Can you?

- Define what is clinical and social care governance.
- Understand what constitutes an incident and how to report one.
- Outline your responsibility is in relation to risk, know how to identify a risk and have an understanding of the system in place to manage them.
- Say why it is important to have a complaints process, what your role is in de-escalation and when things have gone wrong, say sorry.

Questions & Contacts

For more information or to contact a member of the Directorate of Acute Services, Governance Team, please telephone Personal Information redacted by the USI or Personal Information redacted by the USI

Southern Health and Social Care Trust

Trudy Reid, Clinical & Social Care Governance Co-Ordinator – Acute Services
David Cardwell, Senior Governance Officer – Acute Services

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Quality Care - for you, with you

Learning outcomes

At the end of the session you will know:

- What constitutes an incident and how to report one
- How to appropriately grade an incident
- What your responsibility is in relation to the investigation of an incident
- What constitutes a Serious Adverse Incident

Clinical and Social Care Governance

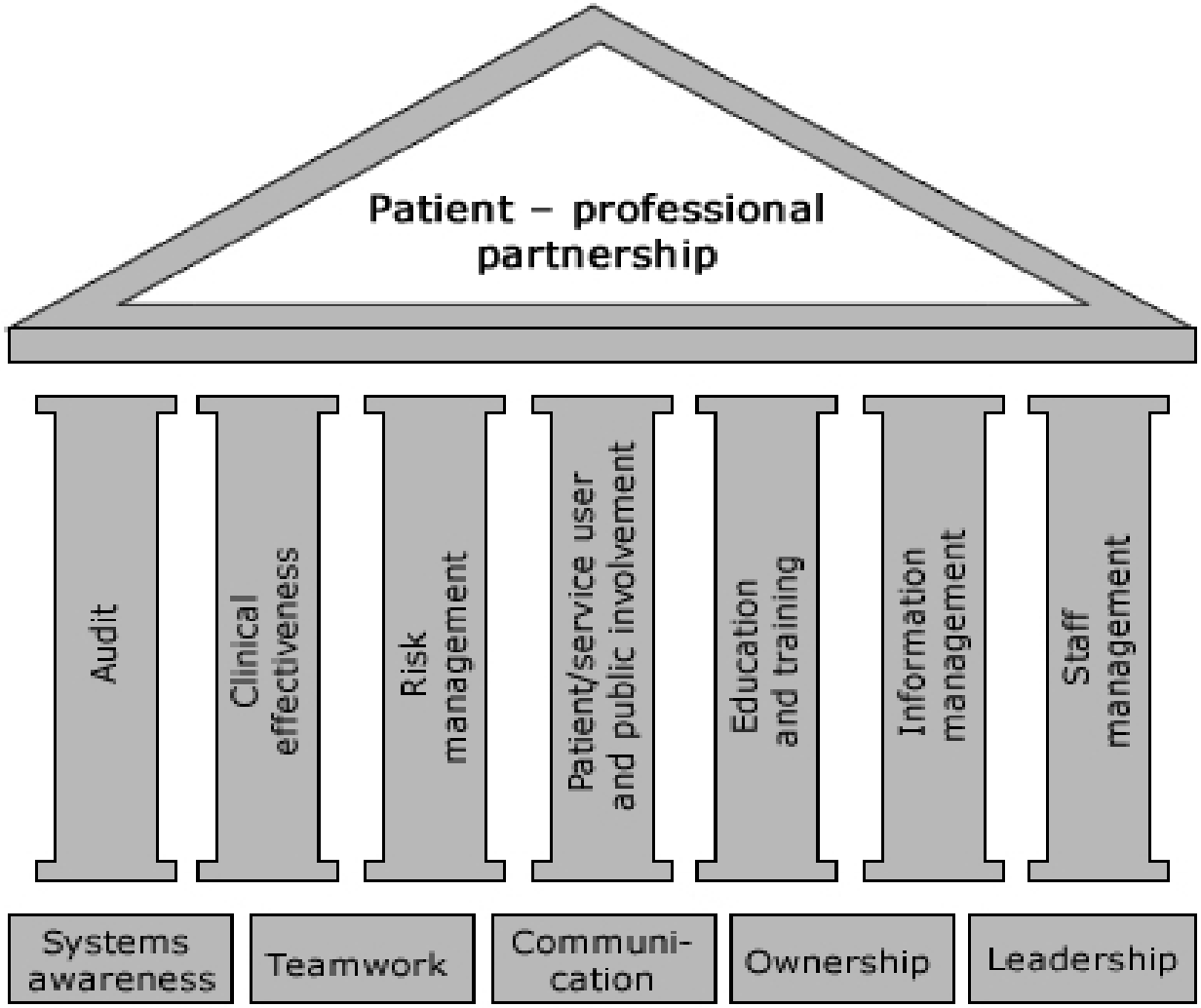
The framework through which organisations are accountable for..

- continuously improving the quality of their services
- safeguarding high standards of care by creating an environment in which excellence in healthcare will flourish

Quality at the heart

- Quality is a fundamental goal in healthcare provision, protecting the patients, clinicians, and the reputation of the organisation.

- Quality services can reduce the levels of human distress, professional stress and the drain on valuable resources arising from clinical negligence or systematic error



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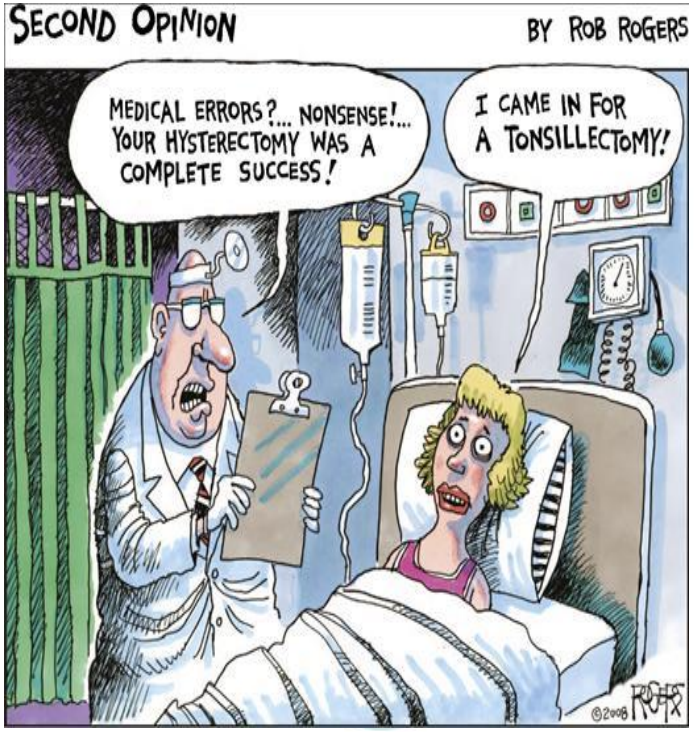
Incident Management

is about minimising risks to patients by:

- identifying what can and does go wrong during care
- accurate reporting of near misses and incidents
- understanding the factors that influence this
- learning lessons from incidents
- ensuring action is taken to prevent recurrence
- putting systems in place to reduce risks



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Incident Reporting

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Quality Care - for you, with you

What is an incident?

Any event that has given or may give rise to actual or possible personal injury, to patient/client dissatisfaction or to property loss or damage

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What is a near miss?

Any event that did not lead to personal harm but could have, an occurrence which but for luck or good management would in all probability have become a fully blown incident.

Note – should be reported using the IR1 form.

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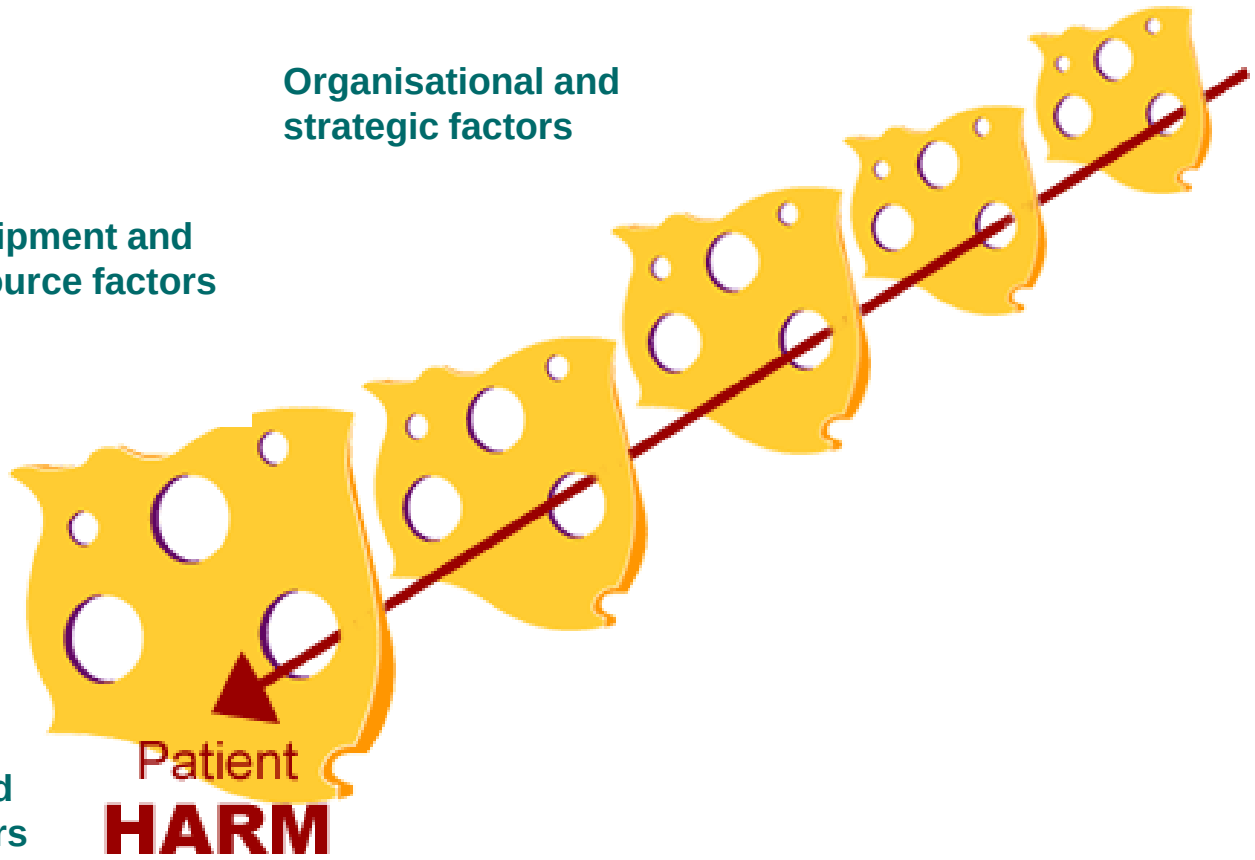
Why do things go wrong- Swiss Cheese Model

Patient factors

Organisational and strategic factors

Equipment and resource factors



Education and training factors

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NPSA Contributory Factors Classification Framework

Who/what suffers from incidents and/or near misses?

- People
- Quality of service
- Resources
- Reputations

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Top 5 incidents for Directorate

(1 April 2017 to 31 March 2018)
Total 5563 Incidents in Acute Services Directorate < 147 on 16/17

Category	2015/16	2016/17	2017/18
Total Incidents	5669		5563
Slips, trips, falls & collisions	1094		1077
Abuse of staff by patients	369	561	407
Discharge (Inc. absconders)	473		328
Admin/supply of Medication from clinical area	296	367	322
Pressure Sore	134	241	276

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What is your role and responsibility?

- Deliver safe care
- Aware of professional standards and legal responsibilities
- Be familiar with Trust policies/procedures
- Maintain confidentiality
- Report incidents and near misses
- Report concerns/risks
- Complete IR1 form electronically

Why Report Incidents?

By reporting an incident you are creating a 'record of the event', and the details can be recalled and referred to in the future. It is important that you report the incident at your earliest opportunity, whilst the event is fresh in your mind. Further details can be added to the incident report, by your manager, at a later date

- If incidents are **reported** and if the chain of events leading up to and contributing to an adverse incident are **analysed**, it allows the individuals and the organisation involved to **identify** what went wrong.

- It is then possible to **learn** from the incident and to develop strategies which **prevent** the same thing happening again.

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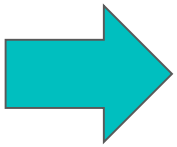
How to Accurately Record an Incident

Datix Demonstration

Southern Health and Social Care Trust

IR1 form

To access the Southern Trust's Electronic Incident Reporting form:

1. Open the Trust's Intranet Site.
2. Click on Useful Links  Other Useful Links
3. Scroll down to Datix. Click Datix Incident Reporting Form

Guidance on how to complete the form can be accessed by clicking on the user guide.

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How to Accurately Grade an Incident

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DOMAIN	IMPACT (CONSEQUENCE) LEVELS				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Minimal injury requiring no/ minimal intervention. • Non-permanent harm lasting less than one month (1-4 day extended stay). • Emotional distress (recovery expected within days or weeks). • Increased patient monitoring	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Increase in length of hospital stay/care provision by 5-14 days.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorized 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.

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

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**

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What happens after you have submitted an incident ?

- An email notification will be sent to your line manager, to inform them of the event. Your line manager will then be able to access all of the incident information.
- A copy email may also be sent to other staff to notify them of the event, dependent on the type/severity of the incident.
- Your line manager and/or other staff will review the incident in a proportionate manner. They may contact you to clarify/find out more information. Some incidents will be reported as Serious Adverse Incidents or may be subject to safe guarding or other investigatory processes.
- Your line manager is able to provide feedback about the event, and record the details directly onto Datix.
- Reports are regularly generated from Datix, to highlight incident trends, and the reports are presented and discussed at Trust Governance meetings.
- Staff should be supported following the incident.

HSC Southern Health and Social Care Trust

How to Accurately Investigate an Incident

Things to consider:

- Notes
- Equipment
- Environment
- Staffing
- Interviews
- Policies
- Guidance

An Example –
Datix ID 69473

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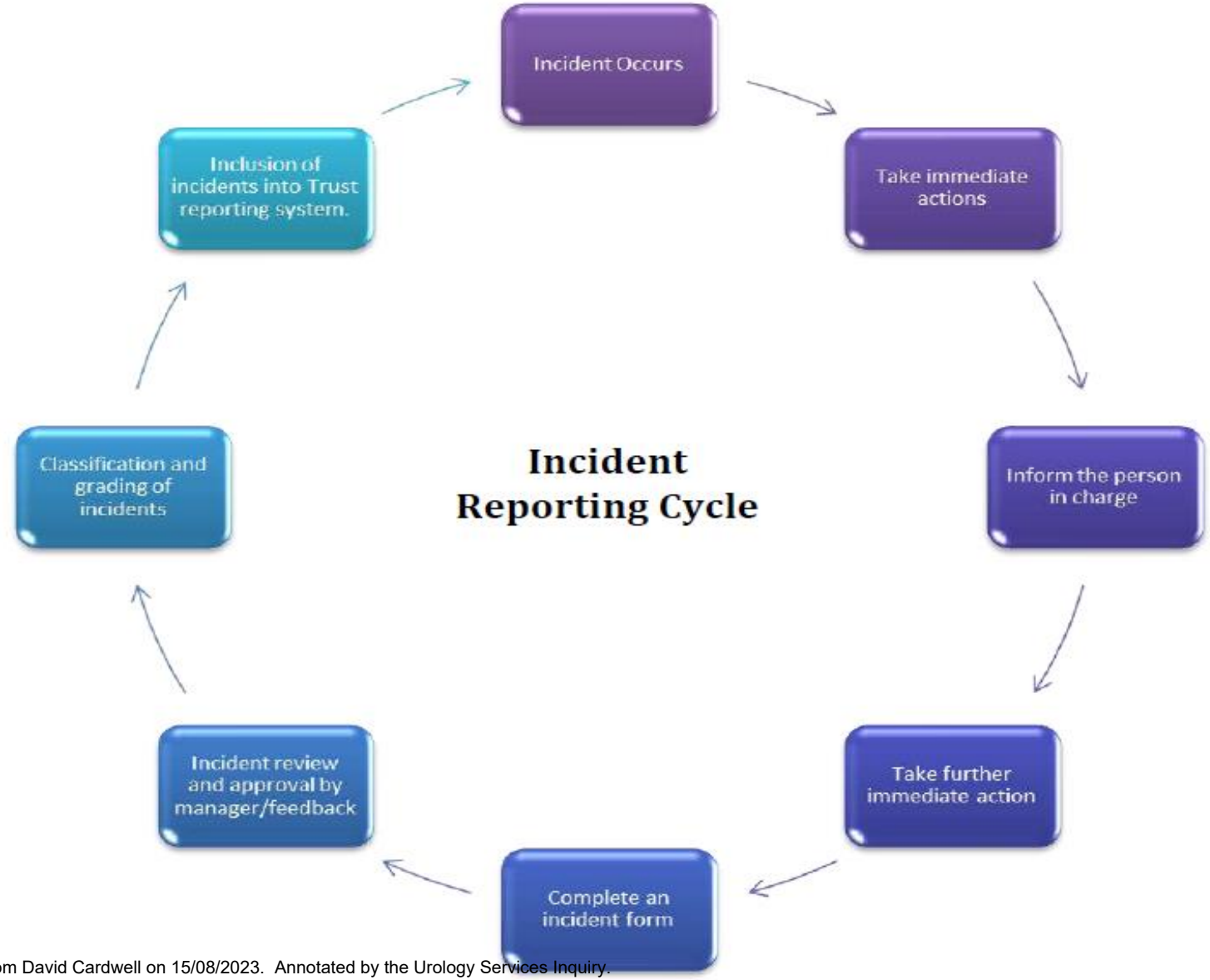
In Summary



Incident Reporting – a bit like recycling!

We all have a responsibility..

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Serious Adverse Incident (SAI) Reporting

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Principles of SAI Management

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Serious Adverse Incident (SAI) Criteria - November 2016
Examples of Actual or Potential Types

4.2.1 serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

4.2.4 serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public
- by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Never Events

Wrong site surgery	Wrong implant/prosthesis
Retained foreign object post procedure	Mis-selection of a strong potassium containing solution
Wrong route administration of medication	Overdose of Insulin due to abbreviations for incorrect advice
Overdose of methotrexate for non-cancer treatment	Mis-selection of high strength of midazolam during conscious sedation
Failure to install functional collapsible shower or curtain rails	Falls from poorly restricted windows

Learning From SAIs

- SAI Team must be clear regarding the aims/boundaries of SAI reviews which are intended solely for the identification and reporting of learning.

- Should determine the causes and learning points should be progressed, ensuring remedial actions are put in place as necessary to reduce the likelihood of reoccurrence.

- Dissemination of learning is core to achieving shared lessons are embedded in practice.

- HSCB in conjunction with PHA will ensure themes and learning from SAIs are identified and disseminated via:
  - Learning letters
  - Learning newsletter
  - Thematic reviews (e.g. Suicide, Falls etc.)

