**NO**
(to draft a Trust response to the complainant, please ensure you address all their issues, and send the draft via email to the Complaints Department as detailed in the Action email)

Checklist	☑ ☒ N/A	Comments
1. At the outset, did you contact the complainant to establish the nature of their complaint and what their expectations are for outcome?		

2.	Have you identified all issues of complaint?		
3.	Have you separated facts from disputed events?		
4.	Have you interviewed any staff / witnesses involved?		
5.	Have you reviewed all relevant records/documentation?		
6.	Was a visit to the relevant site / facility / clinical area required?		
7.	Have you liaised with any other service areas involved to ensure one coordinated investigation and response?		
8.	If the complaint relates to clinical / professional issues, have you included review by clinician / professional with appropriate seniority?		
9.	Have you obtained all evidence to support your findings?		
10.	Have you attached all investigative documentation?		
11.	Has your draft response received all relevant Directorate approval (e.g. Assistant Director; Associate / Clinical Director, etc)		
12.	Have you shared the outcome with any staff complained about?		

Investigating Officer Completing this Complaints Investigation Report

Name: _____ Designation: _____ Date: _____

Keep this form and all documentation supporting your investigation in a secure location

Appendix 6

Staff Guidance Notes on Writing Statements and Reports

Statements and reports

Trust staff may be asked to help with an investigation into a complaint or enquiry by providing a written account. The following guidance aims to help staff with writing a statement or report.

Begin with your full name, work base, job title and location at the time of the complaint. Refer to the service user's case notes or records, if necessary/applicable.

Statements and reports should be:

- Factual;
- A record of what you did and why;
- An accurate and full description of what happened giving precise dates and times;
- Honest;
- Thorough;
- Legible;
- A record of why you did certain things rather than others.

They should not:

- Be written hastily, briefly, dismissively or seek to blame others;
- Avoid giving opinions and use of hearsay (i.e. someone else's view or version of events);
- Make statements beyond your knowledge or recollection;
- Comment on the aftermath, rather than the event;
- Make subjective statements;
- Comment on what you would have done according to normal practice;
- Include jargon or abbreviations (without providing explanations).

Read through your statement carefully. Sign and date your comments at the end. Keep a copy for reference in a safe place and forward to the relevant Directorate Investigating Officer within the identified timescale.

Appendix 7

Guidance notes for complaints-related meetings

Meetings can be a particularly effective way of diffusing a potential complaint, resolving an ongoing complaint or clearing up outstanding issues following a final response to a complaint. It is often far easier to discuss issues and avoid misinterpretation through verbal communication rather than written correspondence.

A meeting may be helpful initially if the complaint is complex.

You may find some staff will say "we've already been through this and have answered their concerns" but maybe the person making the complaints did not understand it or wants clarification. Therefore, a meeting should be seen as a tool to assist resolution of the matter and lessen the likelihood of an escalation of the issue.

If the Investigating Officer considers it would be helpful to have a meeting with a complainant, the Complaints Department will make the arrangements.

Checklist

The Complaints Department will:

- Check with the person making the complaint what their issues are and make them aware they can be supported at the meeting by a person(s) of their own choosing. Seek clarification if anyone will be attending with them.
- Determine with the person making the complaint where and when the meeting will be. The person making the complaint may have views on which staff should be present at the meeting.
- Ensure the venue is appropriate. Have refreshments, water etc. available.

The Investigating Officer will

- Consider carefully which staff need to attend the meeting. Remember too many Trust staff in attendance at the meeting may be intimidating for the person making the complaint.
- Decide who will chair the meeting, which will usually be a senior manager at Level 4 or above.
- In difficult cases you may wish to set a deadline at which the meeting will end.
- Before the meeting, review the circumstances and details with staff involved and with staff who will be at the meeting, to maintain honesty, accuracy and consistency.
- Make sure everyone who is to be involved in the meeting is kept up-to-date.
- If you feel the person making the complaint or those in attendance with them may be intimidating to a staff member you may take the decision not to have that staff member at the meeting.
- Ensure that staff who attend the meeting are briefed and offered support, they should not be left to take the full brunt of the person's anger etc.
- Have someone identified to be a note-taker at the meeting. Their role is to summarise the key points, actions agreed and who will undertake them as well as any outstanding issues. This will enable a written response to be issued after the meeting, if necessary.