Staff Support & Feedback

The Trust has a number of arrangements to support staff through the process if required. You can contact:

- ***Your Supervisor or Line Manager***
- ***The Occupational Health Team***
- ***Inspire***
- ***Your Clinical and Social Care Governance Team***

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Close and Evaluation

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Questions & Contacts

For more information or to contact a member of the Directorate of Acute Services, Governance Team, please telephone [redacted]

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Acute Services Incidents

Please find below a table which contains the most common reasons for completing an IR1 form. The purpose of this table is to provide you with points you may which to be considered when reviewing, investigating and closing IR1 forms. The overriding reason for completing and reviewing IR1's is to understand why the IR1 form was completed and how repetition can be prevented

	Themes	**Action to be taken**
1.	Medication → Omitted/delayed medication → Prescribing error	Factors to be considered: • Need to review kardex • Need to identity staff member involved – first error or have there been others • Need to meet with staff member • Need to complete medication action plan • File action plan in staff members file • Need to establish the circumstances surrounding the error • Has the patient / relative been informed • Discuss with Pharmacist, was prescriber identified? • Was error explained to prescriber and changes made? • Was the consultant informed? • Was this escalated to Educational Supervisor.
2.	Fall	• Any injury noted? • How was patient moved • If patient attended x-ray / CT scan what were results? • What time was patient seen by medical team ? • Were CNS observations carried out half hourly for first 2 hours then hourly • Observations recorded on " notes section" on datix • Was patient risk assessed on admission and if risk identified, was care plan completed & updated post fall? • Was patient moved to observation area? • All questions in falls mandatory info needs to be completed • Relatives informed . • Review care post fall – was the falls pathway followed?
3.	Skin development of pressure sore	• Assess what information was recorded re skin condition on admission • What was Braden Score on admission? • If < 18 was Pathway followed. i.e, Mattress review type, Repositioning chart • Was Braden carried out as per guidelines? • If developed in Hospital is this recorded as part of the Skin Bundle • Was the risk assessment updated as appropriate i.e. after 7 days or on transfer. • Was the Cross completed at ward level
4.	Needle stick	• Was the protocol adhered to? • Was screening carried out? • Was Staff member referred to ED/ OH? • Has staff member attended sharps training and when? • Need to complete Local investigation form and attach to Datix

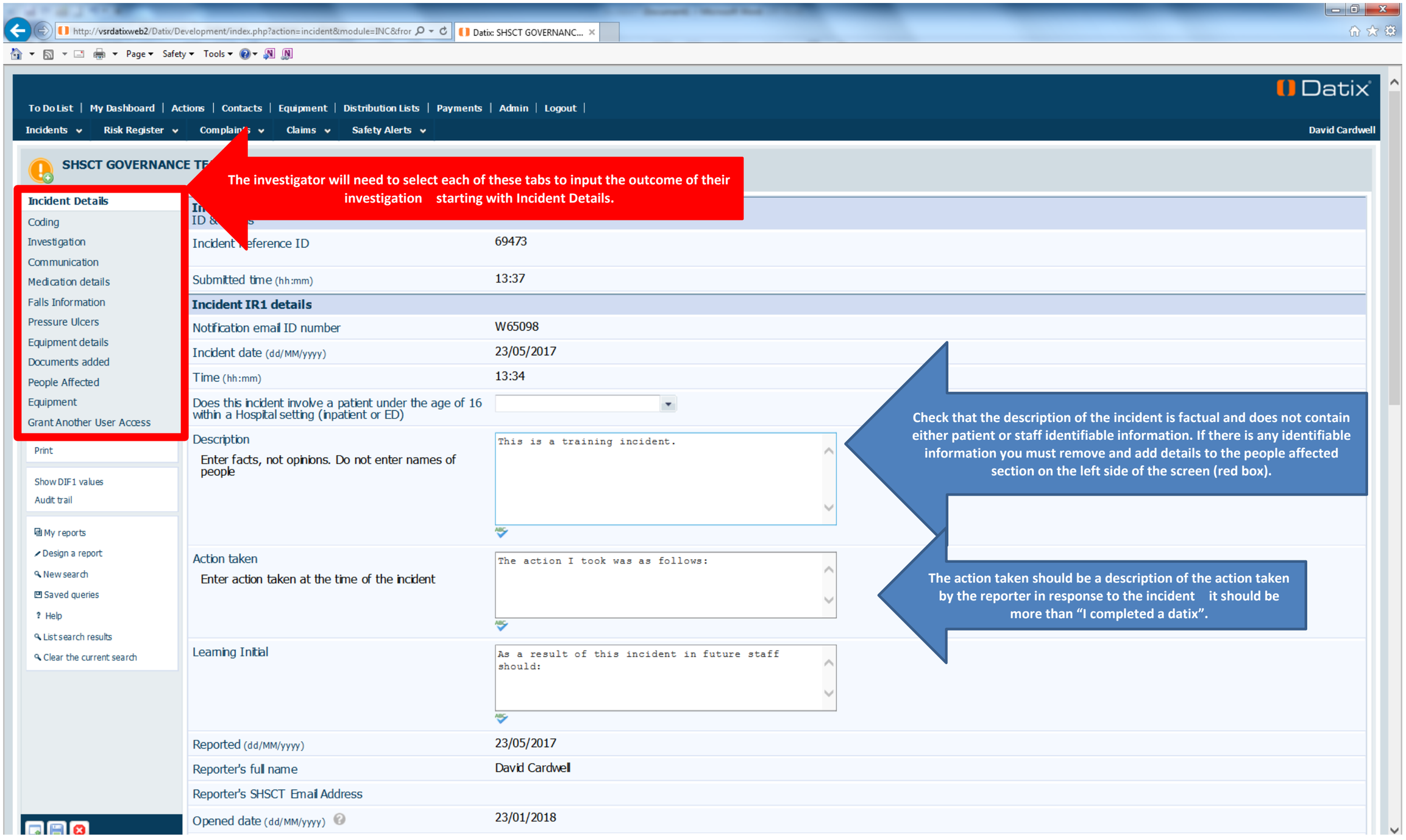
5.	If member of staff was injured at work	• Did staff member attend ED and what was outcome? • Was local investigation form completed and attached to Datix • Review Datix for RIDDOR reportable incidents • Photographs where appropriate • Ensure information is factually accurate for potential future litigation
6.	If patient absconds	• Was medical team informed? • Was protocol adhered to? • Were PSNI contacted? • What was outcome? • Did patient return or not to ED? • If returned what action was taken?
7.	Security incident	• Need to ascertain if any injuries. • If staff member injured follow action as per number 5 above
8.	Infection Control Diagnosed with MRSA/ MSSA/ C Diff whilst in hospital	• Ward Sr/ CN requires to discuss with ICP team if RCA required • If RCA required then review to be arranged as per protocol • Attach completed RCA audit tool to datix. • Date to be confirmed when shared with staff via safety brief • Date to be confirmed when shared with other Ward Srs . Ie Next Ward Srs Meeting – cross divisional sharing & learning.
9.	Staffing Issues/ Levels	• Need to understand why the need arose and what actions were taken • Need to review when identified ie was this last minute sick leave or gap already identified (vacancy) • Trends day duty/night duty/weekend/BH's – particular staff members • Need to review what measures were put in place to address this ie bank request, agency request. • Escalation to senior staff? • Was redeployment considered/explored as an option • Review number of staff on duty • Review number of patients at ward/ dept level • Review if any patient had come to harm during this period.

August 2015.

Incident Reporting: An Investigator's Guide

To access this on-line form you will need to have a datix account (log on details).

1. Tab 1 (INCIDENT DETAILS) This is the first page of the form and the starting point.



Name

This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.

SMITH JOHN

This will be the name of the person affected by the incident and should be automatically entered if the reporter has input the correct detail. If there is no name, the reporter should be asked to provide same.

Location of Incident

Site	Daisy Hill Hospital
Loc (Type)	Ward or Care Area
Loc (Exact)	Stroke / Rehab
Directorate	Acute Services
Division	Medicine and Unscheduled Care
Service Area	Emergency Department Services
Speciality / Team	Accident and Emergency

As the investigator you are responsible for checking the incident has been reported to the correct department. Please amend if incorrect.

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Connolly, Connie	connie.connolly@southerntrust.hscni.net	23/05/2017 13:37:58	9424		Acting Acute Governance Co-Ordinator
Reid, Trudy	trudy.reid@southerntrust.hscni.net	23/05/2017 13:37:58	9421		Interim Assistant Director of Corporate Governance

Management of Incident

Handler

Enter the manager who is handling the review of the incident

David Cardwell

The person investigating the incident should select their name from the drop down box.

Additional/dual handler

If it is practice within your team for two managers to review incidents together use this field to record the second handler

If there is a dual handler their name should be selected from the drop down box.

Escalate

You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.

* Approval status (update at each save)

Before navigating away from an incident update the approval status in this field to reflect which stage of the review process has been reached

The investigator should change the status of the incident to "being reviewed" from the drop down box.

Note the approval status will be changed to "final approval by the Head of Service once the investigation has been completed. They will also insert the date of final approval.

Date of final approval (closed date) (dd/MM/yyyy)

Reasons for Rejection - History

No records to display.

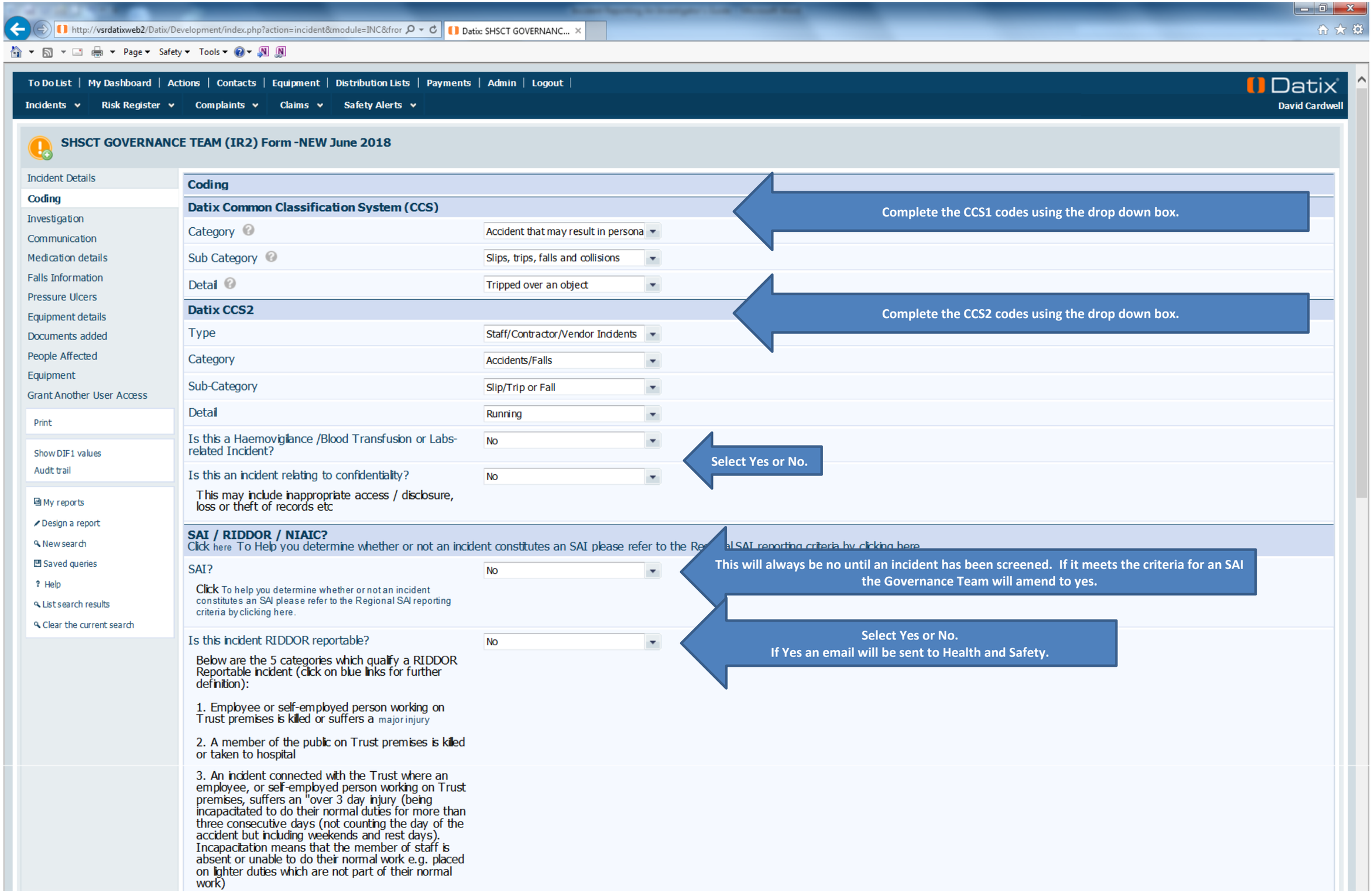
Linked records

No Linked Records.

Link a record.

Save Cancel

2. Tab 2 (CODING).



4. Dangerous Occurence attributable to the work of the Trust

5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease

Is this a NIAIC Incident

No

NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable;

- design or manufacturing problems

- inadequate servicing and maintenance

- inappropriate local modifications

- unsuitable storage and use conditions

- selection of the incorrect device for the purpose

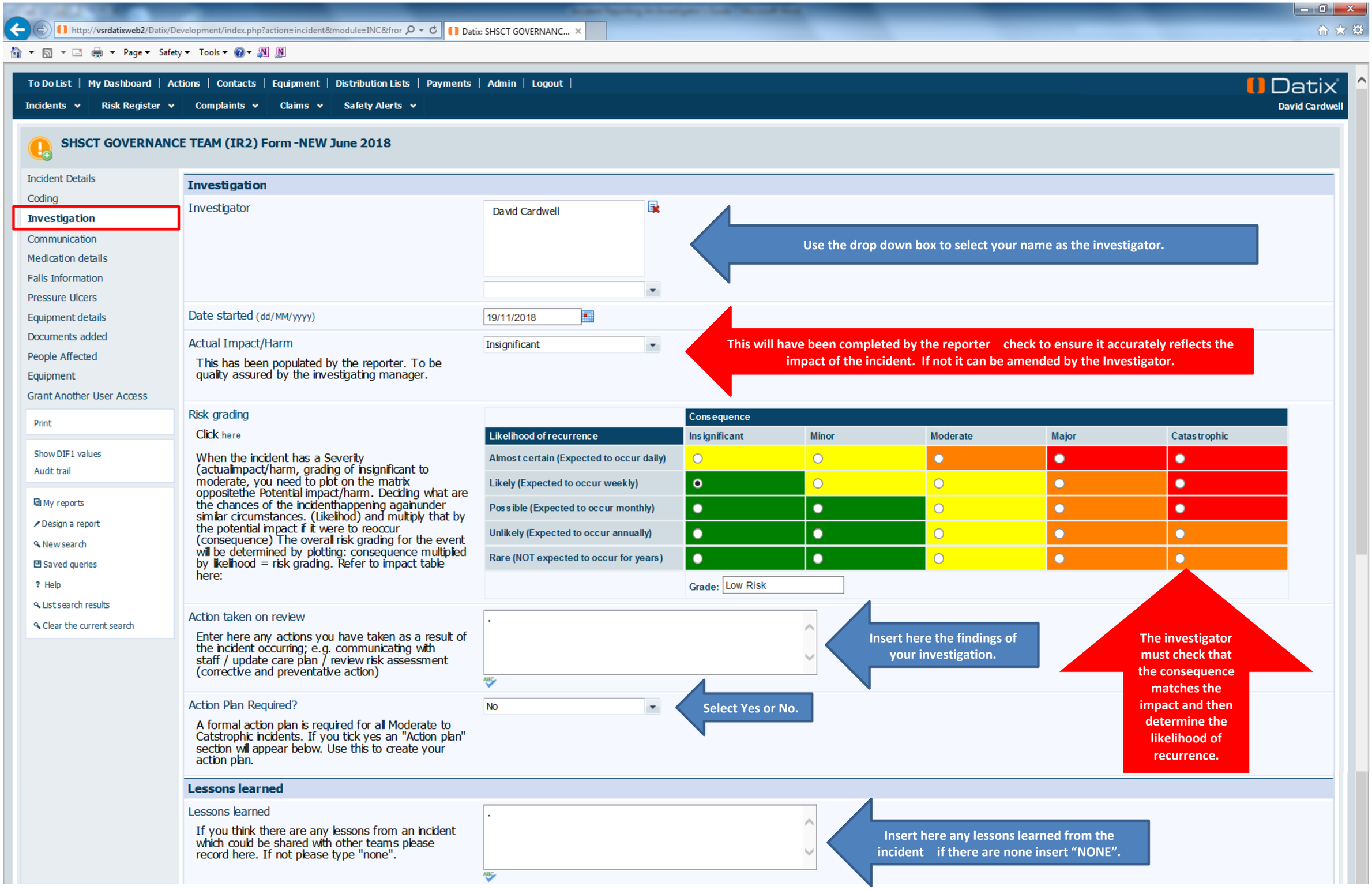
- inappropriate management procedures

- poor user instructions or training (which may result in incorrect user practice

Select Yes or No.
If Yes an email will be sent to Estates.

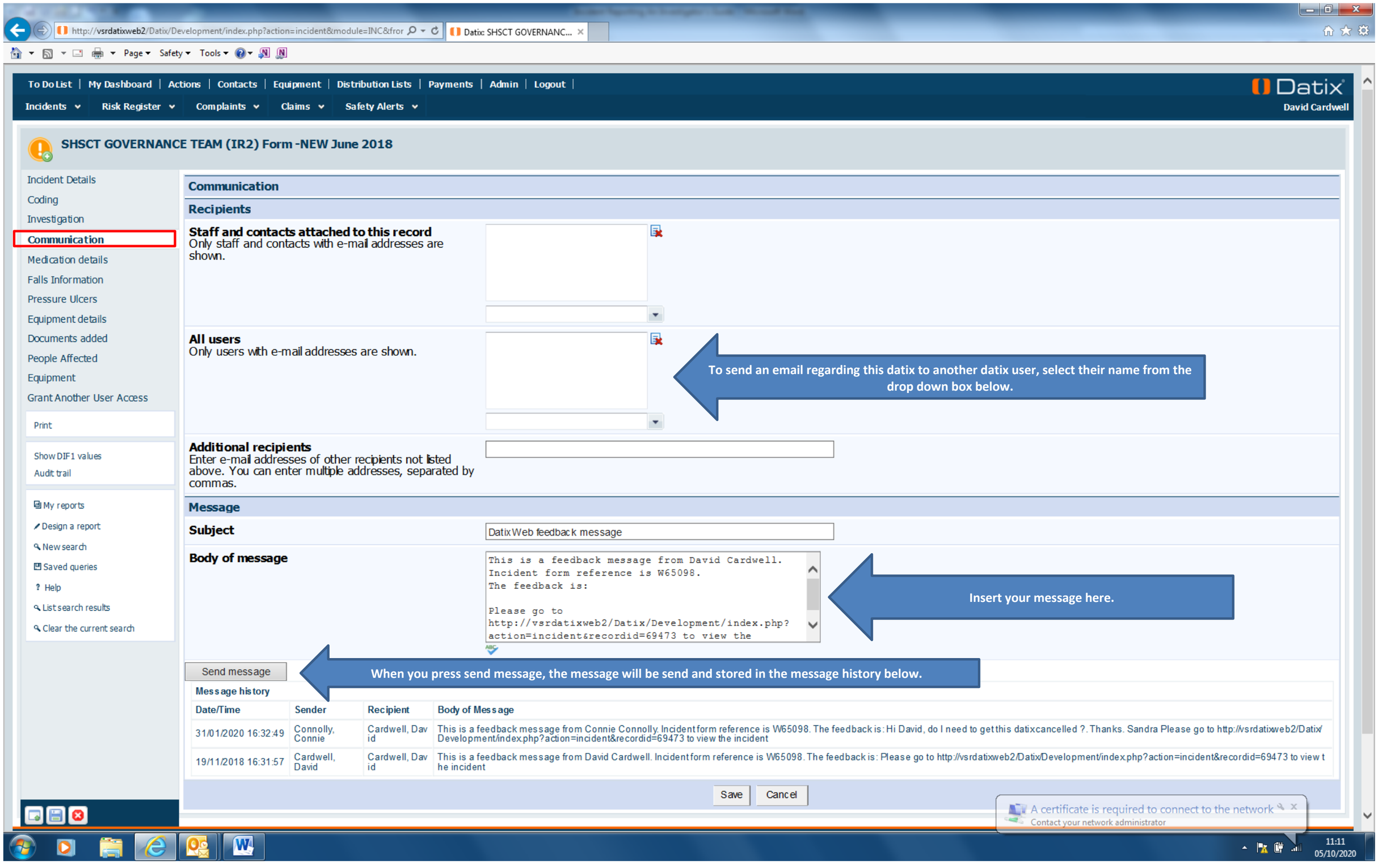
Save Cancel

3. Tab 3 (INVESTIGATION).



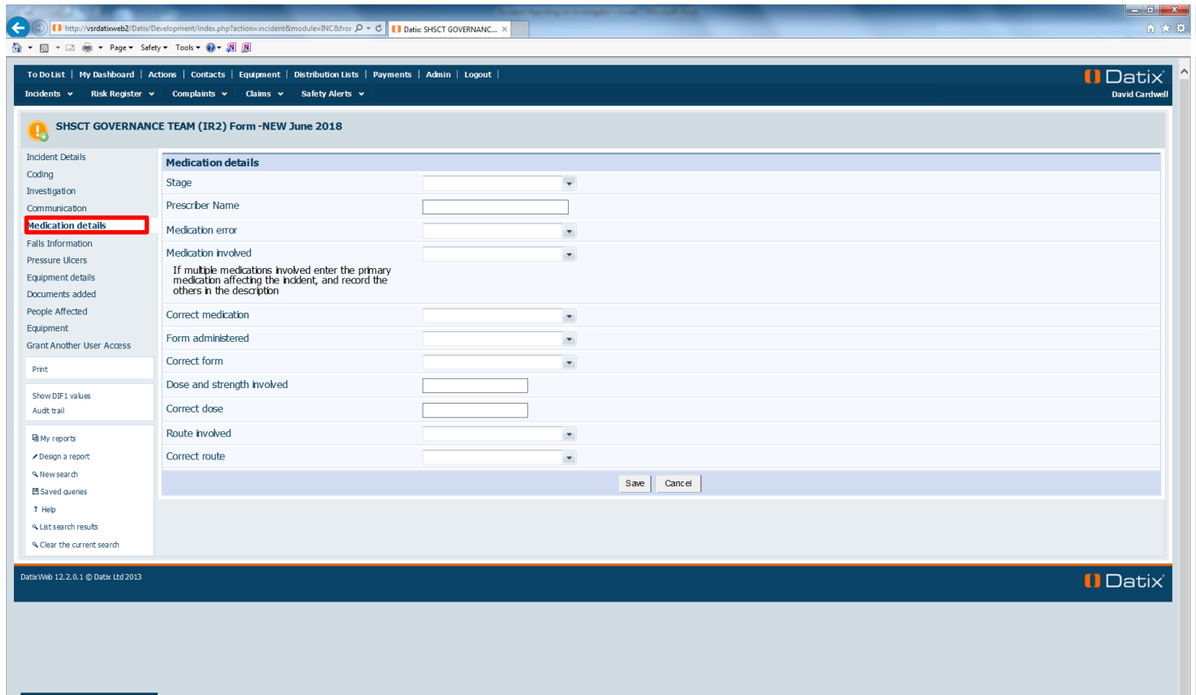
Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

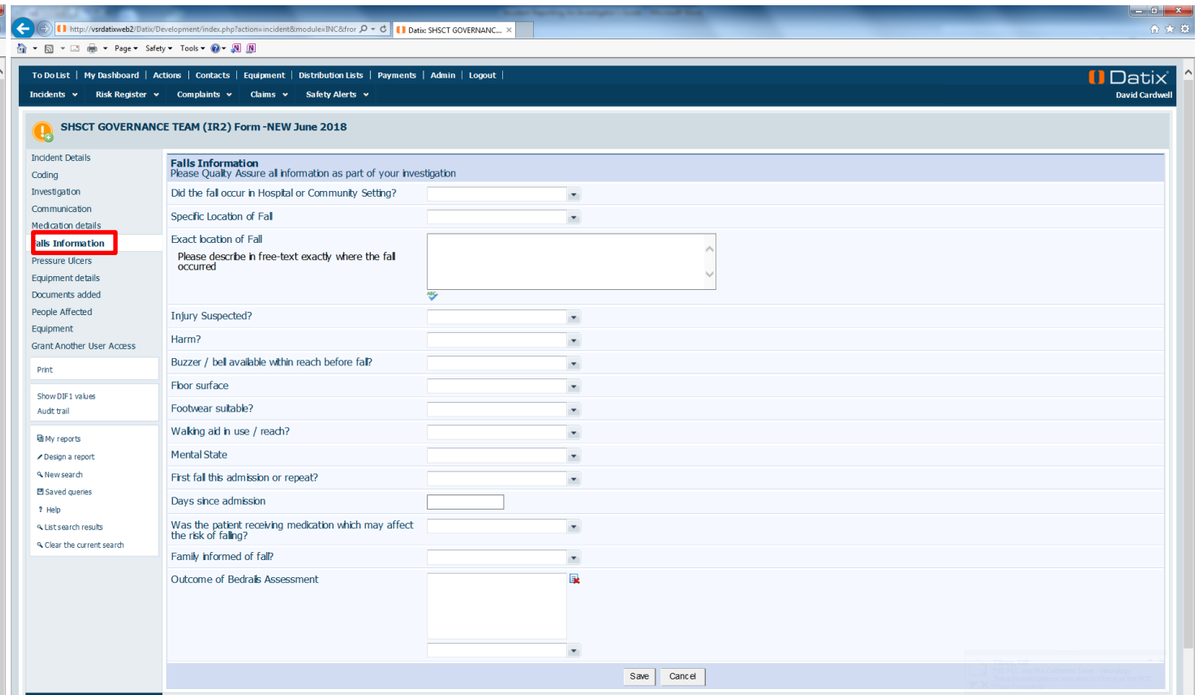
4. Tab 4 (COMMUNICATION).

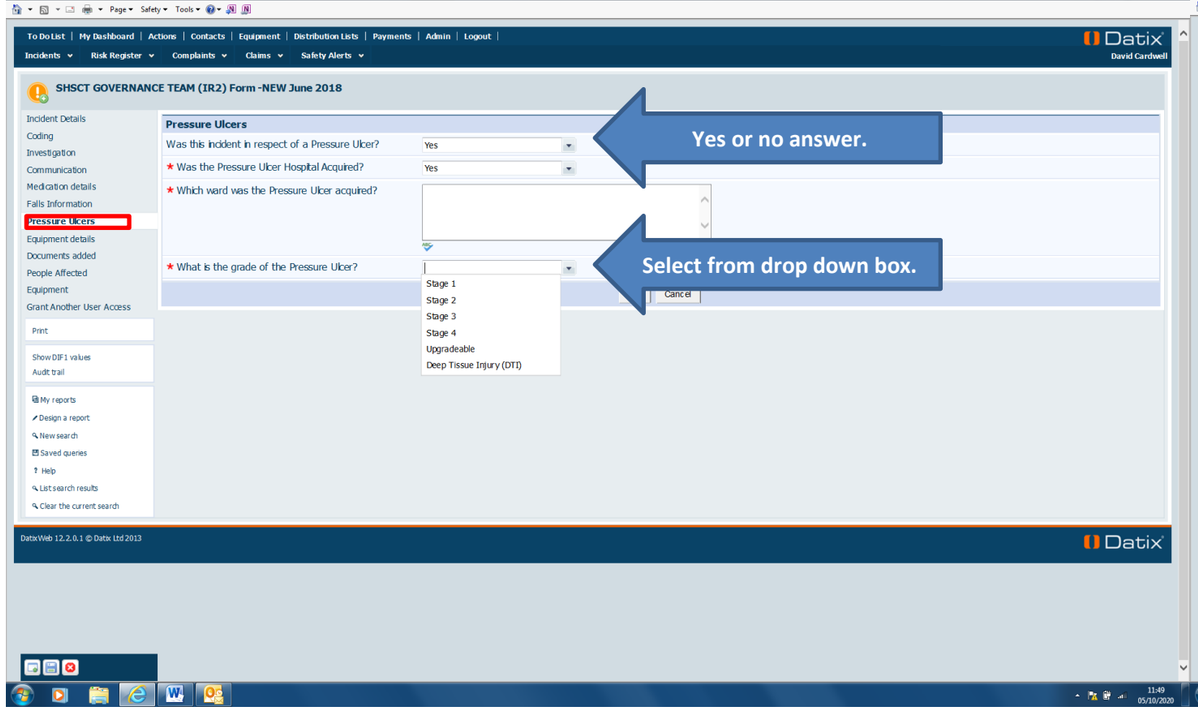


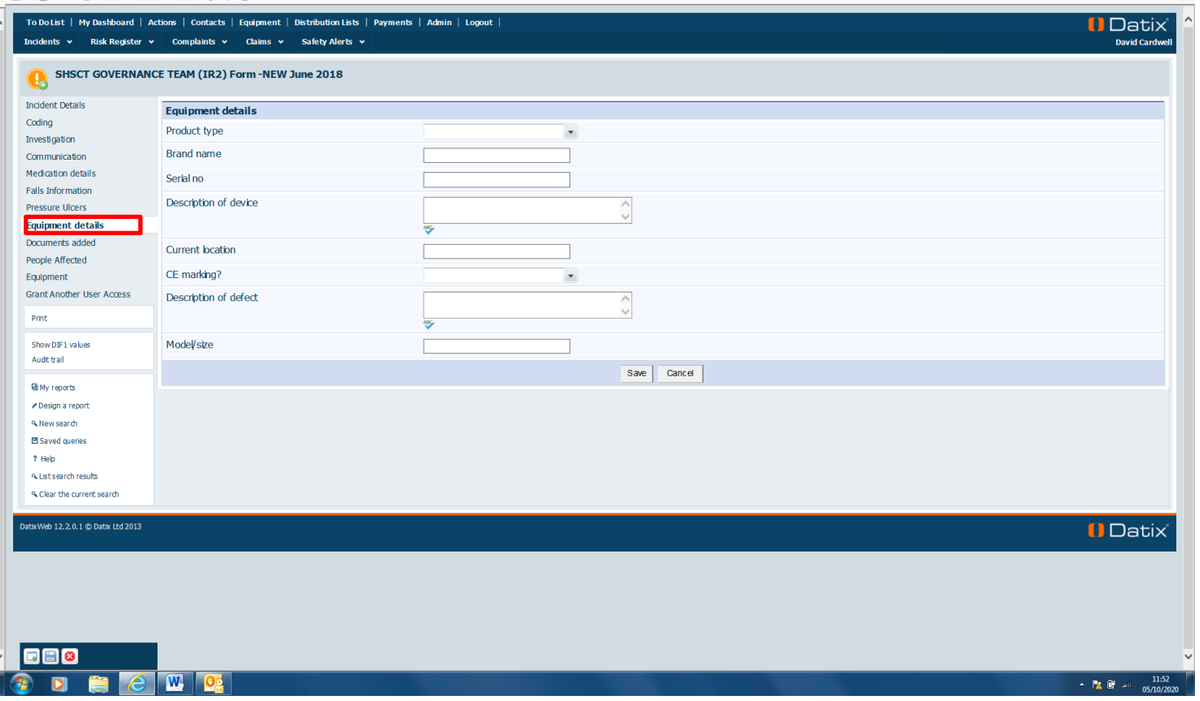
5. Tab's 5, 6, 7, and 8 (MEDICATION DETAILS, FALLS INFORMATION, PRESSURE ULCERS AND EQUIPMENT DETAILS).

If the incident involves any of the above situations then the relevant tab needs to be completed.









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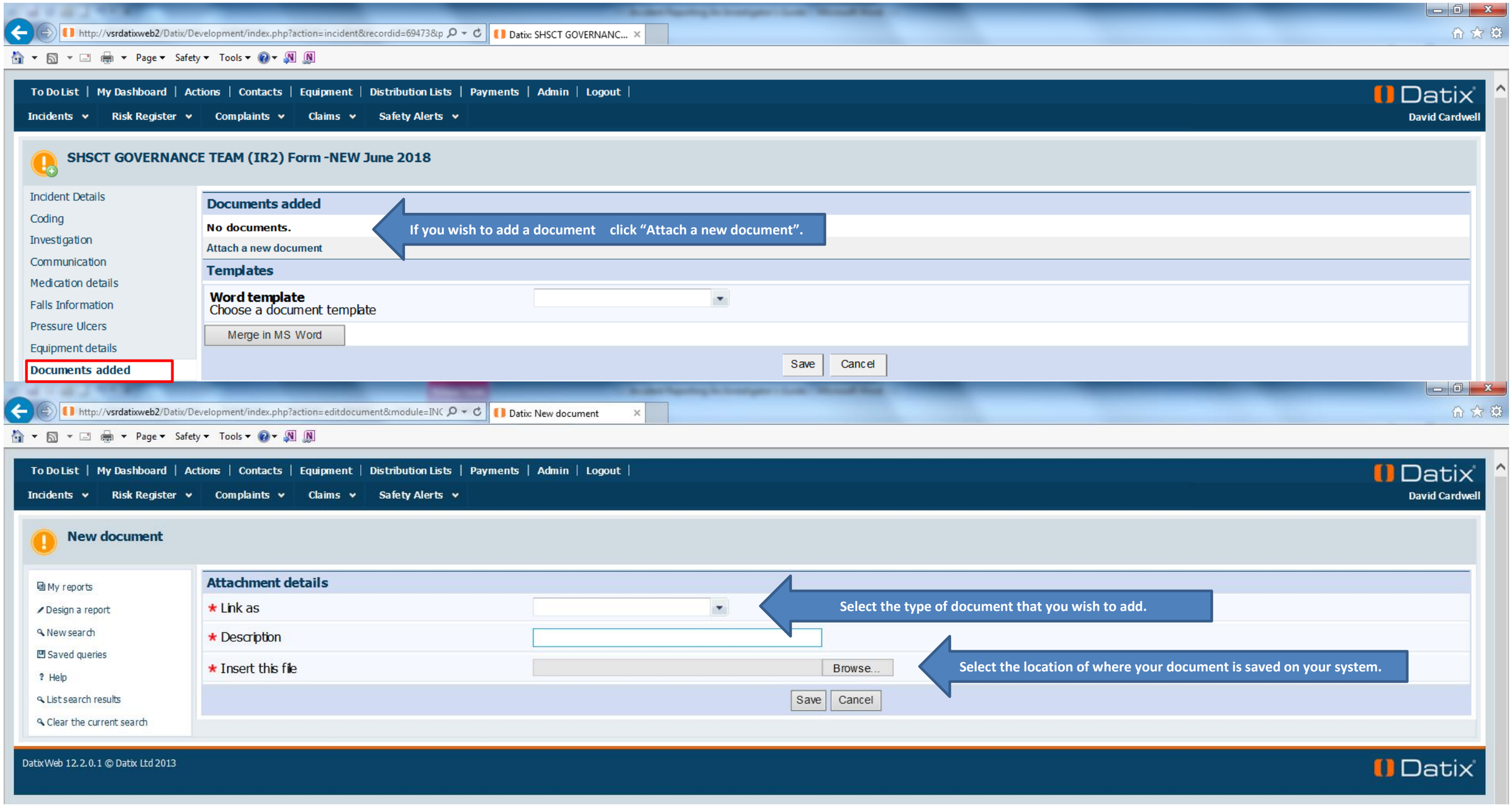
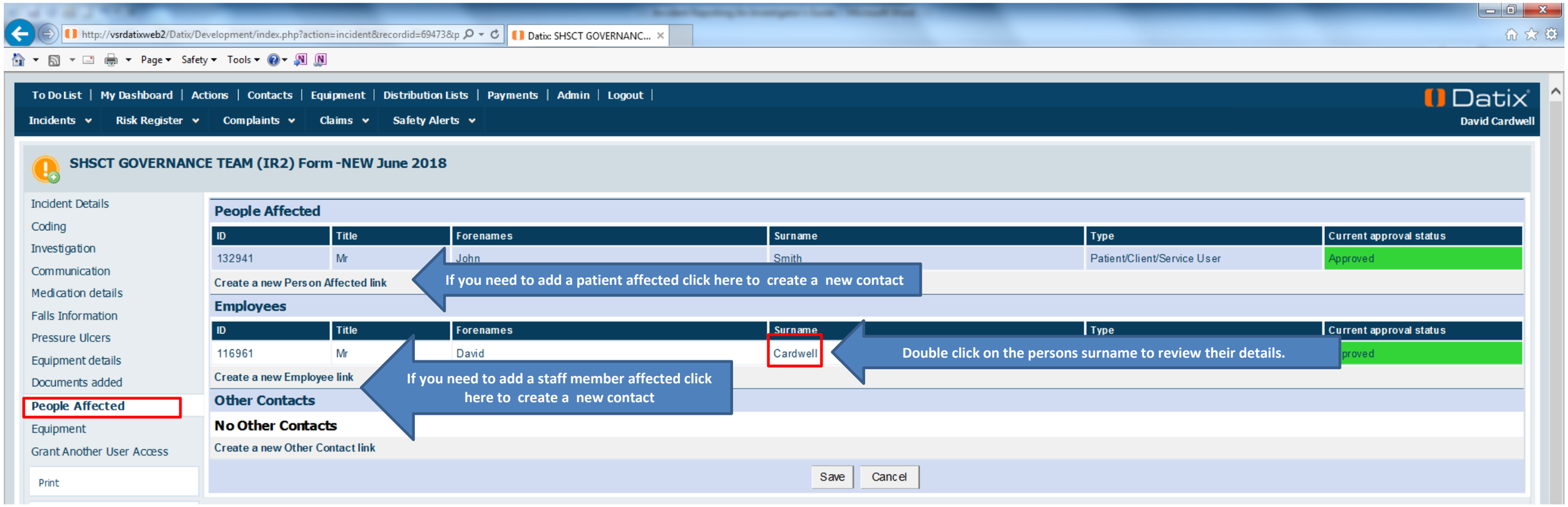
6. Tab 9 (DOCUMENTS ADDED).



Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

7. Tab 10 (PEOPLE AFFECTED).



Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

http://vsrdatixweb2/Datix/Development/index.php?action=linkcontactgeneral&module: Datix: Person Affected

Page Safety Tools

To Do List | My Dashboard | Actions | Contacts | Equipment | Distribution Lists | Payments | Admin | Logout |

Incidents | Risk Register | Complaints | Claims | Safety Alerts

Datix

David Cardwell

Person Affected

Contact details

Employee details

Print

+ Create a new contact
List all contacts
My reports
Design a report
New search
Saved queries
Help

Contact details

Contact Role If not populated by reporter, enter here the person's role in incident-could be a staff member.	Person affected/ Or could have bee
* Contact Type	Patient/Client/Service User
* Approval status	
Title	Mr
Forenames	John
* Surname	Smith
* Gender	Male
Address if this is a member of staff please use work address here	10 Any Street ANYTOWN
Postcode	BT00 2OO
Telephone No:	
Mobile:	
Email	
H&C No/Hospital No	367 383 0007
Staff No if this is a member of staff please use staff no instead of h&c no	
MH Order Section	
Language	
Date of birth (dd/MM/yyyy)	04/02/2002
Deceased?	
Date of death (dd/MM/yyyy)	

Check for matching contacts

DatixWeb 12.2.0.1 © Datix Ltd 2013

Select from drop down

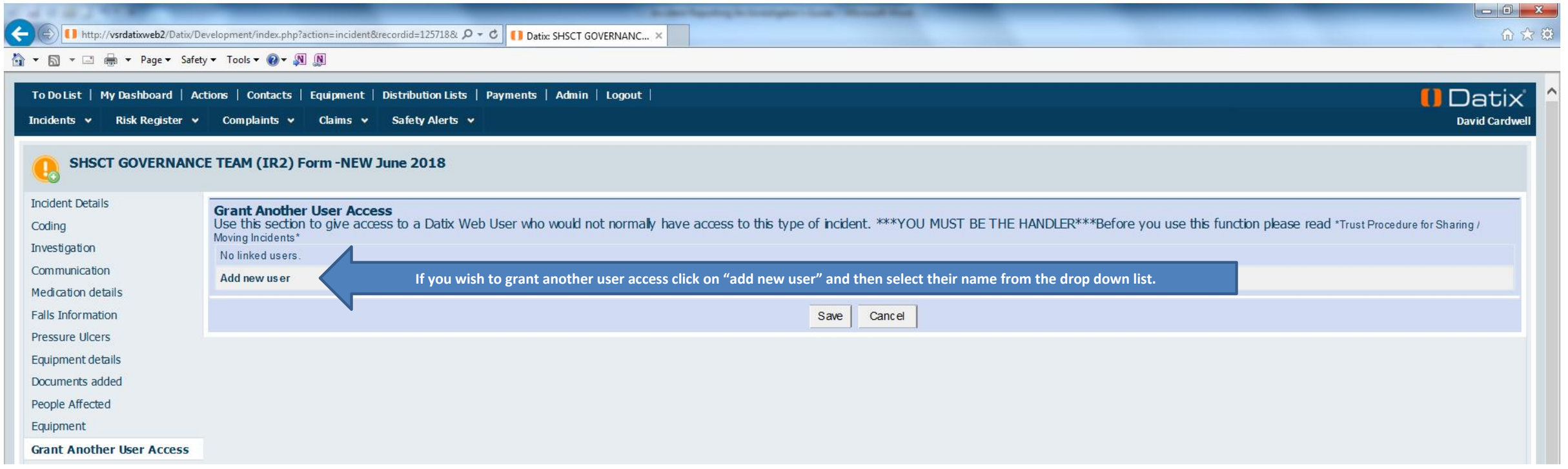
Select from drop down

Add a Health and Care Number if one is not inserted.

Check to see if the person affected is already on the system.
If they are on the system press choose and then create a new link.
If not press cancel, scroll up to approval status and change this to "APPROVED" and then scroll down to the bottom and save. Your contact then becomes approved and will turn from red to green on your screen.

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

8. Tab 11 (GRANT ANOTHER USER ACCESS).



Remember

When you have finished investigating the incident and <u>fully populated</u> the relevant tabs,
please use the communication tool to inform the relevant Manager or Head of Service that the incident is ready for final approval.

As the investigator it is your responsibility to ensure all information recorded is accurate.
For all patient related incidents you must ensure patient details are added to the ‘people affected’ section and a H&C number is included.

Southern Health and Social Care Trust

Quality Care - for you, with you

Policy for Shared Learning

Lead Policy Author & Job Title:	Stacey Hetherington, Corporate Clinical and Social Care Governance Co-Ordinator
Directorate responsible for document:	Medical Directorate
Issue Date:	28 July 2022
Review Date:	29 July 2024

Policy Checklist

Policy name:	Policy for Shared Learning
Lead Policy Author & Job Title:	Stacey Hetherington, Corporate Clinical and Social Care Governance Co-Ordinator
Director responsible for Policy:	Dr Damian Gormley, Interim Medical Director
Directorate responsible for Policy:	Medical Director
Equality Screened by:	Click here to enter text.
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	28 July 2022
Date approved by SMT:	11 October 2022
Policy circulated to:	Learning from Experience Forum, Interim Director for Clinical and Social Care Governance, Deputy Medical Director, Directorate Governance Co-Ordinators, Corporate Clinical and Social Care Governance Manager, Policy Scrutiny Committee, All Staff via SharePoint
Policy uploaded to:	SharePoint - Corporate Clinical and Social Care Governance

Version Control

Version:	**V0_1**		
Supersedes:	**N/A – New Policy**		
Version History			
Version	**Notes on revisions/modifications and who document was circulated or presented to**	**Date**	**Lead Policy Author**
Eg Version 1_0	Click here to enter text	Click here to enter a date.	Click here to enter text
Eg Version 2_0	Click here to enter text	Click here to enter a date.	Click here to enter text

Contents

Introduction

The Southern Health and Social Care Trust (SHSCT) acknowledges the importance of assuring patient, service user and staff safety as a priority within the organisation. In order to achieve this assurance it is necessary to thoroughly investigate and extrapolate learning where opportunities to do this are presented, such as from incidents, all methods of service user feedback (complaints and compliments), audit, litigation (claims and coroners findings), mortality and morbidity meetings, professional fora, whistleblowing etc. (*this is not an exhaustive list*). Analysis of this information will contribute to facilitating pro-active risk management to help ensure the potential of similar events happening again is reduced.

This policy has been developed to demonstrate the SHSCT's commitment to continually improve from lessons learned and covers learning identified from internal sources and, in addition, learning obtained from external sources such as other HSC Trusts, NIAIC, regional learning shared by the Department of Health, particularly that shared from the Strategic Planning and Performance Group (SPPG).

This policy has been developed with the intention to capture and disseminate learning relating to SHSCT Corporate issues and not exclusively to Clinical and Social Care Governance issues only.

This policy and the formal process for sharing learning are intended to strengthen dissemination of identified learning and should not replace any form of direct communication or discussion that occurs in a one to one, team meeting or professional basis.

Safety Alerts issued on a regional or national level, will be issued and circulated separate to this policy and shared learning pathway.

Purpose and Aims

The purpose of this policy is to ensure that the safety lessons learnt, from internal and external sources, are appropriately and widely shared across the SHSCT. Any improvements required in response to lessons learnt will be implemented through an action plan and compliance audited.

Objectives of this Policy

- To ensure learning from internal and external sources is shared with all staff across SHSCT
- To make improvements in response to lessons learnt to reduce the potential of recurrence using a systematic and coordinated approach to solve a problem using specific methods and tools with the aim about bringing about measureable improvement
- To share best practice to enable continuous improvement

- To promote a culture of openness and transparency with findings in regards to incident and near miss reporting
- To promote a risk management ethos across the Trust
- To develop a central source of learning on SharePoint for staff to access as required

Policy Statement

Sources of Learning

Learning may be derived from a number of sources, internal and/or external to the organisation *(this is not an exhaustive list)*:

- Corporate issues
- Adverse incidents
- Serious Adverse Incidents (SAI)
- Structured Judgement Reviews (SJR)
- Significant Event Audits (SEA)
- Near misses
- Complaints
- Ombudsman Case
- Compliments
- Standards and Guidelines
- Mortality and Morbidity review
- Litigation (including claims and coroners findings)
- Audits
- Case Management Reviews (child protection)
- Concerns raised by staff (whistleblowing)
- Professional fora
- Regional learning letters issued from:
    - events in other Trusts
    - NIAIC
    - Department of Health

Method for sharing learning

Shared Learning Template

The SHSCT Shared Learning Template (Appendix 2) will be used to disseminate learning, it is usually a one page document which can be easily read, displayed and filed. It should not name staff or the specific area where the event occurred. Information shared should be in accordance with the Data Protection Act 2018.

The template should be completed at the end of an investigation/review or in any instance where learning has been identified and appropriate dissemination of such learning is required.