The Chair should:

- Begin with introductions and their understanding of the reasons for the meeting.
- Listen – ask the person making the complaint to outline his/her key issues. Clarify any outstanding issues from those that might already have been addressed.
- Have the background file to hand for reference, if required.
- Accept blame and apologise if necessary.
- Highlight at the beginning of the meeting that detailed notes/minutes will not be taken instead information recorded will be as outlined above.
- At the end of the meeting summarise key actions in response to the issues raised to make sure all the points have been covered. Where issues have not been resolved, explain to the person making the complaint what will happen next and when. For example, further information may need to be obtained and forwarded to the person making the complaint or the Trust will write to the person making the complaint outlining the reason why it is not possible to answer the issues raised.
- Adhere to any timescales you have agreed at the meeting.

Similarly, conciliators can be involved to chair a meeting if agreed by all parties. The conciliator is an independent lay person, not employed by the Trust, who acts as a neutral mediator between the person making the complaint and those complained against in order to resolve outstanding concerns. The aim being to identify areas of conflict, make sure all issues are fully discussed and help bring the situation to a satisfactory conclusion and resolution, if possible. Alternatively, a senior manager from another Directorate could be approached to chair the meeting with a view to resolving the person's issues/concerns.

Appendix 8

Using conciliation, independent experts or lay persons

Conciliation

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. Conciliation is a voluntary process available to both the person making the complaint and those named in the complaint. Either may request conciliation but both must agree to the process being used.

The conciliator will assist all concerned to a better understanding of how the complaint has arisen and 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.

In deciding whether conciliation should be used, consideration must be given as to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. Conciliation may be helpful, for example, in the following situations:

- where staff feel the relationship with the complainant is difficult;
- where trust has broken down between the person making the complaint and the Trust and both parties feel it would assist the resolution of the complaint;
- where it is important, for example, because of ongoing care issues to maintain the relationship; or
- when there are misunderstandings with relatives during the treatment of the patient/client.

All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions. Using conciliation does not affect the right of the person making the complaint to pursue their complaint if they are not satisfied. The conciliator should advise when conciliation has ceased and whether a resolution was reached. No further details should be provided.

Agreement to use conciliation must be agreed by the relevant Director and the complainant and then contact should be made with the Corporate Risk Manager who will liaise with the HSC Board and request access to this service.

Independent experts

The use of an independent expert in the resolution of a complaint may be requested by the Trust and/or by the person making the complaint. In deciding whether independent advice should be sought, consideration must be given to the nature and complexity of the complaint. Input may be considered beneficial where the complaint:

- cannot be resolved locally;
- identifies a risk to public or service user safety ;
- threatens public confidence in the service or damage to the Trust's reputation;
- could give rise to a serious breakdown in relationships; or
- requires an independent perspective on clinical/professional issues.

Independent experts must be impartial, objective and independent of any parties to the complaint. They may work within another HSC Trust in Northern Ireland or in certain circumstances may be recruited from outside Northern Ireland.

Consideration to use an independent expert must be discussed with the Head of Governance and Patient Safety. Approval to use an independent expert must be obtained from the relevant Director.

Independent lay persons

Independent lay persons may be beneficial in providing an independent perspective on non-clinical/technical issues being investigated under the Trust's Complaints Procedure. Lay persons are not intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the Trust or the person making the complaint. The lay person's involvement is to help bring a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised.

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

- Communication issues
- Quality of written documents
- Attitudes and relationships
- Access arrangements (appointment systems).

It is essential that both the Trust and the complainant have agreed to the involvement of a lay person. Lay persons should have appropriate training in relation to the HSC complaints procedure and have the necessary independence and communication skills.

Western Health and Social Care Trust

Appendix *9*

Complaints Closure Form

COMPLAINT ID:

LESSONS IDENTIFIED FROM COMPLAINT INVESTIGATION

ACTION PLAN TO IMPLEMENT LEARNING & PREVENT RECURRENCE:

Action	Progress Update	Person Responsible	Target Date for Completion	Date Completed

HOW WILL YOU SHARE THE LEARNING?

NAMES OF STAFF MEMBERS CONNECTED TO THIS COMPLAINT (include staff who are named within the complaint or subsequently have become connected to the cause/issues of the complaint)

DETAILS OF INVESTIGATING OFFICER:

Name: _____ **Designation:** _____

Date: _____

****Send this form and draft response to your Assistant Director for approval and then to Complaints Department**

Appendix 10

Criteria applicable to unreasonable, vexatious or abusive persons making complaints or enquiries

Unacceptable Actions

Aggressive or abusive behaviour

Violence is not restricted to acts of aggression that may result in physical harm. It includes the behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under these headings include: threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. Inflammatory statements and unsubstantiated allegations are also considered to be abusive behaviour.

Staff should be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance approach must be adopted. Often a person making a complaint or enquiry can be angry due to the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards staff.