Learning identified as being relevant to other Directorates and beyond should be discussed by the Director/Assistant Director at relevant

meetings, such as Weekly Governance Meeting, Governance Co-ordinators meeting, SAI Oversight Group, Complaints Group etc. or at the Learning from Experience Forum for a decision on the extent of dissemination required.

All Shared Learning Templates will be disseminated from the Corporate Governance Office to Directorate Governance Co-Ordinators for onward dissemination as identified. Confirmation that learning has been received by each Directorate and that the SHSCT Shared Learning Template has been disseminated will be sought by the Corporate CSCG team.

All SHSCT Shared Learning Templates will be available on the Corporate CSCG link on SharePoint. Additional methods for staff awareness of learning will be dictated by the applicability of learning identified within the template e.g. Southern-I, Global email etc.

Action Plans

Action plans will be generated for improvements required in response to lesson learnt. These actions should have an appropriate timeframe for completion, a named responsible individual and will be subject to audit by Corporate CSCG office.

Types of Learning

Local Learning (within service area, ward, department etc.)

Learning identified as only being relevant to the specific area/department where the incident, complaint, audit etc. occurred should be discussed on an individual basis where necessary and at the local staff/team meeting. Details of the learning and relevant meeting, along with any evidence such as meeting minutes, reflective practice notes etc. should be recorded on Datix. The Datix approver should ensure learning has been annotated, along with details of any investigation completed and actions taken prior to signing off.

Specific local learning is not required to be formally shared more widely, however a Shared Learning Template (Appendix 2) should be completed and sent to the Corporate Governance Office for upload onto Sharepoint.

Shared Learning within Directorates

Often learning identified will apply to other areas within the same Directorate. In this instance, learning should be shared via Directorate Governance Co-Ordinator, included on Directorate Governance meeting

agenda/minutes for audit purposes and also documented on Datix as above.

A Shared Learning template (Appendix 2) should be completed and sent to the Corporate Governance Office for dissemination to the relevant services within that Directorate.

Shared Learning beyond Directorates

Where learning has been identified as being relevant between Directorates, learning should be shared via the Directorate Governance Co-Ordinator, discussed and approved by the appropriate 'Group' within the Assurance Framework and reported to the Learning from Experience Forum which provides assurance that learning has been shared appropriately.

A Shared Learning template (Appendix 2) should be completed and sent to the Corporate Governance Office for dissemination to the relevant Directorates.

Shared Learning Template Trustwide

Where learning has been identified as being applicable across the organisation, learning should be shared via the Directorate Governance Co-Ordinator/Director, discussed and approved by the appropriate 'Group' within the Assurance Framework and reported to the Learning from Experience Forum which provides assurance that learning has been shared appropriately.

A Shared Learning template (Appendix 2) should be completed and sent to the Corporate Governance Office for dissemination across the Trust.

Regional shared learning

The SHSCT is required to address Learning Letters received from the DoH and/or findings from external/regional audit. Learning Letters/findings will be disseminated from the Corporate Governance Department to Directors/Directorate Governance Co-Ordinators for dissemination as appropriate.

If the SHSCT has identified learning that other Trusts across the region should be alerted to urgently, this should be directly shared as a matter of urgency between Trust's and communicated to the SPPG. Where regional learning has been identified through the investigation of an SAI,

this will be communicated by completion of the appropriate form held within the Procedure for the Reporting and Follow up of Serious Adverse Incidents.

Other methods of sharing learning within the Southern Health and Social Care Trust

Shared learning templates will inform and provide an assurance to Governance Committee, Trust Board, PCE etc. of the lessons learned and actions taken to improve patient safety across the organisation.

Learning to be shared Trustwide, from any source, will require oversight and sign-off by a Director.

Where Shared Learning identifies risk within a service area this should be escalated for inclusion on the appropriate Risk Register through the Directorate CSCG Co-Ordinator/Director and an appropriate time bound action plan put in place to minimise and/or mitigate the risk.

Coding of Learning

Shared Learning Templates will be categorised in accordance with the CCS2 codes on Datix, this will enable learning to be catalogued and themed as the resource expands. It is anticipated that this information will be used to develop dashboards and help identify areas of risk, quality improvement and staff training. Coding will also enable Shared Learning Templates to be re-issued as appropriate by way of a reminder should a trend in similar incidents, complaints etc. be identified prior to the review/investigation being fully completed.

Implementation of Policy

Dissemination

Following approval, the policy will be disseminated to all staff across the organisation. Implementation will begin immediately upon approval and issue of Policy and once Corporate CSCG department commence issuing and storing shared learning templates.

Exceptions

None

Monitoring

The process for monitoring the effectiveness of all of the above will be primarily monitored through the Learning from Experience Forum but will also be managed via the following arrangements:

- Controls Assurance Standards
- Governance Committee Meetings
- SAI Oversight Group
- Complaints Review Group
- Governance meetings
- Litigation meetings
- Morbidity & Mortality (M&M) Review Meetings
- Audit
- Professional Governance Structures
- SHSCT Education and Learning teams

Scope of Policy

This policy applies to all staff (permanent, temporary, locum, agency, bank, students, contractors and voluntary) in the SHSCT.

Responsibilities

Corporate Clinical and Social Care Governance (CSCG) will be responsible for receiving Trustwide learning from multiple sources and for disseminating the learning as indicated. The Corporate CSCG team will also be responsible for maintaining a central source of learning shared for staff to access as required on Sharepoint. As directed, Corporate CSCG team will be responsible for sharing awareness of learning e.g. Southern-I, Global email etc.

Directors and Directorate CSCG Co-Ordinators will be responsible for the onward dissemination to relevant staff and teams. It is important that where learning has been identified for specific teams/services that this is discussed at team meetings, through Supervision or at Directorate corporate/governance meetings and/or M&M review meetings, implementing safety improvements if necessary.

The Corporate CSCG team will monitor and report on shared learning activity, with particular focus on those which identified safety improvements required on a quarterly basis through the Governance Committee report. The team will also be responsible for auditing action plans generated from identified learning.

Legislative Compliance, Relevant Policies, Procedures and Guidance

HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents (November 2016)

Equality & Human Rights Considerations

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1988), Targeting Social Need Initiative, Disability discrimination

and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

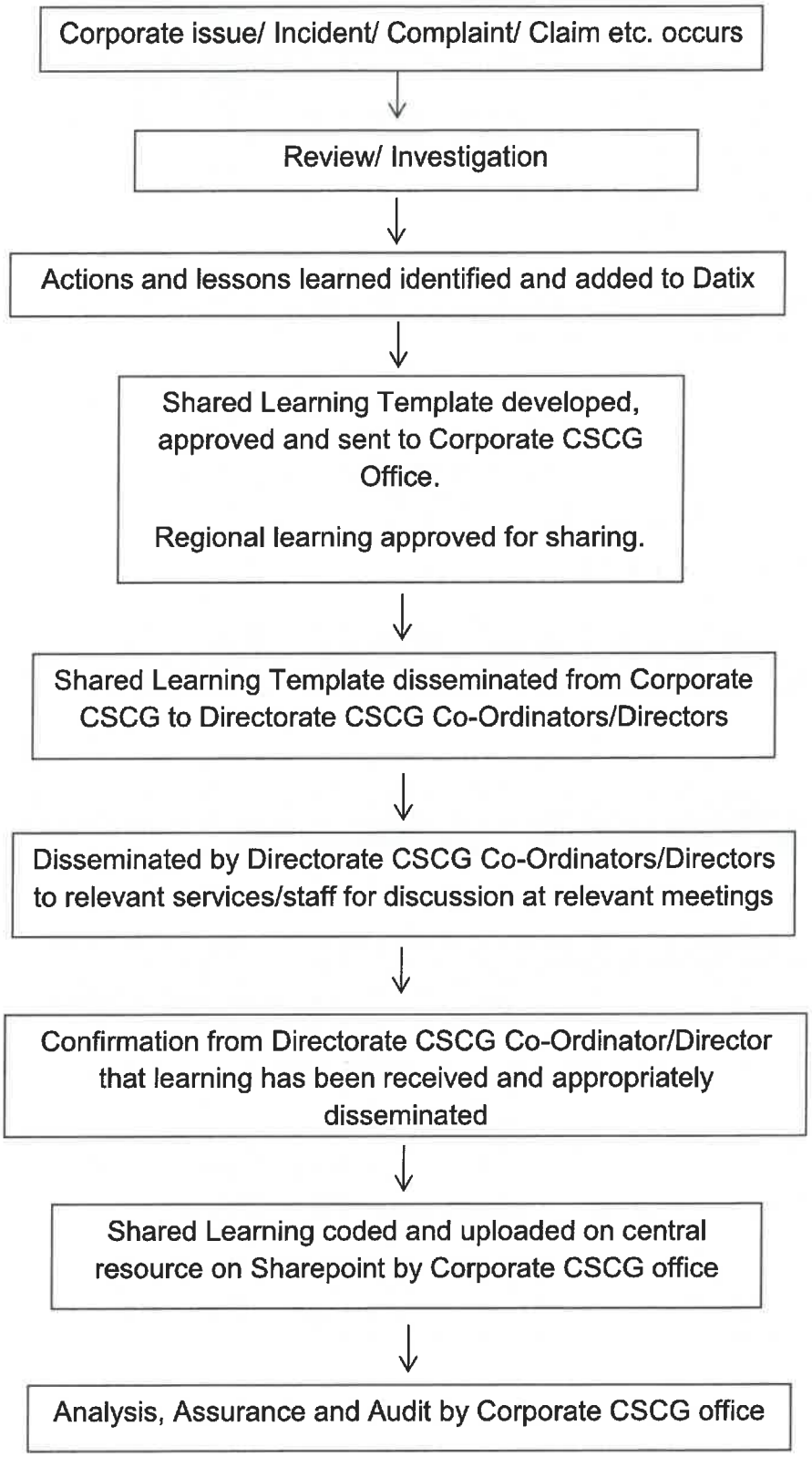
No impact ☐

SIGNATORIES: ***DATE:***

Sources of Advice & Further Information

Appendix 1: Flowchart for Sharing Learning
Appendix 2: SHSCT Shared Learning Template

Appendix 1 – Flowchart for Sharing Learning



Appendix 2 – SHSCT Shared Learning Template

Shared Learning Template			
Date issued:		**Ref. No.**	
Area learning identified: (Please highlight, in the case of 'Other' please identify source)	*Corporate Issue / Incident / SAI / SJR / SEA / Adverse Incident / Complaint / Compliment / Audit / Litigation / M&M / External Learning Letter / Other*		
Shared Learning Title:			
Summary – what happened?			
Please provide a brief, confidential summary of the event			
What went well?			
Please provide details of positive actions/outcomes			
What, if anything, could we improve?			
Please make any suggestions you think may improve this situation or prevent it from reoccurring			
What have we learned?			
In bullet form, please provide details of any immediate, urgent learning to be shared			
Shared Learning to be disseminated:			
Locally, where event occurred:	☐	**To other services within Directorate: (Please specify)**	☐
To other Directorate(s): (please specify)	☐	**Trustwide:**	☐
Regionally: (please complete HSCB form)	☐	**Professional Specific Practice: (please specify)**	☐
Other: (please specify)	☐		
Coding:			
Director Signature:		**Date:**	

Cardwell, David

From: Cardwell, David [redacted]
Sent: 24 May 2018 15:59
To: Curran, Andrew
Cc: Reid, Trudy
Subject: RE: Datix Dashboard

Hi Andrew, thanks for your advice.

I have now created individual dashboards for each division and one for the whole of Acute Services and granted access to those working in these specific areas. All appears to be working at present.

Kind Regards

David Cardwell

Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: [redacted] | Email: [redacted]

From: Curran, Andrew
Sent: 21 May 2018 10:26
To: Cardwell, David
Cc: Reid, Trudy
Subject: RE: Datix Dashboard

David

After checking the number of users you have listed I had a conversation with Datix UK Support team – they have confirmed that only 60 individual users can be added to dashboard options. No other choice but to create a user group specifically for each dashboard you need to deploy.

If you let me know what Divisions you want I shall create all the groups and you will be able to add them to the dashboards plus add users to each group via the Acute_Dashboard account.

Andrew

From: Cardwell, David
Sent: 18 May 2018 16:46
To: Curran, Andrew
Cc: Reid, Trudy
Subject: RE: Datix Dashboard

Hi Andrew, as discussed I have taken all the reports of the dashboard and left it blank.

I have then tried to add users and save. All appears OK and the users have moved up into the relevant box, I click save and then go back into the list straight after and the new users are not added.

Can you help?

Kind Regards

David Cardwell

Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: Personal Information redacted by the USI | Email: Personal Information redacted by the USI

From: Curran, Andrew
Sent: 17 May 2018 18:12
To: Cardwell, David
Subject: RE: Datix Dashboard

David

I have created a quick query for you under the acute dashboard account to show use of the @ variables, it is called "DAVID CARDWELL - TEST @today-365 (ACUTE|MUC)" I advise that once you no longer need it is deleted (along with any other items no longer in use, as it keeps the system as clean as possible).

The query is

incidents_main.inc_directorate like 'ACUTE'
AND incidents_main.inc_specialty like 'MUC' AND
CAST(FLOOR(CAST(incidents_main.inc_dincident AS FLOAT)) AS DATETIME) >= '@today-365'

So looks for anything in ACUTE | MUC where the incident date >= today-365 days.

I can see a number of errors occurring when trying to add new users, they are related to performance (synchronous connections), so it might be worthwhile removing some of the reports to see does it allow for changes.

Andrew

From: Cardwell, David
Sent: 17 May 2018 16:15
To: Curran, Andrew
Cc: Reid, Trudy
Subject: RE: Datix Dashboard

Andrew, if you are around tomorrow could we meet? I am having significant issues around datix dashboard and one I log in it can take up to 20 minutes before I can make a change.

I have spent all afternoon on it and can't get it to do what I need it to do.

Kind Regards

David Cardwell

Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: Personal Information redacted by the USI | Email: Personal Information redacted by the USI

From: Cardwell, David
Sent: 17 May 2018 15:19
To: Curran, Andrew
Cc: Reid, Trudy
Subject: Datix Dashboard

Hi Andrew, I have previously added Donna King and Patricia Kingsnorth to the list of users on the Acute_Dashboard account but they keep disappearing. There are others too which I have added and are no longer there.

If you were around could I bring my laptop over to show you what is happening or could you call (I am in the maples)?

It seems to be very problematic and is taking a very long time to process information I am inputting.

Kind Regards

David Cardwell

Southern Health and Social Care Trust

Senior Governance Officer | Acute Services Clinical and Social Care Governance Team |
The Maples | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ |
Tel: Personal Information redacted by the USI | Email: Personal Information redacted by the USI

DIRECTORATE OF ACUTE SERVICES
Incident Position, 1 January 2014 to 5 April 2017

	Awaiting Review	In Review	Finally Approved	Grand Total
ATICS	0	36	1760	**1800**
CCS	30	27	555	**614**
FSS	52	42	1754	**1850**
IMWH	4	250	2972	**3226**
MUC	96	275	7018	**7393**
PHARM	13	7	196	**216**
SEC	48	171	2867	**3096**
Grand Total	**250**	**811**	**17123**	**18206**

Directorate of Acute Services - ATICS
Incident Position, 1 January 2014 to 5 April 2017

	Awaiting Review	In Review	Finally Approved	Total
Anaesthetics, Theatres and IC Services		**36**	**1760**	**1800**
1 West Gynae			5	5
2 East Midwifery Led Unit			1	1
4 North			2	2
4 South			2	2
Admissions/Assessment Unit			1	1
CEAW			5	5
Corridor/Stairs			2	2
Day Hospital			1	1
Day Procedure/Day Surgery Unit		23	261	287
DEAW			3	3
Delivery Suite, CAH			6	6
Delivery Suite, DHH			3	3
Discharge Lounge			1	1
ECT Suite			1	1
ED Majors			1	1
ED Resus			11	11
ENT Clinic			2	2
Female Medical, Level 5			1	1
Female Surgical/Gynae			4	4
General OutpatientsTreatment Room			1	1
ICU (HDU)		2	512	514
Male Surgical/HDU			1	1
MRI Unit			2	2
Orthopaedic Ward			1	1
Pain Management Clinic			1	1
Pre-operative Assessment Clinic		1	6	7
Recovery Unit			102	102
Switchboard			1	1
Theatre		9	650	660
Trauma Ward			3	3
Trauma/Orthopaedic Theatre		1	157	158
Urology Clinic			1	1
X-ray Dept (Radiology)			9	9

Directorate of Acute Services - CCS
Incident Position, 1 January 2014 to 5 April 2017

	Awaiting Review	In Review	Finally Approved	Total
Acute Directorate AHP's	**30**	**27**	**555**	**614**
2 North Resp/Medical			1	1
2 South Medical			2	2
4 North			1	1
4 South			1	1
Basement			1	1
C Floor			1	1
Canteen/Dining Room			1	1
CEAW			1	1
Corridor/Stairs			2	2
ED Resus			1	1
ENT Clinic			1	1
General Male Medical, Level 5			1	1
Health Records			1	1
John Mitchel Place, HSSC			1	1
Male Surgical/HDU			1	1
MAU			2	2
Occupational Therapy Dept			2	2
Orthopaedic Ward			2	2
Physiotherapy Outpatients Department			2	2
Reception/Waiting Area			1	1
Recovery Unit			1	1
Rheumatology Clinic			1	1
Speech Therapy Outpatients Department			1	1
Stroke / Rehab			2	2
Trauma Ward			2	2
Breast Clinic			6	6
Breast Screening Unit		2		2
Car Park/Grounds		1	1	2
Cardiology Clinic			1	1
Corridor/Stairs			1	1
Day Hospital			1	1
ED Majors			1	1
Emergency Department			1	1
ENT Clinic			1	1
Entrance/Exit			1	1
General Outpatients Reception/Waiting Area			1	1
General OutpatientsTreatment Room		1		1
General Surgery Clinic		2		2
Gynae Clinic			1	1
Haematology Clinic	3	3	20	26
Home of client			1	1
Kitchen			1	1
Laboratory				1
Lung Clinic, Mandeville Unit			3	3
MEC	1			1
Non Trust premises	1			1
Oncology Clinic, Mandeville Unit	2	5	60	67
Ramone Building		1		1
X-ray Dept (Radiology)	1			1
1 South Medical			1	1
2 North Resp/Medical			1	1
Audiology Clinic			5	5
Breast Clinic		1	8	9
Breast Screening Unit			18	18

Coronary Care Ward, Level 5		1		1
Corridor/Stairs			1	1
CT Scanner			48	48
Day Procedure/Day Surgery Unit			6	6
Delivery Suite, CAH			1	1
ED Clinical Decisions Unit			2	2
ED Majors			4	4
ED Minors			1	1
ED X-ray			35	35
EEG Clinic			3	3
ENT Clinic			1	1
Entrance/Exit			1	1
Fracture Clinic			1	1
General Male Medical, Level 5			1	1
General Outpatients Reception/Waiting Area			3	3
General Surgery Clinic			1	1
ICU (HDU)			1	1
MRI Unit	2	1	65	68
Oncology Clinic, Mandeville Unit		1	1	2
Portadown HSSC			2	2
Public Toilets			1	1
Reception/Waiting Area			2	2
The Maples			1	1
Theatre			3	3
Ulster Independant Clinic			1	1
X-ray Dept (Radiology)	2	2	126	131
1 West Gynae			1	1
2 North Resp/Medical			1	1
2 South Medical			1	1
4 North			1	1
Antenatal Clinic			1	1
Bio-chemistry Lab	3	1	11	15
Blood Transfusion Lab			6	6
Car Park/Grounds	1		1	2
Cellular Pathology Lab	12		10	22
Day Procedure/Day Surgery Unit			1	1
Delivery Suite, CAH			2	2
ED Clinical Decisions Unit			1	1
Emergency Department			5	5
General Male Medical, Level 5			1	1
General OutpatientsTreatment Room			1	1
Haematology Lab		1	6	7
ICU (HDU)			2	2
Laboratory	2	1	9	12
Male Surgical/HDU			1	1
Maternity Ward			1	1
MAU			1	1
Microbiology Lab		2	3	5
Mortuary		1	2	3
Oncology Clinic, Mandeville Unit			1	1
Pre-operative Assessment Clinic			1	1
Stroke / Rehab			1	1
Theatre			4	4

Directorate of Acute Services - FSS
Incident Position, 1 January 2014 to 5 April 2017

	Awaiting Review	In Review	Finally Approved	Total
Functional Support Services	**52**	**42**	**1754**	**1850**
1 East Maternity Antenatal		1	2	3
1 North Cardiology	1		8	9
1 South Medical	3		44	47
1 West Gynae			4	4
2 East Midwifery Led Unit			5	5
2 Medical			1	1
2 North Haematology			6	6
2 North Resp/Medical			15	15
2 South Medical			15	15
2 South Stroke			23	23
2 West Maternity Post Natal			6	6
3 South			23	23
4 North			35	35
4 NORTH STOMA CLINIC			1	1
4 South			16	16
Admissions/Assessment Unit			1	1
Antenatal Clinic			5	5
B Floor			1	1
Basement		1	17	18
Blood Transfusion Lab			7	7
Bluestone Day Hospital	3			3
Boiler House			1	1
Booking Centre			2	3
Breast Clinic			2	2
Breast Screening Unit			2	2
Bronte Ward			3	3
Brownlow HSSC, Legahorry Centre	1		3	4
Canteen/Dining Room		1	8	9
Car Park/Grounds	3	3	112	118
Cardiology Clinic			1	1
Carepoint			2	2
CEAW			7	7
Cellular Pathology Lab			1	1
Cloughmore Ward			3	3
College of Nursing/ST Headquarters			3	3
Coronary Care Ward, Level 5		1	23	24
Coronation Building	1		1	2
Corridor/Stairs	1	3	26	30
CT Scanner			3	3
Daisy Hill Resource Centre			2	2
Day Clinical Centre			5	5
Day Hospital			2	2
Day Procedure/Day Surgery Unit	1	7	18	26
DEAW			1	1
Delivery Suite, CAH	1		7	8
Delivery Suite, DHH			2	2
Dermatology Clinic			3	3
Doctors Accommodation			8	8
E Floor			1	1
ED Clinical Decisions Unit	1		21	22
ED Majors	3		140	143
ED Minors	1		34	35
ED Resus	3		39	42
ED X-ray			2	2

Emergency Department	1		60	61
ENT Clinic			2	2
Entrance/Exit	1		32	33
Female Medical, Level 5			17	17
Female Surgical/Gynae			11	11
Ferns Resource Centre	1			1
Finance Department			2	2
Finance Dept			1	1
Firbank House			2	2
Fracture Clinic			4	4
General Male Medical, Level 5		1	42	43
General Medicine Clinic	1		1	2
General Outpatients Reception/Waiting Are	1		8	9
General OutpatientsTreatment Room			2	2
General Surgery Clinic			1	1
Gilford Health Clinic			2	2
Gillis Memory Centre			1	1
Gynae Clinic			1	1
Haematology Lab		1	2	3
Health Records	1		7	8
Hill Building			2	2
ICU (HDU)		2	10	12
John Mitchel Place, HSSC	1		3	4
Kilkeel Health Centre			1	1
Kitchen	3	3	53	59
Laboratory			12	12
Laundry Room			83	83
Lift	1		8	9
Male Surgical/HDU	2		27	29
Maternity Ward			3	3
MAU	2		142	144
Meadow View			1	1
MEC			3	3
Memory Service Clinic			1	1
Minor Injuries Unit			1	1
Mortuary		1		1
Mourne House			1	1
Neonatal Unit/SCBU		1	1	2
Non Trust premises			1	1
Nurses Home			7	7
Occupational Therapy Dept			1	1
Oncology Clinic, Mandeville Unit		1	2	3
Opthamology Clinic			6	6
Orthopaedic Ward			7	7
Paediatric Ward			5	5
Patient Flow Team			2	2
Physiotherapy Outpatients Department			3	3
Pinewood Villas, Longstone Site			1	1
Portadown HSSC			2	2
Post Room			2	2
Public Toilets			6	6
Ramone Building	1	1	6	8
Ramone Ward			1	1
Reception/Waiting Area	2	1	26	30
Recovery Unit	1		13	14
Rehabilitation, Level 4			6	6
Renal Unit			2	2
Rheumatology Clinic			1	1
Rosebrook	1			1

Silverwood Ward			4	4
Staff accommodation	1		36	37
Sterile Services Dept	2	3	134	139
Stroke / Rehab			14	14
Switchboard	1	1	106	108
The Bungalow, Lurgan Hosp Site (Equality Assurance Unit)			1	1
The Elms			2	2
The Maples			1	1
The Oaks			1	1
The Rowans			1	1
Theatre		5	22	27
Tower Block			1	1
Trauma Ward		1	10	11
Trauma/Orthopaedic Theatre		1	13	14
Ulster Independant Clinic			2	2
Urology Clinic			3	3
Ward 1, Assessment & Rehabilitation			2	2
Ward 1, Stroke			1	1
Ward 2, Assessment and Rehabilitation			1	1
Ward 3, Assessment and Rehabilitation			4	4
Warrenpoint Health Centre		1	1	2
Waste Transfer Station	2		6	8
Willowbank			2	2
Willows Ward	3			3
Winter Pressures Ward(Ramone)			12	12
X-ray Dept (Radiology)		1	1	2

Directorate of Acute Services - IMWH
Incident Position, 1 January 2014 to 5 April 2017

	Awaiting Review	In Review	Finally Approved	Total
Integrated Maternity and Womens Health	**4**	**250**	**2972**	**3226**
1 East Maternity Antenatal		1	20	21
1 West Gynae	1	17	238	256
2 East Midwifery Led Unit		8	106	114
2 West Maternity Post Natal	1	64	366	431
3 South			1	1
Admissions/Assessment Unit		9	73	82
Antenatal Clinic		11	145	156
Armagh Community Clinic			1	1
Banbridge HSSC		1	2	3
Bio-chemistry Lab			6	6
Brownlow HSSC, Legahorry Centre			1	1
C Floor		2		2
Car Park/Grounds			2	2
CEAW			4	4
Cellular Pathology Lab			1	1
Clanrye Surgery		1		1
Colposcopy Clinic		1	31	32
Corridor/Stairs			3	3
Day Hospital		1	2	3
Day Obstetric Unit			3	3
Day Procedure/Day Surgery Unit		1	14	15
Delivery Suite, CAH		79	845	924
Delivery Suite, DHH	1	14	418	433
Discharge Lounge			3	3
Early Pregnancy Problem Clinic			15	15
ED Clinical Decisions Unit		1	3	4
ED Majors			1	1
ED Minors			2	2
ED Resus			2	2
Emergency Department			2	2
Entrance/Exit		1	2	3
Female Medical, Level 5			1	1
Female Surgical/Gynae		1	82	83
Fertility Clinic			1	1
General Outpatients Reception/Waiting Area		1	2	3
General OutpatientsTreatment Room		1	5	6
Gynae Clinic		2	35	37
Home of client		13	131	144
John Mitchel Place, HSSC		1	3	4
Kilkeel Health Centre			6	6
Lift			4	4
Male Surgical/HDU			1	1
Maternity Ward	1	15	303	319
Menopause Clinic			1	1
Non Trust premises			3	3
OOH SW Service			1	1
Patient Flow Team			1	1
Patient Support Office			1	1
Physical Disability Team, Manse View, Newry			1	1
Portadown HSSC		1	3	4
Public place			2	2
Public Toilets			1	1
Reception/Waiting Area			1	1
Recovery Unit			5	5

SAUCS (GPOOH) Armagh		1	1
SAUCS (GPOOH) Craigavon		5	5
SAUCS (GPOOH) Newry		1	1
Theatre	3	56	59
Trust transport		1	1
X-ray Dept (Radiology)		2	2

Directorate of Acute Services - MUC
Incident Position, 1 January 2014 to 5 April 2017

	Awaiting Review	In Review	Finally Approved	Total
Medicine and Unscheduled Care	**96**	**275**	**7018**	**7393**
1 East Maternity Antenatal			1	1
1 North Cardiology	5	31	396	432
1 South Medical	2	34	748	784
1 West Gynae	2	1	3	6
2 Medical		3	64	67
2 North Haematology		6	256	262
2 North Resp/Medical	1	10	368	379
2 South Medical	2	20	424	446
2 South Stroke		13	305	318
2 West Maternity Post Natal	1			1
3 South		3	8	11
4 North			9	9
4 South			5	5
Admissions/Assessment Unit	3	5	3	11
Air (Respiratory) Lab	1			1
Antenatal Clinic		1		1
Basement			1	1
Canteen/Dining Room	1			1
Car Park/Grounds	5	3	13	21
Cardiac Catheterisation Lab	1		57	58
Cardiology Clinic		2	4	6
Cardiology Research			7	7
CEAW			3	3
Chest Clinic			2	2
Collegelands Nursing Home		1		1
Coronary Care Ward, Level 5		12	54	66
Corridor/Stairs	1	2	4	7
CT Scanner	1			1
CYP A&E			1	1
Day Clinical Centre	1		63	65
Day Hospital		2		2
Day Procedure/Day Surgery Unit		3	2	5
DEAW		3	1	4
Dermatology Clinic		2	83	85
Dermatology Ward	1		5	6
Diabetology Clinic	1		2	3
Discharge Lounge	1	1	4	6
ECG Clinic			9	9
ED Clinical Decisions Unit		2	288	290
ED Majors	7	9	816	832
ED Minors	1	2	229	232
ED Resus		5	153	158
ED X-ray	1	4	2	7
Emergency Dental Clinic			1	1
Emergency Department	2	5	286	294
Entrance/Exit	5	2	7	14
Female Medical, Level 5		4	394	398
Female Surgical/Gynae	1	1	8	10
Gastroenterology Clinic			1	1
General Male Medical, Level 5		8	263	271
General Medicine Clinic	2		3	5
General Outpatients Reception/Waiting Are	4			4
General OutpatientsTreatment Room	1		1	2
Heart Failure Clinic		1	1	2

Home of client	2	3	2	7
ICU (HDU)		1	4	5
Kitchen			1	1
Lift	1			1
Male Surgical/HDU	3		23	26
MAU	16	13	914	944
Minor Injuries Unit			24	24
MRI Unit		1	1	2
Neurology Clinic			3	3
Non Trust premises	3			3
Orthopaedic Ward			1	1
Patient Flow Team	1	6	10	17
Patient Support Office		1		1
Physiotherapy Outpatients Department			2	2
Public Toilets			1	1
Ramone Building	1			1
Ramone Day Clinical	2	1	10	13
Ramone Ward	1	14	20	35
Reception/Waiting Area	1		5	6
Recovery Unit			1	1
Rehabilitation, Level 4	2	5	25	32
Renal Clinic			5	5
Renal Unit		1	31	32
Rheumatology Clinic	5		1	6
Stroke / Rehab		16	381	397
Theatre	1	1	14	16
Tower Block			1	1
Trauma Ward			2	2
Trauma/Orthopaedic Theatre			1	1
Ward 1, Assessment & Rehabilitation		2		2
Ward 1, Stroke			2	2
Ward 2, Assessment and Rehabilitation	1			1
Ward 3, Assessment and Rehabilitation			1	1
Winter Pressures Ward(Ramone)	1	8	173	183
X-ray Dept (Radiology)	1	1	1	3

Directorate of Acute Services - Pharmacy
Incident Position, 1 January 2014 to 5 April 2017

	Awaiting Review	In Review	Finally Approved	Total
Pharmacy	**13**	**7**	**196**	**216**
1 North Cardiology			1	1
2 North Resp/Medical			2	2
2 South Medical	1		1	2
4 South			1	1
Admissions/Assessment Unit			1	1
Air (Respiratory) Lab	1			1
Basement			1	1
Car Park/Grounds			4	4
Cardiac Catheterisation Lab			1	1
Corridor/Stairs			1	1
Day Clinical Centre			1	1
Day Hospital			1	1
Day Procedure/Day Surgery Unit		1	1	2
Dietetics Outpatients Department			1	1
ED Clinical Decisions Unit			1	1
ED Majors			1	1
General Male Medical, Level 5			1	1
Haematology Clinic		1		1
Home of client	1		1	2
ICU (HDU)		1		1
MAU	1		3	4
Non Trust premises			1	1
Oncology Clinic, Mandeville Unit	1		2	3
Orthopaedic Ward			1	1
Pharmacy Aseptic Unit	6		24	30
Pharmacy Dispensary	2	2	112	116
Pharmacy Production			1	1
Pharmacy Stores / Distribution		1	14	15
Portadown HSSC			1	1
Reception/Waiting Area			1	1
Recovery Unit			1	1
Stroke / Rehab			1	1
Switchboard			1	1
Thorndale Unit			1	1
Ward 1, Assessment & Rehabilitation			1	1
Ward 1, Stroke			6	6
Ward 2, Assessment & Rehabilitation		1	1	2
Ward 2, Assessment and Rehabilitation			1	1
Waste Transfer Station			1	1
Willows Ward			1	1

Directorate of Acute Services - SEC
Incident Position, 1 January 2014 to 5 April 2017

	Awaiting Review	In Review	Finally Approved	Total
Surgery and Elective Care	**48**	**171**	**2867**	**3096**
1 South Medical			1	**1**
1 West Gynae		2	6	**8**
3 South	2	58	424	**486**
4 North		6	405	**415**
4 NORTH STOMA CLINIC			3	**3**
4 South	1	2	322	**325**
Admissions/Assessment Unit			**2**	**2**
Car Park/Grounds			6	6
CEAW		3	181	185
Cellular Pathology Lab	1			1
Colposcopy Clinic			1	1
Corridor/Stairs			1	1
CT Scanner			1	1
Day Clinical Centre	1			1
Day Procedure/Day Surgery Unit	4	28	84	116
DEAW	1	4	22	28
Dermatology Clinic			1	1
Diabetology Clinic			2	2
Dietetic Clinic			1	1
Discharge Lounge			1	1
Early Pregnancy Problem Clinic	1			1
ED Clinical Decisions Unit			11	11
ED Majors	1		4	5
ED Minors			4	4
Emergency Department	1		3	4
ENT Clinic			19	19
Entrance/Exit	1	1	5	7
Female Surgical/Gynae	2	18	163	184
Firbank House			1	1
Fracture Clinic		3	29	32
Gastroenterology Clinic			1	1
General Medicine Clinic			3	3
General Outpatients Reception/Waiting Are	1		14	15
General OutpatientsTreatment Room	4	3	14	21
General Surgery Clinic	1		14	15
Gynae Clinic	1			1
Health Records			1	1
Home of client			7	7
ICU (HDU)		1		1
Laboratory			1	1
Male Surgical/HDU	8	6	240	254
Minor Injuries Unit			2	2
MRI Unit			1	1
Oncology Clinic, Mandeville Unit		2		2
Opthamology Clinic			5	5
Orthopaedic Clinic			3	3
Orthopaedic Ward			200	200
Paediatric Ward	1	2	16	19
Patient Flow Team			2	2
Pharmacy Dispensary			2	2
Physiotherapy Outpatients Department			1	1
Pre-operative Assessment Clinic		1	11	12
Public Toilets			2	2
Reception/Waiting Area	1	1		2
Recovery Unit	1	2	8	11
Rehabilitation, Level 4			1	1
Rheumatology Clinic			1	1
Sleep Lab			1	1
Stroke / Rehab		1		1
Surgical Assement Unit	2	1	6	9
Theatre	10	18	120	149
Thorndale Unit	1		8	9
Tower Block	1			1
Trauma Ward		5	426	431
Trauma/Orthopaedic Theatre		1	32	33
Urology Clinic		1	14	15
Ward 1, Stroke			1	1
Waste Transfer Station			1	1
X-ray Dept (Radiology)		1	5	6

DIRECTORATE OF ACUTE SERVICES

Surgery & Elective Care

Governance Report - August 2012 Governance Meeting

Risk Register

	Corp	Direc	Div	HoS	Team
Aug-12	5	3	7	4	1
Jul-12	5	3	7	4	1
Jun-12	5	2	7	4	1

Incidents

	Cat	Maj	Mod	Min	Insig	Total
Jun-12	0	2	5	27	2	36
May-12	0	0	9	30	9	48
Apr-12	0	2	4	19	12	37
Jun-11	0	3	16	35	25	79

NIAC Referrals

Jun-12	0

Riddor Reportable Incidents

	No
Jun-12	1
May-12	0
Apr-12	0
Jun-11	0

Serious Adverse Incidents

New	Ongoing	Closed

Complaints

	Formal	Informal	% Resp
May-12	24	0	50%
Apr-12	6	5	50%
Mar-12	9	2	77%
May-11	6	4	66%

Section 1 - SEC Risks on Directorate Register - August 2012

ID	Opened	Div	Location	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Consequence (current)	Likelihood (current)	Rating (current)	Register Holding
2594	16-Apr-2010	SEC	CAH	Insufficient capacity and resources to manage patients waiting for a review appointment in Acute Services	Potential of harm to the patient secondary to not having timely management of condition and/or disease-possible progression of disease/worsening status of condition. Risk of harm to patient by unmanaged progression or monitoring of condition in a timely manner secondary to SHSCT not having sustained capacity to provide review appointments, within the appointed time. Risk of harm to Medical and Nursing staff as addressing the patients needing review are all done as 'extra sessions'. Potential for exhaustion and escalation of sick leave. There has been inadequate Nursing resources recruited to support the increase work load. Risk of escalation of clinical risks as the Trust is under strict financial constraints, and does not have an obvious form of funding for this risk. Potential harm to patient family secondary to anxiety of not having a timely review. Potential of litigation against staff and Trust due to not providing treatment in a timely manner. Potential of harm to reputation of Trust due to potential lack of adequate patient management.	RVBL teams established to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity. This group will also continue to meet and create effective strategy to manage this chronic gap in capacity. Monthly reports monitoring review waiting lists to give current position. Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time. Vacant Outpatient sessions have been backfilled with Review Backlog patients, when Consultant available. Heads of Service are meeting with Relevant Consultants and conveying current provision on a monthly basis.	01.08.12 - Update Mid July: General Surgery 637; Breast Surgery 4; Oral Surgery 7; Urology 2766; ENT 1868; Opthalmology 921; Orthopaedics 399; total 6602. 19.06.12 - Update June 2012. General Surgery 527; Breast Surgery 3; Oral Surgery 7; Urology 2610; ENT 1563: Opthalmalogy 927; Orthopaedics 344. Total 5981. 19.04.12 - All patients in general surgery due a RVBL appointment are within 2012 - currently 431 patients. Urology RVBL to date 2273 from 2009 - 2012. ENT RVBL to date 1267 from 2010 - 2012. 24.02.12 - Review backlog reduced considerably. 2 Outstanding areas of concern which are Urology and Opthalmalology which work is ongonig with. 10.11.11 Current position 2007 cleared, 2008 38 remain (Urology only), 2009 981 review backlog, Holding additional RVBL Clinics, Virtual clinics in operation.	Catastrophic	Almost Certain	25	DIREC
3166	19-Jun-2012	SEC	CAH	Urology Access Waiting Times	Urology access waiting times has increased significantly from 36 weeks for inpatient and daycases. First appointment ICAT patients has increased from 17 weeks.	This is currently being addressed via approval to go to Independent Sector and the appointment of new consutlants.	19.06.12 - Plan to review in 2 months.	Catastrophic	Almost Certain	25	DIREC
3070	23-Jan-2012	SEC		Omitted and delayed medications within Acute Directorate Wards	Wards and departments not administering medications in a timely manner. Patients are receiving an inadequate quality of service with the potential risk for harm.	Staff nurse or ward based pharmacist where possible highlights all incidents via datix. Proforma is to be completed in conjunction with the Band 6 and the staff nurse responsible for the omission or delay to reinforce learning and improve standards. Staff nurse to escalate to Ward Sister if any delays or omissions at ward level.	19.06.12 - Organisation of care project - medication module currently being rolled out accross 4 north, trauma, male surgical. Excellent progress and up take to date with a plan to roll out to all wards in SEC. Plan to review in 2 months. 17.04.12 - Organisation of care project currently working with 3 wards in SEC with a focus on omitted and delayed medications. Audit to take place end April 2012.	Moderate	Almost Certain	15	DIREC

Section 2 - SEC Risks on Divisional Register - August 2012

ID	Opened	Div	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Consequence	Likelihood	Rating	Register Holding
2085	9-Jul-2009	SEC	CAH	Health & Safety of patients, staff and visitors who attend the Fracture Clinic	Health & Safety of patients, staff and visitors could be compromised due to no waiting room for Fracture Clinic as follows:- 1. No seats for patients. Standing with plasters insitu, risk of fall. 2. Narrow corridor - patients sitting with leg plasters on - leg extended. Risk of fall and further injury. 3. Patients waiting in main thoroughfare for A&E - Rushing through with sick patients. Delay of transfer and risk of injury to patients and relatives. 4. Patients in wheelchairs - no room. Risk of injury.	Maintain patient's safety until relocation of fracture clinic.	01.08.12 - Works nearing completion. Plan to move into new location by end August 2012. Review in 1 month. 19.06.12 - Refurbisment programme progressing well. Due for completion July 2012. Review in 1 month. 17.04.12 - refurbishment programme commenced. Works ongoing and due to be completed May 2012. 23.01.12 - A new location and facilities have been sourced for the fracture clinic. A refurbishment programme is due to commence in February 2012 with completion due in May 2012. 10.11.11 Additional seating now in place on back corridor to A&E, plans for new fracture clinic now in progress. 01.10.11 Awaiting feedback from fire dept regarding the placement of additional seating.	Major	Possible	12	DIV
2631	29-Apr-2010	SEC	DHH	Risk of delay in treatment for patients with fractures awaiting a bed or further management in the regional centre in Belfast.	Poor outcome for the patient. Delay in treatment. Potential for developing complications of bed rest eg: pressure sores, thrombosis, infection. Potential for increased complaints, litigation for the Trust. Patients may develop complications of bed rest and of having a fracture eg: fat embolism, thrombosis, infection. Delays in surgery may mean death or poor fracture healing. Bed flow may be impaired which will have an effect on elective lists and may result in theatre cancellations and breach of PFA targets. Loss of confidence in the Organisation.	Close liaison with Bed Manager who in turn communicates with regional centre. Control measure discounted - Patients should be admitted directly from A+E to RVH. Ensure CT scans and X-Rays are sent to RVH # Clinic or wherever designated, and signed for on receipt to ensure timely treatment. Communication with medical staff in regional centre at least daily when awaiting transfer.	19.06.12 - Processes in place continue to work well with optimum utilisation of CAH Trauma Ward encouraged in conjunction with RVH as required. Plan to review in 2 months. 17.04.12 - Current position remains. 23.01.12 - Processes in place are working well. 10.11.11 Improvements noted in access to Belfast. 01.10.11 Awaiting feedback from patient flow team. 27.5.11- Dr Loughran has received correspondence from Dr Tony Stevens RVH re issue: - New rota hoped to improve response - Monitor success of new rota CAH taking patients requiring surgery subject to bed availability to facilitate prompt treatment.	Moderate	Likely	12	DIV
2424	14-Dec-2009	SEC	DHH	Infection Control risks due to lack of decontamination facilities, non compliant taps and sinks in the blood room.	High volumes of patients, public and staff working within/accessing General Outpatients are at increased risk of infection secondary to the non compliant taps, sinks and damaged flooring in department and toilets. Risk of infection to patients, public and staff due to poor provision for hand washing and decontamination. Risk of infection due to broken/damaged flooring and/or units around sinks. Risk of loss of reputation secondary to non-compliance with RQIA recommendations. Risk of infection to patients, staff secondary to decontamination of ENT scopes being done in the same room as patients being assessed.	Daily cleaning of department. Patients are taken to other areas for assessment where possible to separate from Endoscopy decontamination.	19.06.12 - Refurbishment programme of Ramone building for additional facilities and upgrade of current area is near completion. Plan to review in 1 month. 26.03.12 - Will be addressed via outpatient works in early Summer 2012. 23.01.12 - Outstanding working remain on hold until current renovations and proposals complete. 19 May 2011 Decontamination Room complete, sink tops in Rooms 4/5/6/7 have been replaced. Awaiting the replacement of flooring in toilets, and taps/sink in blood room. Estates contacted again 19/05/11 by DHH OPD manager. Awaiting response. Continued risk.	Moderate	Unlikely	6	DIV
3069	23-Jan-2012	SEC		Wards and Departments not meeting their mandatory requirements for Right Patient Right Blood training.	Risk of no staff or minimal staff at ward level who can competently erect and monitor a blood transfusion. Risk of harm to patient and loss of Trust reputation as well as confidence.	Close liaison with the Haemovigilance Practitioner. Additional inhouse training has been commissioned. Staff have been issued with desist notices if relevant. Patient Flow team are aware of issues and how to manage same if situation arises out of hours.	01.08.12 - RPRB Training - SEC position now well improved at a minimum of 80% achieved. 19.06.12 - Significant number of staff require training. All available dates have been utilised to maximum level by Ward Sisters in SEC. Plan to review in 1 month. 17.04.12 - reduction in number of staff who require training and those staff who need trained booked onto available dates. 23.01.12 - An up to date training matrix has been made available to enable all ward sisters to manage requirements as many staff who have had training has expired. Staff have been prebooked onto available dates with 72% compliance in CAH.	Moderate	Likely	12	DIV