Unreasonable demands

A person making a complaint or enquiry can make unreasonable demands through the amount of information they seek, the nature and scale of service expected or the number of approaches he/she makes. What amounts to unreasonable demands will always depend on the circumstances surrounding the behaviour and the seriousness of the issues raised. 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 telephone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

Such demands will be considered 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 persons making complaints or enquiries or functions.

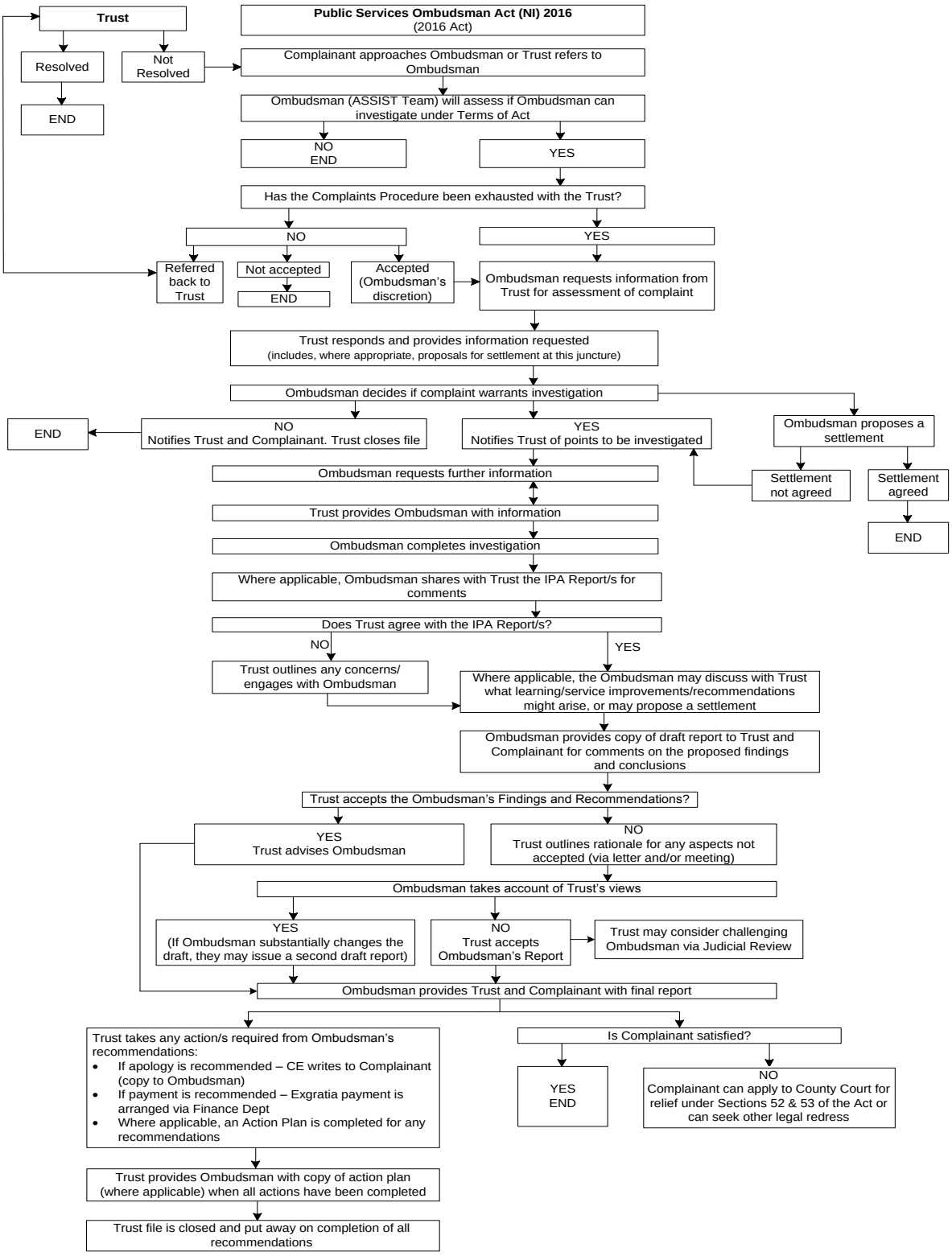
Unreasonable persistence

Some persons making complaints or enquiries will not, or cannot, accept that the Trust is unable to assist them further or provide a level of service other than that provided already. Such persons may persist in disagreeing with the action or decision taken in relation to their complaint or enquiry or contact the Trust 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, unwillingness to accept documented evidence as being factual, persistent refusal to accept explanations relating to what the Trust can or cannot do and continuing to pursue a complaint without presenting any new information. Such actions are considered unacceptable when they take up what the Trust regards as being a disproportionate amount of time and resources.

Appendix 11

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)



V1 – July 2019