ID	Opened	Div	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Consequence	Likelihood	Rating	Register Holding
1079	11-Aug-2008	SEC	CAH	Wards and departments SEC not meeting requirements of mandatory yearly training requirements for manual handling, CPR and fire	Wards and departments not meeting requirements of mandatory yearly training requirements for lifting, manual handling, CPR and fire; inability to meet all the requirements for mandatory training within the Trust due to sickness, maternity leave, vacancies and the requirement to meet the PFA targets; resulting in potential for injury to staff and patients; all wards, CAH.	Prioritisation and allocation of staff for training days.	19.06.12 - Sustained improvement within SEC wards but dates remain difficutle to secure due to high demand for same. Plan to review in 2 months. 17.04.12 - up to date training matrix has been made available to enable ward sisters manage requirements. Uptake improved although still some concerns over availability of dates. 23.01.11 - This is an improvement in compliance across all wards with mandatory training. Focus remains in maximising same for all staff. 10.11.11 Issue was escalated to the ELD who are planning to meeting with H Trouton and Acute colleagues to further explore issues and resolve same. 01.10.11 Training matrix now in place to identify and highlight any gaps in mandatory training. Ward Manager reviews regularly and prioritises training as per resources. Lead nurse, HOS and Ad kept informed.	Moderate	Likely	12	DIV
3071	23-Jan-2012	SEC		Risk of Point of Care Testing at Ward Level	Risk of staff not competent in use of machine and machine not maintained properly. Potentially inaccurate readings resulting in potential harm to patients, increased complaints and litigation.	Close liaison with laboratory staff, particularly Consultant Chemical Pathologist. Discussed with all Ward Sister to cascade to all staff the importance of quality control/cleaning/competency of users.	19.06.12 - Staff aware of responsibilities - ongoing work in relation to equipment and point of care testing at ward level. Plan to review in 2 months. 17.04.12 - All wards issued with folders in SEC containing list of all equipment and staff responsibilities. Ward Sisters to continue to reinforce same. 23.01.12 - discussed with all Ward Sisters to cascade to all staff the importance of quality control/cleaning/competency of users.	Moderate	Possible	9	DIV
3006	21-Jun-2011	SEC	CAH	Environmental works at 4 North, 4 South & 3 South wards pose threat to management of HCAI;compliance with fire and disability	Outstanding Environmental works at 4 North, 4 South and 3 South wards pose threat to management of HCAI;compliance with fire and disability regulations. Each of the wards have the following areas which need a minor works programme to include: Toilet facilities upgraded; Bathroom / shower facilities upgraded; Installation of sinks in bays; Painting and plastering; Various Ceiling tiles replaced; Nurses station to be upgraded; The facilitation of a waste room in 4N; Floor tiles.	All reasonable measures are in place at present; cleaning schedules; decluttering; good housekeeping practices.	01.08.12 - Programmed of works completed in 4 North and 4 South. Awaiting funding to commence 3 south. 19.06.12 - Programme of works completed 4 south, programme of works near completion 4 North, awaiting funding to commence 3 south. 17.04.12 - Programme of works has commenced in Wards 4 North and 4 South. 3 South no date as yet - awaiting funding. 23.01.12 - Funding has been approved and refurbishment programme commencing February 2012. 10.11.11 Funding has now been allocated and a workable program for dates is being progressed. 01.10.11 Awaiting costing from Estates for refurbishment have walked the wards. Awaiting feedback. Review July 2011	Moderate	Likely	12	DIV

Section 3 - SEC Major and Catastrophic Incidents - June 2012

ID	Ref	Incident date	Division	Site	Loc (Exact)	Adverse event	Consequence	Severity	Description	Action taken	Lessons learned
8192	W4517	01/06/2012	SEC	Craigavon Area Hospital	4 North	Dose or strength was wrong or unclear	Major	Major	Patient prescribed 1.5mg/kg of enoxaparin twice daily instead of 1.5mg/kg daily in 2 divided doses. Subsequently 2 morning doses omitted. No code recorded on kardex (administration section blank)	Personal Informati Ward Sister to identify Consultant of patient; incident to be forwarded for learning; critical Med RCA will also be carried out Personal; consultant in charge has been informed via Ward sister	
8358	W4683	05/06/2012	SEC	Craigavon Area Hospital	3 South	Wrong/ unclear frequency	Major	Major	MEDICATION DOSE ON MEDICINE KARDEX INCORRECTLY PRESCRIBED PHENYTOIN 100MGS PRESCRIBED BD RATHER THAN TID. S/N ALERTED BY PATIENTS NOK	Personal; Full investigation of events is being carried out by Ward sister's 4N and 3S; Critical Medication RCA will also be completed Personal;30/06/12:Critical Red Med RCA completed by MDT and learning to be distributed throughout SEC	

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Section 4 - SEC Out of Hours Incidents - June 2012

ID	Ref	Incident date	Division	Site	Loc (Exact)	Time	Adverse event	Consequence	Severity	Description	Action taken	Lessons learned
8358	W4683	05/06/2012	SEC	Craigavon Area Hospital	3 South	1945	Wrong/ unclear frequency	Major	Major	MEDICATION DOSE ON MEDICINE KARDEX INCORRECTLY PRESCRIBED PHENYTOIN 100MGS PRESCRIBED BD RATHER THAN TID. S/N ALERTED BY PATIENTS NOK	F1 BLEEPED AND INFORMED. DOCUMENTED IN NURSING NOTES. KARDEX AMENDED. IR1 COMPLETED. NOK INFORMED.	
8519	W4844	11/06/2012	SEC	Craigavon Area Hospital	General OutpatientsTreatment Room	0840	Tripped over an object	Minor	Minor	staff member tripped on wheel of Hba1c machine and fell to ground onto left leg/hip. Did not sustain any apparent injury or discomfort. jumped quickly to her feet and stated she was not in any pain/ discomfort and no cuts/bruises evident at that time on body	placed on a chair and advised to rest, staff member sat for short period of time and then insisted to continue work. prior to accident she did not have any symptoms of dizziness etc and she continued with her working day without any problems. she was asked on occasion throughout the working day by myself in relation to pain/ discomfort/ bruising and staff member had no complaints of same.	
8548	W4873	14/06/2012	SEC	Craigavon Area Hospital	Day Procedure/Day Surgery Unit	0830	Failure in referral process	Minor	Minor	Patient arrived fasted from 10pm 13/06/12 for surgery. stated he received phonecall from lady offering him cancellatation for 14/06/12 advised to fast as above and attend DSU CAH 8.30am. Patient scheduled for pm list so arrived too early and not required to fast this long	Patient advised of status re pm list. Offered complaint form. Sr spoke with Consultant Anaesthetist on ward to enquire could she provide patient with light early breakfast as last on pm list , inappropiately fasted. Patient fed, scheduling team informed. Pateint wen5t home to return 1.30 for pm list	
8597	W4922	14-Jun-12	SEC	Craigavon Area Hospital	4 South	1730	Fall on level ground	Minor	Minor	STAFF MEMEBER WAS WALKING UP CORRIDOR WHEN SLIPPED ON WHAT APPEARED TO BE BUTTER FROM THE MEAL TROLLEY	STAFF MEMBER WAS SENT TO EMERGENCY DEPT AND REVIEWED.	

8575	W4900	14-Jun-12	SEC	Craigavon Area Hospital	3 South	2250	Fall on level ground	Minor	Minor	Patient called out for nurse. Patient was found on her knees on the floor leaning forward onto the bed. She denied hurting herself just said her knees are sore but they usually are sore anyway. Patient explained she was gettting up out of bed to go to toilet and felt unsteady so she tried to turn back onto bed and in doing so ended up on her knees at bedside.	mews score 1. Patient assisted back into bed and reassurance given as patient very anxious at this time. nurse call buzzer given to patient and advised to get help next time she needs to get up out of bed. reviewed by FY1 Personal Information nil ordered. Nurse in charge present and aware of incident.	
8711	W5036	15-Jun-12	SEC	Daisy Hill Hospital	Female Surgical/Gynae	800	Injury from dirty sharps	Minor	Minor	member of staff walked into disposal room hit leg against a yellow clinical waste bag and used venflon caused injury to left leg	attended a/e documentation completed	
8714	W5039	20-Jun-12	SEC	Daisy Hill Hospital	Female Surgical/Gynae	800	Lack of/delayed availability of beds (general)	Minor	Minor	Male Patient admitted to female surgical at 5am history of abdominal pain and vomiting, patient has a history of dementia and had a fall fracture femur in May2012,night coordinator contacted regarding safety of patient being nursed in a side room. Patient admitted to side room no beds male surgical, patient to climb out of bed and had to be nursed in treatment room along main corridor for safrty.	no beds male surgical patient nursed in treatment room . Patient moved to male surgical at 8am	
8723	W5048	20-Jun-12	SEC	South Tyrone Hospital	Day Procedure/Day Surgery Unit	1740	Collision with an object	Minor	Minor	Patient was getting changed to go home and stated he put his hand to the chair and the chair moved and he lost his balance and fell.	Patient able to get up on his own. Clinical obs, 142/70, P87, Spo2 99%. Lift home informed and next of kin wife Personal Information contacted. Patient did not complain of any pain and no bleeding noted. Patient very keen to go home and refused further assessment.	
8731	W5056	21-Jun-12	SEC	Craigavon Area Hospital	Orthopaedic Ward	600	Fall on level ground	Minor	Minor	Nursing auxillary found patient sitting on the floor and called myself and the other Nurse on duty	Patient assisted onto her feet and brought immediately to the toilet as ugently needed to pass urine. contacted HAN who came to see the patient-nil concerns. Mews score '0'. BP slightly elevated 154/73.	

8792	W5117	22-Jun-12	SEC	Daisy Hill Hospital	Female Surgical/Gynae	1730	Fall from a height, bed or chair	Minor	Minor	patient mobilised to desk outside ward 19 with mobility aid, patient requested to use telephone, was witnessed by medical f1 attempting to sit on a chair and patient missed seat and slipped on to floor, grazing left lower calf on rollator causing injury.	clinical observations recorded, doctor informed and reviewed patient, patient assisted safely to bed, family contacted and informed, SR Fee also informed.	
8891	W5215	26-Jun-12	SEC	Craigavon Area Hospital	Trauma Ward	830	Suspected fall	Minor	Minor	patient was found sitting in the floor beside his bed.	next of kin informed, present in the ward. Adviced to inform staff while leaving the ward and 1 to 1 observation commenced.	
9028	W5350	29-Jun-12	SEC	Craigavon Area Hospital	4 North	1800	Test results/ images - available but inaccurate	Minor	Minor	Phone call recieved from microbiology informing ward that patient had C diff in faeces but no toxins. Lab advised staff to consult with medical staff to determine if they felt her illness due to C Diff or diverticulitis.	Discussed with registrar who felt patient should be treated as C Diff. Patient informed and information leaflet given. Recorded in nursing notes and daily review chart implemented. Bristol stool chart already implemented and patient already isolated. IV Tazocin stopped and Movicol stopped and patient commenced on oral metronidazole. Consultant informed and patient transferred to Ramone Ward on 30th June .	

Section 5 - SEC Insignificant - Moderate Incident Trends Jun-12

Omitted/delayed medicine or does	6
Fall on level ground	5
Suspected Fall	3
Fall from a bed, height or chair	2
Collision with an object	1

Section 6 - SEC NIAC Referrals Jun-12

Location	Reported by	Date Reported	Device	Details
None				

Section 7 - SEC Riddor Reportable Incidents Jun-12

Ref	Date	Location	Adverse Event	Description
8597	14.06.12	Ward 4 South	Fall on level ground	Staff member was walking up corridor when slipped on what appearedd to be butter from the meal trolley.

Section 8 - SEC Serious Adverse Incident Update

Recommendations and actions on all SAI's completed since 1 July 2011 have been sent to Assistant Directors on 22 May 2012 for update prior to June 2012 Governance Meeting.

Section 9 - Formal Complaints- May 2012

Ref	Date Received	Division	Site	Loc	Subjects	Staff	Description	Outcome	Action taken (Investigation)	Replied to	Response time
AS25.12/13	02-May-12	SEC	Craigavon Area Hospital	4 North	Treatment and care quality	Medical and Dental	Complainant remains very discontented about the care her late father received prior to his death.				0
AS25.12/13	02-May-12	SEC	Craigavon Area Hospital	4 North	Treatment and care quality	Nursing and Midwifery	Complainant remains very discontented about the care her late father received prior to his death.				0
AS27.12/13	04-May-12	SEC	South Tyrone Hospital	ENT Clinic	Communication/information to patients	Non Staff	Complainant unhappy that they were told to be at South Tyrone Hospital for an 8am appointment. However when they arrived were told that they did not need to be there until 10am.	Apology given for misunderstanding and breakdown in communication.		24-May-12	13

AS2912/13	09-May-12	SEC	Craigavon Area Hospital	2 South Medical/Stroke	Treatment and care quality		Complainant unhappy with general standard of treatment and care offered to patients.				0
AS31.12/13	10-May-12	SEC	Craigavon Area Hospital	Orthopaedic Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	MLA complaining about length of time patient has had to wait for injections to ease pain and discomfort he is having in his knees.	Confirmation provided that patient has been provided an appointment which was within the DHSSPS access waiting time standards.		17-May-12	5
AS40.12/13	10-May-12	SEC	Craigavon Area Hospital	Orthopaedic Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Patient unhappy with the delay in provision of date for orthopaedic surgery.	Investigation confirmed that patient required specialist treatment in England which involved the raising of an ECR with the HSCB. Confirmation provided to patient that ECR had been approved and arrangements were being put in place for treatment.		08-Jun-12	19

AS24.12/13	16-May-12	SEC	South Tyrone Hospital	Booking Centre	Communication/information to patients	Non Staff	Complainant unhappy that her mother received a telephone call from someone asking her to attend an appointment at STH, and when she arrived no such appointment was made. Complainant also disappointed that follow up letter which was agreed never materialised.	Investigation unable to confirm who made telephone call to patient as system has been checked and there was no need for a call to have been made.		08-Jun-12	15
AS42.12/13	16-May-12	SEC	Craigavon Area Hospital	General Surgery Clinic	Addmission into hospital (delay cancellation) (inpatients)	Non Staff	Complainant unhappy with length of time she has had to wait to get a hernia operation. Reports that she was offered a date in summer 2011 but as she was only given 9 days notice she had to decline. 2nd time that her operation was planned it was cancelled as a cancer pt took priority. Unable to have operation in June as there is no time to sort out dependants.	Apology given for cancellation of surgery. Confirmation provided that surgery would be scheduled for end of year at a time when suits complainant.		11-Jun-12	16
AS46.12/13	17-May-12	SEC	Craigavon Area Hospital	Urology Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Complainant unhappy with the length of time his wife has had to wait for a urology procedure. Also dissatisfied that each time he telephones the consultants secretary there is no reply.				0

AS48.12/13	18-May-12	SEC	Craigavon Area Hospital	Opthamology Clinic	Appointments, delay/cancellation (outpatients	Non Staff	Complainant unhappy that her GP 's urgent referral was downgraded to routine and that she was forced to pay for private treatment.	Confirmation that patient's condition did not warrant an urgent category being placed upon her referral.		14-Jun-12	17
AS49.12/13	21-May-12	SEC	Daisy Hill Hospital	General Surgery Clinic	Treatment and care quality	Non Staff	Complainant concerned that she was not sent bowel preparation in advance of procedure and that procedure, when undertaken, was painful.	Complainant advised that is is now practice to administer bowel preparation at the outpatient clinic in advance of examination rather than at home. Apology given that patient experienced pain during procedure.		15-Jun-12	17
AS50.12/13	21-May-12	SEC	Craigavon Area Hospital	Urology Clinic	Treatment and care quality	Medical and Dental	Complainant unhappy with treatment given for kidney stones whilst he was a patient on ward. Also unhappy with the delays experience in getting an appointment for follow up care.				0

AS50.12/13	21-May-12	SEC	Craigavon Area Hospital	Urology Clinic	Appointments, delay/cancellation (outpatients	Non Staff	Complainant unhappy with treatment given for kidney stones whilst he was a patient on ward. Also unhappy with the delays experience in getting an appointment for follow up care.				0
AS51.12/13	21-May-12	SEC	Craigavon Area Hospital	General Surgery Clinic	Treatment and care quality	Medical and Dental	Complainant is unhappy with the treatment and lack of communication provided to his wife following surgery between the 18th November to her discharge in December 2011 in CAH.	Closed patient has went to LITIGATION		23-May-12	2
AS51.12/13	21-May-12	SEC	Craigavon Area Hospital	General Surgery Clinic	Treatment and care quality	Medical and Dental	Complainant is unhappy with the treatment and lack of communication provided to his wife following surgery between the 18th November to her discharge in December 2011 in CAH.	Closed patient has went to LITIGATION		23-May-12	2

AS51.12/13	21-May-12	SEC	Craigavon Area Hospital	General Surgery Clinic	Communication/information to patients	Medical and Dental	Complainant is unhappy with the treatment and lack of communication provided to his wife following surgery between the 18th November to her discharge in December 2011 in CAH.	Closed patient has went to LITIGATION		23-May-12	2
AS60.12/13	25-May-12	SEC	Craigavon Area Hospital	4 North	Treatment and care quality	Nursing and Midwifery	Complainant dissatisfied with the standard of nursing care provided to her husband whilst he was an in-patient. Complainant provided examples of times when her husband was not shaved, assisted with personal hygiene and left sitting in wet clothes. Also unhappy that he was discharged when he was unfit and was offended by comments made by nurse regarding discharge home.				0
AS60.12/13	25-May-12	SEC	Craigavon Area Hospital	4 North	Discharge/transfer arrangements	Nursing and Midwifery	Complainant dissatisfied with the standard of nursing care provided to her husband whilst he was an in-patient. Complainant provided examples of times when her husband was not shaved, assisted with personal hygiene and left sitting in wet clothes. Also unhappy that he was discharged when he was unfit and was offended by comments made by nurse regarding discharge home.				0

AS60.12/13	25-May-12	SEC	Craigavon Area Hospital	4 North	Communication/information to patients	Nursing and Midwifery	Complainant dissatisfied with the standard of nursing care provided to her husband whilst he was an in-patient. Complainant provided examples of times when her husband was not shaved, assisted with personal hygiene and left sitting in wet clothes. Also unhappy that he was discharged when he was unfit and was offended by comments made by nurse regarding discharge home.				0
AS61.12/13	29-May-12	SEC	Craigavon Area Hospital	3 South	Discharge/transfer arrangements	Non Staff	Complainant unhappy with the length of time it took to get her medication before discharge.			28-Jun-12	20
AS64.12/13	30-May-12	SEC	Craigavon Area Hospital	Orthodontic Clinic	Appointments, delay/cancellation (outpatients	Non Staff	Complainant concerned that Trust appeared unwilling to treat patient and that her prognosis was delayed.				0

AS63.12/13	30-May-12	SEC	Craigavon Area Hospital	4 North	Environmental	Works and Maintenance	Complainant feels that noise levels on ward were too high during environmental works. Also concerned that all showering facilities were closed at the same time.			0
AS65.12/13	30-May-12	SEC	Daisy Hill Hospital	Oral Surgery Clinic	Appointments, delay/cancellation (outpatients)	Non Staff	Complainant unhappy with the length of time it has taken him to receive an appointment for oral surgery.			0
AS66.12/13	31-May-12	SEC	Craigavon Area Hospital	Orthopaedic Clinic	Addmission into hospital (delay cancellation) (inpatients)	Non Staff	Patient who was scheduled for hip operation in May was cancelled as he had taken medication that was not prescribed to him. Now disappointed that surgery will not be rearranged until August.	Confirmation provided that anaesthetist was not happy to proceed with operation as patient had taken antibiotics which were not prescribed to him at that time by a medic. Assurance given that patient will be operated on by end of July 2012.	13-Jun-12	7

Appendix 1

Datix Web Procedure where Incidents Cross Departments

Sharing and Moving Responsibility for Investigation

Currently on Datix Web an incident is reported and is investigated by the assigned "Leads" in that Reporting Area.

There are two types of scenario where an incident needs to be shared with another Department, and this document aims to clarify the appropriate procedure for each.

Sharing Scenario 1: Giving Access / Sharing

When an incident is reported to one department, but it would be beneficial to share the incident with an Investigator from another area who does not have normal access;

- This sharing is purely for information purposes
- It is agreed the incident belongs with the reporting area
- New user will be able to update the incident record / use communication screen

Sharing Scenario 2: Moving Responsibility

When an incident is reported in one department, but it is apparent the inherent issue of the incident stems from another Department, and should be investigated by another Department. In this case the Investigator does not simply share with the incident another Department, but moves the incident across, along with the responsibility to investigate.

- This action will move the responsibility for investigating the incident to another Department
- It is agreed the ownership of the incident sits with the "Other Area"
- The original investigator will no longer have access but will be able to receive a report on this category of incident upon request from the relevant Directorate Governance Office

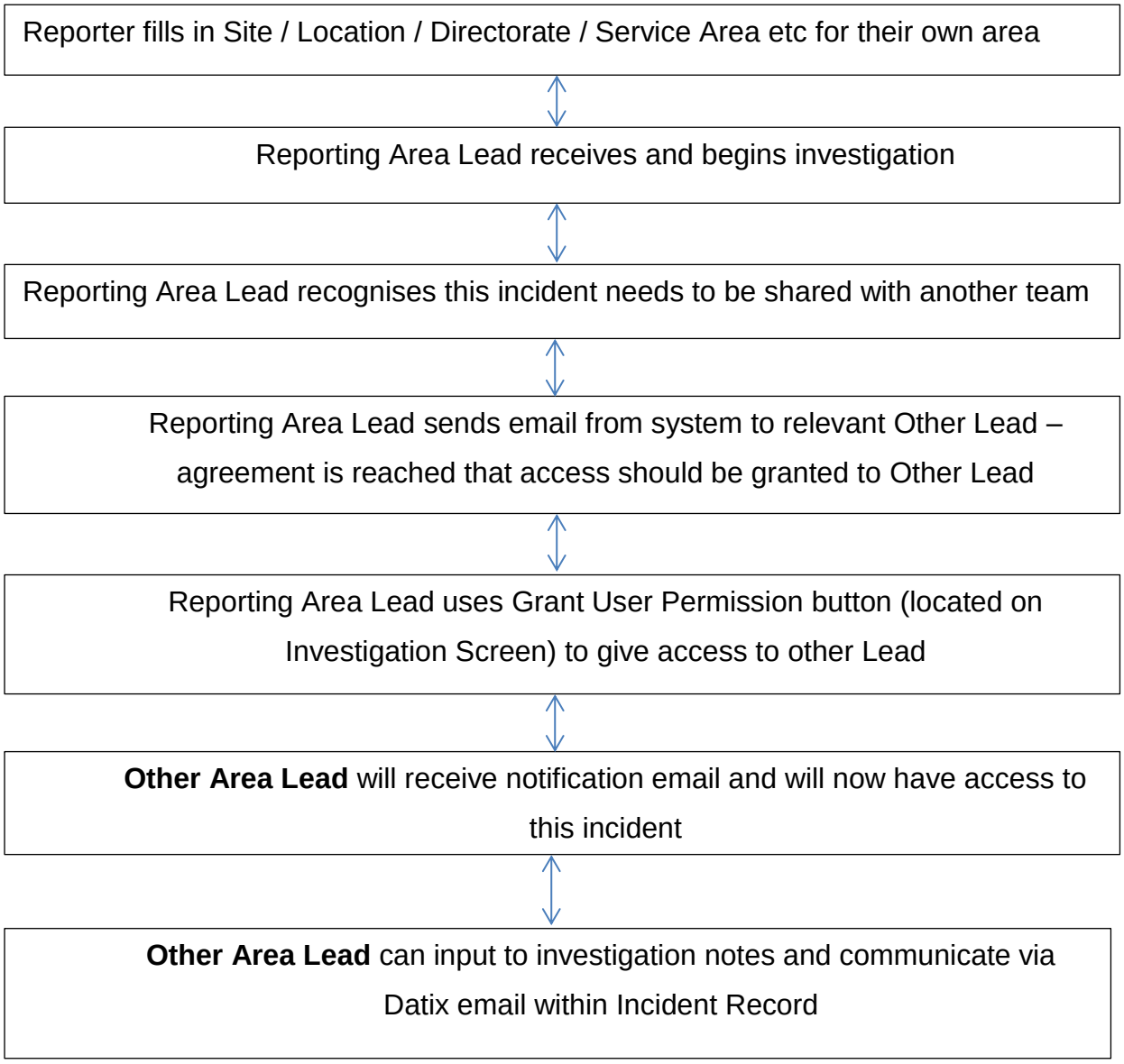
Appendix 1

Process:

Scenario 1: Giving Access / Sharing e.g. Issue with epidural

- Reporting Area: Delivery Suites
- Input required from: Anaesthetics

This is an example of an Incident which is **investigated** by the Reporting area but requires **some input** from another area



Outcome:

- Incident remains with “Reporting Area” in terms in counting and reporting
- Reporting Area Lead remains the “Investigator”

Appendix 1

Scenario 2: Moving Responsibility e.g. Incident regarding missed operation is reported by Theatre staff but the main issue originates with Scheduling team

- Reporting Area: Theatres
- Originating Area: Scheduling

This is an example of when the Reporting Area Lead attempts to investigate but recognises the incident should be **investigated by the Other Area Lead** and should be **moved to the other area**

Reporter fills in Site / Location / Directorate / Service Area - all as Reporting Area

↓

Reporting Area Lead receives and begins investigation

↓

Reporting Area Lead recognises incident **stems from** another area and should be investigated by another area

↓

Reporting Area Lead discusses verbally with other team – agreement is reached that incident should be moved to Other Department.

↓

If agreement cannot be reached the Investigator will seek advice from the relevant Directorate Governance Office

↓

If agreed, the Reporting Area Lead* changes the Directorate / Division / Service Area / Specialty fields to that of **Other Area***

Note: mandatory fields will need to be completed – if the information for these is not available you will need to contact your Directorate Governance to re-assign the incident.

↓

Other Area Lead will now have access to this incident, and investigating responsibility

↓

If necessary, Other Area Lead can grant Reporting Area Lead access to the incident upon request using the Grant User Permission button (located on Investigation Screen)

Outcome:

- Incident “owned” by **Originating Area**
- **Originating Area Lead** becomes the Investigator

Cardwell, David

From: Cardwell, David [redacted] >
Sent: 11 December 2015 15:00
To: Forde, Helen
Cc: Corrigan, Martina [redacted] Clayton, Wendy
Subject: RE: Datix

Hi Helen, thank you. They are both moved over and an email forwarded to Martina and Wendy for investigation.

Regards

David.

From: Forde, Helen
Sent: 11 December 2015 11:39
To: Cardwell, David
Subject: Datix

There are 2 Datix against me at the minute

[redacted] – I think it should go to Martina Corrigan as it says there was no correspondence for the appointment – so it wasn't that the secretary didn't type it – I think it was that it wasn't dictated so that would need to go to Head of Service for urology to discuss with consultant

[redacted] – this is staff in theatres and day surgery unit in DHH and they come under Wendy Clayton.

Thanks.

Helen Forde
Head of Health Records
Admin Floor, CAH
DDI [redacted] Ext [redacted]

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MAJOR / CATASTROPHIC INCIDENT CHECKLIST Patient 16

Directorate:	**Acute Services**
Reporting Division:	**Acute**
Date of Incident:	
Incident (IR1) ID:	**Complaint requires datix to be completed**
Grade of Incident:	**Major**
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	Mr R Carroll Mr C Weir Coordinator Mrs T Reid
If Incident involved the death of a service user, was the coroner informed:	**No**
Brief Summary of Incident:	Patient 16 had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. Patient 16 was considered for palliative pelvic radiotherapy in July 2016, urology stents management was required prior to radiotherapy; there was a delay in the management of stents. In December 2016 radiotherapy was no longer considered an option for Patient 16. Patient 16 died 27th December 2016.
Summary of discussions re SAI / RCA/ major / catastrophic incident review:	The review team considered there was sufficient failings in systems and processes including communication within the urology department to require a SAI review.

Decision on Level Review Type AND rationale for this:	Level ? SAI
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	
Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☒ X ☐ **NO**
Contact for service user and / or designated relatives / carers: *(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place*:(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	

(Corporate Governance Office / Litigation to complete) Date and by whom Trust Litigation Dept informed:	
Does this incident meet the DHSSPS Early Alert Criteria including rationale:	
POST REVIEW COMPLETION: Date and by whom and how Review is shared with the service user and / or designated relatives / carers: *(In exceptional cases where this is inappropriate, rationale should be documented)*	
Date and by whom and how Review is shared with the Coroner:	

Southern Health and Social Care Trust

Quality Care - for you, with you

POLICY FOR THE MANAGEMENT OF COMPLAINTS

This Policy has been developed using the Regional Standards on Complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning, April 2009. These are endorsed in full by the Trust.

Section one has been and adapted to reflect Southern Trust Practices
Section two has been and adapted to reflect Southern Trust Practices
Section three are the regional guidelines and have not been altered.

Author	Mr David Cardwell, Patient/Client Liaison Manager
Directorate responsible for this Document	Chief Executive's Office
Date of Implementation	1 November 2010
Date of Review	1 November 2011
Screened by	
Screening Document Reference Number	
Approved by (Signature)	

Policy Checklist

Name of Policy:	Policy for the Management of Complaints
Purpose of Policy:	To ensure that health and social care staff are clear on the Trust's Policy for the Management of Complaints in line with the Complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning, April 2009.
Directorate responsible for Policy	Chief Executive's Office
Name & Title of Author:	Mr David Cardwell Patient/Client Liaison Manager
Does this meet criteria of a Policy?	Yes
Staff side consultation?	Yes
Equality Screened by:	Mrs Roberta Wilson Governance Lead, Medical Directorate
Date Policy submitted to RM&PC:	08.10.2009
Members of RM&PC in Attendance:	
Policy Approved/Rejected/ Amended	Approved
Communication Plan required?	Yes
Training Plan required?	Yes – training provided by Complaints Project Manager to all Trust Employees
Implementation Plan required?	**Yes**/no/not applicable
Any other comments:	
Date presented to SMT	26.08.2010
Director Responsible	Dr Patrick Loughran Medical Director
SMT Approved/Rejected/Amended	Approved
SMT Comments	
Date returned to Directorate Lead for implementation (Board Secretary)	
Date received by Board Secretary (HQ) for database/Intranet/Internet	
Date for further review	01.11.11

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Policy for the Management of Complaints Version 2.0
Supersedes	Supersedes: SHSCT Complaints Policy and Procedure April 2007. Description of Amendments(s)/Previous Policy or Version: amended to incorporate changes to regional complaints procedures post April 2009
Originator	Mr David Cardwell Patient/Client Liaison Manager
RM/Policy Committee & SMT approval	Referred for approval by: Roberta Wilson, Governance Lead Date of Referral: 14 September 2009 RM/Policy Committee Approval: 8 October 2009 SMT approval: 26.08.10
Circulation	Issue Date: 01.11.11 Circulated By: Dr Patrick Loughran, Medical Director Issued To: All Directors for cascading.
Review	Review Date: 01.11.11 Responsibility of (Name): Roberta Wilson Title: Governance Lead, Medical Directorate

Contents:

Section One: Management of Complaints Trust Procedures.

Section one has been developed by using the Regional Standards on Complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning, April 2009.

These are endorsed in full and adapted to reflect Southern Trust Practices

1.0 Introduction

1.1 The Southern Health & Social Care Trust (hereafter referred to as the "Trust") Complaints Policy has been based on the **complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning Guidance April 2009.** The Trust has also taken cognisance of ongoing regional work to ensure best practice in the management of complaints.

1.2 A separate specific policy and procedure is in place for the management of complaints regarding services to children and young people in accordance with the Children (NI) Order 1995 Representation and Complaint Procedure.

1.3 The Trust is committed to ensuring that robust integrated governance arrangements are in place in the operation of its business. The Trusts emphasis is on improving the safety and quality of care provided through improved arrangements for driving forward quality improvements across HSC. This policy sets out how the Trust should deal with complaints raised by service users and provides a streamlined complaints process. It provides a simple, consistent approach for all staff who handle complaints and for service users who wish to raise complaints about services.

1.4 This policy should be read in context with other policies which express the rights and obligations of Trust staff. Further information on these policies can be found on the Trust intranet. The Trust has a reciprocal responsibility in its duty of care towards staff.

1.5 The Trust is committed to providing a high quality service to all service users and considers that all complaints should be used as a means of promoting continuous service development and improvement, through listening, learning and improving.

1.6 All complaints received within the time limits set out in the DHSSPSNI Guidance will be fully investigated and responded to. Complaints made outside these time limits will be dealt with at the discretion of the relevant service Director in consultation with the relevant Patient/Client Liaison Manager The Trust will not unreasonably reject a request for investigation and response to a complaint.

1.7 This Policy has been developed in accordance with the Trust's key principles for policy development.

1.8 This Policy has been developed in consultation with the appropriate internal stakeholders.

1.9 The Trust sees complaints as an integral part of good Clinical and Social Care Governance arrangements and views them positively as a significant source of learning which provide opportunities for improved outcomes for service users and enhancement of the quality of services being delivered.

2.0 Definitions

2.1 For clarity the following definitions are provided:

2.1.1 **Complainant** – Whoever has raised the complaint, whether that be an existing or former patient, client, resident, family, public representative or carer.

2.1.2 **Complaint** – A complaint is "an expression of dissatisfaction which requires a response".

2.1.3 **Service User** – For consistency the term 'service user' is used throughout this document to include any person who is or has been a patient, client, resident, carer or any other person accessing HSC services.

2.1.4 **Independent Contractor** – This term includes private medical practices who have a contract with the Trust to provide specialist services, or other independent contractors providing a health/social care service to the Trust (including nursing homes and domiciliary care providers).

3.0 Purpose and Aims

3.1 The purpose and aim of this policy is to:

3.1.1 provide ease of access for those persons wishing to make a complaint, through listening to develop an understanding of their concerns and needs;

3.1.2 ensure the process for dealing with complaints is simple and straightforward;

3.1.3 ensure responses to complainants are timely whilst being comprehensive, accurate and open with an emphasis on enhanced local resolution of the complaint;

3.1.4 ensure staff and complainants are treated with the same independent and fair approach;

3.1.5 ensure that complaints are used positively to support learning and continuously improve the services we provide whilst endeavouring to prevent a recurrence and re-establishing a positive relationship with the complainant.

4.0 Policy Statement

4.1 The Trust aims to provide the highest possible standard of care and treatment to all service users, but within busy services, care and treatment do not always go according to plan. When this happens, it is important to put things right quickly and use the experience to improve our services and prevent reoccurrence in the future.

4.1.1 Where there is cause for a complaint, the Trust wishes to know;

4.1.2 The Trust believes the process of making a complaint should be simple and straight forward. How to make a complaint is outlined in the Trust's We Value Your Views leaflet available in all Trust areas or on the Trust's Website.

4.1.3 The Trust aims to resolve all complaints using enhanced local resolution, within the timescale stipulated in the DHSSPSNI Guidance, (April 2009) currently 20 working days;

4.1.4. Where the Trust cannot resolve a complaint within 20 days the Trust will ensure the appropriate measures are taken for further attempt(s) to resolve the complainants concerns.

4.1.5 The Trust is committed to making it easy for any person, who is dissatisfied with a service to complain to the relevant member of staff at the point of service delivery;

4.1.6 The Trust expects all staff to listen to and respond positively to complaints and, if possible, resolve the complaint, apologising when appropriate;

4.1.6 The Trust will ensure that leaflets detailing the Trust's complaints procedure are displayed in all areas and can be made available to all service users in alternative languages and formats as required.

4.1.7 All staff will respect the need for confidentiality and sensitivity at all times when dealing with complaints, in line with the Data Protection Act 1998 and the DHSSPSNI Improving the Patient Experience Standards November 2008.

4.1.8 The Trust recognises the importance and value of appropriate complaints management training and is committed to ensuring that staff at all levels receive training in the handling and management of complaints.

4.1.9 The Trust will use issues raised through the complaints process as an important source of information for safety and quality improvement. This information will inform learning and development and will be fed into the Trust's governance systems as well as being directly fed back to staff involved.

5.0 Scope of the Policy

5.1 This Policy is applicable to all services provided by the Trust with the following exceptions for which alternative procedures are already in place:

5.1.1 Children (NI) Order 1995 Representation and Complaints Procedure;

5.2 A complaint may be made by any existing or former service user of Trust services. The complaint may relate to the level of service offered or provided or to any facility offered or provided in relation to care. A complaint may also be made by a third party, including a Member of Parliament, a Member of the Local Assembly and a local Councillor on behalf of an existing or former service user who has given consent.

5.3 Anonymous complaints make it more difficult for the Trust to properly investigate and understand them, as well as providing appropriate responses or redress. The Trust may record and investigate anonymous complaints, but encourages names and addresses so that a response can be made.

5.4 Normally, a complaint must be made within 6 months of the occurrence of the matter giving rise for concern or the complainant becoming aware of the action giving rise to their complaint. Full and proper investigation is hindered where timescales extend beyond a six month period. However, this should not be stringently applied and advice should be sought from the relevant Patient/Client Liaison Manager.

5.5 All complaints, irrespective of their route into the Trust, should be forwarded immediately to the Central Reporting Point for Complaints for recording and appropriate management/follow up. It is important that all formal complaints are coordinated through a single point to ensure adherence to timescales for responses and to avoid duplication in developing a response.

5.6 Separate guidance is in place for the handling of enquiries made by public representatives. The Trust will endeavour to respond to MLA enquiries within a two week timescale. It should be noted that in some instances, depending on the nature of the issue raised, these may need to be handled under the formal complaints process. The Trust will also seek to respond to MLA complaints within a two week timescale.

5.7 This policy deals with complaints management and is not part of the Trust's disciplinary procedures. Should a disciplinary issue arise during the investigation of a complaint; these aspects of the complaint will be suspended until the disciplinary issues have been completed. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the complaints procedure.

5.8 The Complaints Procedure will be suspended where the complainant explicitly indicates an intention to take legal action in respect of the complaint.

6.0 Responsibilities

6.1 Role of the Chief Executive.

6.1.1 Accountability for the handling and consideration of complaints rests with the Chief Executive.

6.1.2 Whilst the Chief Executive has delegated responsibility for the day to day management of complaints to the Medical Director, the Chief Executive must maintain an overview of the issues raised in complaints, the responses given and be assured that appropriate organisational learning has taken place.

6.2 Role of the Medical Director.

6.2.1 The Medical Director has delegated responsibility for the day to day management of complaints within the Trust. The Medical Director is to ensure that the Trust complies with the regulations laid down by the Department of Health, Social Services and Public Safety. The Medical Director will be assisted with this by the Head of Governance.

6.2.2 The Medical Director should also ensure that all staff are aware of, and comply with the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the Trust's governance arrangements.

6.2.3 The Medical Director should ensure that all resources managed within his area to support operational service areas are being used in an effective and efficient way.

6.2.4 Medical Director has overall responsibility, as lead Director, for appropriate management and analysis of information provided through the complaints process.

6.2.5 The Medical Director will ensure that staff have the opportunity to use this intelligence on both individual complaints and trends to address service issues, improve safety and quality of care, and continually improve services.

6.3 Role of Executive Director

6.3.1 It is the role of the Executive Director to refer any professional issues, about which they have concerns to the relevant professional body.

6.4 Role of Operational Directors, Assistant Directors and Heads of Service

6.4.1 All Operational Directors are responsible and accountable for the proper management of, and accurate, effective timely responses to complaints in received in relation to the services they manage. This responsibility should also include the prompt instigation of local investigations at an appropriate level determined by the seriousness of the complaint.

6.4.2 All Operational Directors will endeavour to ensure that those tasked with investigating and responding to complaints, implementing and sharing learning and improvement have the necessary resources, the co-operation of all staff and the support of senior management.

6.4.3 It is the responsibility of all Trust Directors, Assistant Directors, Service Heads and Senior Managers to utilize the information and trends from complaints within their governance processes to ensure learning and improvement, and to develop and monitor action and learning plans in response to issues identified from complaints.

6.4.4 It is the role of the Assistant Director, in complaints where concerns are raised about clinical treatment and care, to share and agree the proposed draft response to the complaint with the relevant clinician, prior to it being submitted to the Director for approval.

6.4.5 Regular updates on actions and learning arising from complaints must be provided by Assistant Directors to their respective Directorate governance fora for approval and forwarding onto the Medical Directorate.

6.5 Front-Line Staff and Line Managers

6.5.1 Complaints may be made to any member of staff. Staff must be trained and empowered to deal with complaints as they arise. Appropriately trained staff will recognise the value of the complaints process and as a result will welcome complaints as a source of learning. Advice and assistance is available from the relevant Patient/Client Liaison Manager as necessary.

6.5.2 The first responsibility of a recipient of a complaint is to ensure that, where applicable, the service user's immediate health and social care needs are being met before taking action on the complaint. Thereafter, the complainant's concerns should be recorded and dealt with rapidly and in an informal, sensitive and confidential manner.

6.5.3 Some complainants may prefer to make their initial complaint to a member of staff who has not been involved in the care provided. In these circumstances, the complaint should be dealt with by an appropriate member of senior staff or the relevant Patient/Client Liaison Manager as necessary. The relevant Patient/Client Liaison

Manager is also available to support and advise front-line staff on the handling of complaints.

6.5.4 Where a complainant raises a clinical matter or professional matter, an appropriately qualified person should be asked to review it in light of the investigation and advise on accuracy and details prior to the proposed response being finalised.

6.5.5 All staff are required to promote and maintain service user and staff confidentiality and to comply with the requirements of legislation, for example, the Data Protection Act. The need for sensitivity and confidentiality is paramount.

6.6 Role of the Patient/Client Liaison Managers

6.6.1 The Trust will designate senior staff to act as the Patient/Client Liaison Manager within each Directorate. They will promote this policy and oversee the training agenda and will assist other Managers to ensure that the Trust meets its obligations under this policy. They will also:

6.6.2 Manage all complaints received within their respective Directorates.

6.6.3 Maintain a comprehensive database of all complaints received.

6.6.4 Provide support and advice to staff responding to complaints

6.6.5 Have access to all relevant records (including personal medical records) which are essential to any complaint referred to him/her.

6.6.6 Take account of any corroborative evidence available relating to the complaint.

6.6.7 Identify training needs of staff and ensure that appropriate programmes are organised in conjunction with line managers.

6.6.8 Provide the Directorate and the organization with analysis and intelligence on complaints received to ensure that trends are identified as well as appropriate responses to individual complaints.

6.6.9 Comply with control assurance standards criteria in respect of complaint management.

6.6.10 Be aware of the availability of, and advise complainants about:-

- the support available from the Patient Client Council;
- the role and availability of conciliation, advocacy, independent experts and lay persons; and
- the Ombudsman/Commissioner for Complaints.

7.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

7.1 Staff must take cognisance of relevant professional standards and guidance applicable to their own profession.

7.2 The Regulation and Quality Improvement Authority is the independent Health and Social Care regulatory body for Northern Ireland. In its work the RQIA encourages continued improvement in the quality of these services through a programme of inspections and reviews.

RQIA have a duty to assess how Health and Social Care bodies handle complaints in light of the criteria drawn down from the standards and regulations laid down by the Department of Health, Social Services and Public Safety.

8.0 Equality and Human Rights Considerations

8.1 This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

8.2 Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

8.3 This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

8.4 This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

8.5 This document can be made available on request in alternative formats, e.g., Braille, disc, audio cassette and in other languages to meet the needs of those who are not fluent in English.

9.0 Policy Approval

9.1 During development, this policy was considered in draft form by the Trust's Patient/Client Liaison Managers and Governance Lead for the Medical Directorate.

9.2 This policy was presented in final draft and approved on 26 August 2010.

10.0 Policy Implementation, Training and Education

10.1 Following approval this policy was circulated to all Trust staff in October 2010

10.2 The Complaints Project Manager in conjunction with the Patient/Client Liaison Managers will provide any necessary training with regard to this policy.

10.3 A copy of this policy was placed on the Trust's intranet in October 2010.

10.4 All Trust managers must ensure that their staff have access to this policy, understand its content, and are aware of its aims and purpose immediately upon its release.

10.5 All Trust staff must comply with this policy.

11.0 Review of Policy

11.1 The Trust is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

11.2 This policy will be reviewed by the Governance Lead Medical Directorate and the Patient Client Liaison Managers in November 2011 or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

12.0 Sources of Advice and Further Information

12.1 Further advice and information regarding this document can be obtained from the Patient/Client Liaison Manager for each Directorate.

Section Two: Complaints Procedures Incorporating Local Resolution Procedures

Section two has been developed by using the Regional Standards on Complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning, April 2009.

These are endorsed in full and adapted to reflect Southern Trust Practices

Complaints in Health and Social Care – Standards and Guidelines for Resolution and Learning (DHSSPS for implementation 01 April 2009)

1.0 Introduction

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

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

The changes to the new HSC complaints procedure include:

- The removal of the independent review stage;
- The introduction of standards for complaints handling;
- The introduction of an "Unacceptable Actions" policy for the handling of unreasonable, vexatious or abusive complainants; and
- Clarity on the application of the Children Order Representations and Complaints Procedure.

The new single tier process also aims to provide:

- A strengthened, more robust, local resolution stage;
- An enhanced role for commissioners in monitoring, performance management and learning; and
- An emphasis on improving the safety and quality of care provided through improved arrangements for driving forward quality improvements across HSC.

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

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

This document outlines the Trusts procedures for managing complaints incorporating information on managing the various stages of a complaint from informal complaint or raising of concerns through to exhausting the trusts options for local resolution prior to consideration by the office of the Ombudsman.

2.0 Informal Stage

It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation.

Staff can access the Trust's ***"Need to know guide for Staff on Complaints in Health and Social Care."***

Where possible complaints should be dealt with immediately. In these circumstances:

1. The complaint is raised by or on behalf of the service user at the point of service delivery.

2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

   Where appropriate if the member of staff attempting to resolve the matter feels it would be beneficial to involve a patient's advocate at this stage, they should seek advice from the relevant Patient/Client Liaison Manager.

3. The member of staff who has attempted to resolve the complaint at point of service delivery should complete sections A – E of the "Complaints/Issues at Point of Service Delivery Form" and discuss it with their manager who is required to complete section F and G in relation to action and learning. The manager should also indicate if the complaint has been resolved and if the complainant is expecting further contact from the Patient/Client Liaison Manager regarding the matter. This documentation should be forwarded to the Central Reporting Point within 5 working days.

3.0 Formal Stage

This is the starting point for anyone who approaches Central Reporting Point directly with their complaint or for those who are dissatisfied with attempts to resolve their complaint at point of service delivery.

All days referred to below are ***working days.***

1. The Central Reporting Point for Complaints is to forward complaint to relevant Patient/Client Liaison Manager by **day 1.**

2. The Patient/Client Liaison Manager should clarify the details of the complaints raised directly with the complainant if required and acknowledge it by **day 2** (expressing sympathy or concern regarding the complaint and thanking the complainant for drawing the matter to the attention of the Trust. A copy of the regional "What happens next?" leaflet should be included with the acknowledgment letter.

If consent is required it should be sought from the patient at this point. Investigation of the complaint should be initiated without delay, however a response to specific issues will not be provided unless the consent of the patient is forthcoming. (*The 20 working days only starts in these instances on the day in which the consent is received).*

Confidentiality must be respected at all times, and therefore if a complaint is made by a third party (including those made by MP's, MLA's and Local Councillors), and it refers to an individual's care, the matter of knowledgeable and informed consent must be considered. Patient/Client Liaison Managers will be able to provide further advice and guidance in relation to this matter. Consent Forms are held by Patient/Client Liaison Managers.

3. All complaints which occur in the Southern Trust area are graded in a standardised manner using the Southern Trust Risk Management Strategy (May 2008) currently under review. Updated version due November 2010

4. In the case of "mixed Directorate" complaints, it is best practice for the Patient/Client Liaison Manager in the Directorate where the problem has started to handle the complaint and seek input from other Patient/Client Liaison Managers where appropriate.

5. By **day 2,** Investigating Officer(s) should be given detail of complaint and advised that they are expected to provide their response as well as their action and learning plan by **day 10.** The names of the staff involved in the complaint, when identified, should be provided to the Patient/Client Liaison Manager.

   A copy of the complaint should be forwarded to the Director and Assistant Director responsible for the service area in order that the can take immediate action where serious governance issues are raised.

   *Investigating staff can reference the Trust's **"Investigating Complaints – Advice Sheet"** for best practice guidance on investigations.*

   Service Managers should bear in mind that staff will often require support if a complaint is received. Support is available, including, line management support, occupational health, Care Call as well as support from the relevant Patient/Client Liaison Manager.

6. The draft response to complainant is to be written by the Patient/Client Liaison Manager and forwarded to Assistant Director(s) by **day 15** for approval/amendment.

7. Where a complaint involves clinical/professional issues, the draft response must be shared, by the Assistant Director, with the relevant clinicians/professionals to ensure the factual accuracy and to ensure those staff agree with and support the draft response. Assistant Director(s) to approve and return to Patient/Client Liaison Manager by **day 17.** The Assistant Director(s) are to indicate if they are satisfied with the content of the action and learning plan, details of which will be captured on the Datix system.

Should further work be required on the action and learning plan it is the responsibility of the Assistant Director(s) to initiate this within their Division and report back to the relevant Patient/Client Liaison Manager.

8. Final response, which will include the names of staff involved, to complainant forwarded to the Lead Director for approval and signature by **day 18.**

9. Patient/Client Liaison Manager to issue response to complainant by **day 20.**

10. A copy of the signed response will be issued to all investigating officers involved in the investigation process. It is their responsibility to share this with the staff involved in the complaint and provide relevant feedback.

There is some flexibility built into the above internal timescales to allow investigating officers to complete complex complaint issues and to give the Director signing off more than 24 hours to sign if required. Where there are difficulties in gaining a response from the investigating officer the Patient/Client Liaison Manager will escalate any breaches of the timeframes to the line manager as appropriate for further action.

4.0 Acknowledgement of delays

Complainants must be given a written explanation of any reason for delay in responding to a complaint and this should happen as soon as it becomes apparent that the Trust will be unable to meet the 20 day timescale. The relevant Director(s) should be informed of any delay at this stage.

5.0 Further local resolution beyond 20 days

Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain, consideration needs to be given to providing enhanced local resolution where practicable. All complainants should be advised that if they remain unhappy with the Trust's response they should contact the relevant Patient/Client Liaison Manager to discuss the options available. At this point all complainants should be asked to state clearly which aspect(s) of their complaint that they feel remain unresolved. On receipt of this documentation, options may include one or a number of the following:

- Further written response to outstanding issues;
- Meeting with the Complainant;
- Enhanced local resolution investigation by a second team;
- Conciliation;
- Use of Lay people to assist;
- Use of independent experts.

5.1 Further written response to outstanding issues

The first step of further local resolution should be the offer of a further response to the complainant. This may be in the form of a further written response signed off by

the Director(s). This response should be issued within **20** days of the complaint being re-opened.

5.2 Meeting with the Complainant

Offer of facilitation of a meeting with the relevant staff. This will usually be taken forward by the existing investigation team and chaired by the Head of Service. The relevant Director(s) should be advised of the outcome of the meeting, notes agreed with all present and issued to complainant. This meeting should take place within **30** days of a second response being issued.

5.3 Additional measures

In extreme cases where a complainant cannot be satisfied with the response provided along with the facilitation of a meeting and where the Trust has provided further information there are still a number of options available. At this stage the initial local resolution stage will have been exhausted with further measures taken to provide additional information either in person by meeting with the complainant or by providing a further written response.

The decision on which option to be used will be agreed by the lead Director responsible for the management of the complaint and the relevant Patient/Client Liaison Manager with specific terms of reference and timescales being agreed. This may also include involvement of the Patient Client Council to support the local resolution process. Once the choice of option is agreed this should be acknowledged with the complainant and additional information provided on the option to be used. Options include the following:

- Enhanced local resolution investigation by a second team
- Conciliation
- Involvement of Lay Persons
- Involvement of Independent Experts
- Review by Independent Panel

5.4 Enhanced local resolution investigation by a second team

An enhanced local resolution investigation should examine the initial complaint, response to it and all information gathered in formulating that response. The decision to progress to this option will be taken by the relevant Director(s) in conjunction with the relevant Patient/Client Liaison Manager. The enhanced local resolution team should be lead by a Manager/Clinician from another service area within the Directorate, have a Manager/Clinician from another Directorate and the relevant Patient/Client Liaison Manager. The rationale for this is to:

a) provide a more detailed response with a measure of independence in responding to the complainant and
b) make best use of Trust internal resources.

If the complaint progresses to this stage, the following guidelines should be adhered to as best practice.

1. A draft report on findings should be forwarded to the Assistant Director responsible for the service area within **20 days** of the decision to use this option. A copy should be provided to the relevant Patient/Client Liaison Manager.

2. By **day 25** the Assistant Director should have discussed the content of the draft report with the relevant Director and have secured approval to approve release the final report to the complainant.

3. Patient/Client Liaison Manager to issue response to complainant by **day 30** of the decision to use this option.

If the all of the above measures fail to resolve the issues raised in a complaint, the Trust may consider the use of the following resources available to it.

5.5 Conciliation

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to achieve a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but may be helpful in situations where staff feel the relationship with the complainant is difficult and trust has broken down as well as at times where there are ongoing healthcare issues where it is important to maintain relationships or when there are misunderstandings with relatives during the treatment of a patient.

5.6 Involvement of Lay Persons

Lay persons may be beneficial in providing an independent perspective of non clinical or technical issues within the local resolution process. They are not intended to act as advocates, conciliators or investigators and neither do they act on behalf of the Trust or the complainant. They lay person's involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. Input from a lay person is valuable when testing issues such as communication, quality of written documents, attitudes and behaviours and access arrangements.

5.7 Involvement of Independent Experts

The use of an independent expert in the resolution of a complaint may be requested by the complainant at any time, however the Trust reserves the right to accept/decline this request. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution. Input will normally only be required in cases where there are major clinical issues or concerns, but the use of the option may be helpful when it is indicated there may be a risk to patient or public safety or a serious breakdown in

relationships which would threaten public confidence in services and damage the Trust's reputation.

5.8 Review by Independent Panel

In a small number of cases where a complainant is not satisfied with the Trust's response the Trust may wish to use an independent panel as a final attempt to resolve the complaint issue. This will only be used in extreme cases. An independent panel should be chaired by an operational Assistant Director with the support of an internal independent person (for example professional governance lead, clinical expert, social care expert etc) and an external lay person. The panel would be supported by the relevant Patient/Client Liaison Manager.

The panel would be given clear terms of reference and provided with all the relevant information. They may wish to meet with the complainant or individual members of staff to discuss the complaint in detail and to clarify issues raised.

The panel would provide a draft report and action plan to the relevant Director(s) for discussion and issue to the complainant.

The panel may also wish to comment on other issues as they arise. For example, Trust policies and procedures, team practices, line management arrangements etc. A separate report should be provided to the Director(s) highlighting areas of concern for further action by the Director(s).

5.9 Northern Ireland Commissioner for Complaints

Once all options available to the Trust under enhanced local resolution have been exhausted and the complainant remains unsatisfied, the complainant should be advised of the role of the Ombudsman and provided with contact details for the same.

Section Three: Handling of Unreasonable, Vexatious or Abusive Complaints Regional Guidance

Section three is direct guidance from the Regional Standards on Complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning, April 2009.

These are endorsed in full and have not been altered

1.0 Introduction

1.1 The Southern Health & Social Care Trust (hereafter referred to as the "Trust") Policy for handling unreasonable, vexatious or abusive complainants has been based on the complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning Guidance April 2009.

1.2 This section of the Policy is to provide guidance to staff on how to manage an unreasonable, vexatious or abusive complainant. It is also to provide clarity on the Trust's procedures to complainants whose behaviour may be considered to be unreasonable, vexatious or abusive

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

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

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

2.0 Unacceptable Actions Policy

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

2.1.1 to make it clear to all complainants, both at initial contact and throughout their dealings with the organisation, what the HSC organisation can or cannot do in relation to their complaint. In doing so, the HSC organisation aims to be open and not raise hopes or expectations that cannot be met

2.1.2 to deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered unacceptable. All complainants have the right to be heard, understood and respected. HSC staff have the same rights

2.1.3 to provide a service that is accessible to all complainants. However, HSC organisations retain the right, where it considers complainants' actions to be unacceptable, to restrict or change access to the service;

2.1.4 to ensure that other complainants and HSC staff do not suffer any disadvantage from complainants who act in an unacceptable manner.

3.0 Defining Unacceptable Actions

3.1 *Complainants Actions*

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

3.2 Aggressive or abusive behaviour

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

3.2.2 HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a Zero Tolerance[1] approach must be adopted. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

3.3 Unreasonable demands

Complainants may make what the HSC consider unreasonable demands through the amount of information they seek, the nature and scale of service they expect or the number of approaches they make. What amounts to unreasonable demands will always depend on the

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

circumstances surrounding the behaviour and the seriousness of the issues raised by the complainant. Examples of actions grouped under this heading include demanding responses within an unreasonable timescale, insisting on seeing or speaking to a particular member of staff, continual phone calls or letters, repeatedly changing the substance of the complaint or raising unrelated concerns.

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

3.4 Unreasonable persistence

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

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

3.5 Managing Unacceptable Actions

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

restrict contact with the organisation to either written communication or through a third party.

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

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

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

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

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

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

3.5.7 Complainant action may be considered unreasonably persistent if all internal review mechanisms have been exhausted and the complainant continues to dispute the HSC organisation's

decision relating to their complaint. The complainant is told that no future phone calls will be accepted or interviews granted concerning this complaint. Any future contact by the complainant on this issue must be in writing. Future correspondence is read and filed, but only acknowledged or responded to if the complainant provides significant new information relating to the complaint.

3.6 Deciding to restrict complainant contact

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

3.7 Appealing a decision to restrict contact

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

3.8 Recording and reviewing a decision to restrict contact

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

Appendix 1

SIMPLIFIED PROCESS FOR DEALING WITH COMPLAINTS

Complaint is raised by or on behalf of a service user at the point of service delivery

→ Member of staff who first learns of complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

IS THE MATTER **RESOLVED**?

← **YES**

→ **NO**

Member of staff who has resolved complaint at point of service delivery should complete the Concerns/Issues at Point of Service Delivery Form and forward it to the relevant Head of Service and Central Reporting Point for Complaints.

Instigate Formal Complaints Process.This is also the starting point for all complaints not raised at the point of service delivery.

BY DAY	ACTION	BY WHOM
1	▪ Complaint sent to relevant Patient/Client Liaison Manager	Central Reporting Point
2	▪ Send acknowledgement to complainant. (Seek consent if required) ▪ Forward complaint to relevant manager for investigation. Copies provided to relevant Assistant Director(s) and Director(s) for information.	Patient/Client Liaison Manager
10	▪ Provide report of investigation and action plan if appropriate to relevant Patient/Client Liaison Manager.	Relevant Manager
15	▪ Forward draft response to the appropriate Assistant Director for comment/amendment.	Patient/Client Liaison Manager
17	▪ Assistant Director to agree and finalise response, in conjunction with clinicians if there are clinical/professional concerns raised, as well as ensuring arrangements are in place to implement action plan if appropriate.	Assistant Director
18	▪ File forwarded to Director responsible for POC for signature.	Patient/Client Liaison Manager
20	▪ Patient/Client Liaison Manager to issue response.	Patient/Client Liaison Manager

IS THE MATTER **RESOLVED**?

← **YES**

→ **NO**

Complaint file closed

Assistant Director to consider the following measures
Further written response to outstanding issues. (within 20 days of complaint being re-opened).
Meeting with the complainant. (within 30 days of second response being issued).
Enhanced local resolution investigation by a second team.
Conciliation, Patient Client Council, Use of Lay persons and experts
Establish Independent Panel to examine complaint issue

Director to make decision re Enhanced local resolution investigation by second team. Decision should be taken within two weeks of the complainant advising that they remain unhappy.

Whatever option is chosen there is an expectation that the Trust to attempt to resolve the complaint within a timescale of a 12 weeks. There is also an expectation that the Chief Executive will sign off the response to complaints at this stage.

IS THE MATTER **RESOLVED**?

← **YES**

→ **NO**

Complaint file closed

Where the Trust has exhausted all options available to it and there is no resolution to a complaint the complainant will be advised of the procedures for contacting the Ombudsman's office.

Appendix 2

List of Service Areas covered by Patient/Client Liaison Managers

Acute Services – Includes Finance, HROD and P&R	
A&E	Outpatients
Medical Admissions Unit	Ophthalmology
Cardiology	Oral/Dentistry/Orthodontics (Acute)
Renal Services	Cancer Services
Dermatology	Laboratory Services
General Surgery	Anaesthetics
General Medicine	Theatres
Urology	ICU
ENT	Infection Control
Rehabilitation	Diagnostics
Trauma and Orthopaedics	Obstetrics
Acute Elderly	Gynaecology
Linen and Laundry Services	Community Midwifery
Decontamination	Locality functional management
Administrative Services	
Children and Young People's Services	
Paediatrics (Acute and Community)	Children in Accident and Emergency
Dental (Non Acute)	Children in Out-patients
Paediatric Speech and Language Therapy	Special Care Baby Units
Paediatric Occupational Therapy	Ambulatory Paediatrics
Children's Community Nursing	Corporate Parenting
Social Work Services for Children	Agency Decision Services
Children with Disabilities	Looked After Children
Child and Adolescent Mental Health Services	Short Term Residential Care
Child Health	Long Term Residential Care
Safeguarding	Leaving and Aftercare Services
Health Visiting	Family Placement Services
School Nursing	Neonatology
Early Years and Parenting	Paediatric Intensive Care
Family Support	
Mental Health and Disability	
Acute Mental Health Services	Specialist
Community Mental Health Services	Physical and Sensory Disability
Mental Health Support Services	Support Services
Specialist Mental Health Services	Community Services for Adults
Supported Living Services	with a Physical Disability
Learning Disability Services –	Services for Sensory Disability
Community Learning Disability Services	
Older People and Primary Care	
Adult Physiotherapy	Specialist Services
Adult Occupational Therapy	GP Out of Hours
Podiatry	Minor Injury Unit
Dietetics	Domiciliary Care
Speech and Language Therapy for Adults	Supporting People and Residential Care
District Nursing	Independent Sector
Social Work - Older People	Community Development Teams
Community Dementia	Health Promotion Teams
Care Management	Area Health Promotion Department
Non-Acute Hospital	Health Action Zone
Intermediate Care	
Stroke Care	

Southern Health and Social Care Trust

Policy Checklist

Name of Policy:	Policy for the Management of Complaints (Working Draft)
Purpose of Policy:	To ensure that Trust staff are informed and aware off the Trust's complaints handling process and to provide service users, patients and clients with the information they require to make a complaint.
Directorate responsible for Policy	Chief Executive's Office
Name & Title of Author:	Joscelyn Magennis, Corporate Complaints Officer
Does this meet criteria of a Policy?	Yes/No/Not Applicable
Trade Union consultation?	Yes/No/Not Applicable
Equality Screened by:	
Date Policy submitted to Policy Scrutiny Committee:	
Members of Policy Scrutiny Committee in Attendance:	

Policy Approved/Rejected/ Amended	
Policy Implementation Plan included?	
Any other comments:	
Date presented to SMT	
Director Responsible	
SMT Approved/Rejected/Amended	
SMT Comments	
Date received by Employee Engagement & Relations for database/Intranet/Internet	
Date for further review	2 year default

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Policy for the Management of Complaints Version: Reference number/document name:
Supersedes	Supersedes: Policy for the Management of Complaints, November 2010 Description of Amendments(s)/Previous Policy or Version: Reviewed and updated in-line with changes to the Governance structures within the Trust and to ensure continuing compliance with regional complaints procedures.
Originator	Name of Author: Joscelyn Magennis Title: Corporate Complaints Officer
Scrutiny Committee & SMT approval	Referred for approval by: Date of Referral: ScrutinyPolicy Committee Approval (Date) SMT approval (Date)
Circulation	Issue Date: Circulated By: Issued To: As per circulation List (details below)
Review	Review Date: Responsibility of (Name): Title:

Southern Health and Social Care Trust

Quality Care - for you, with you

Policy for the Management of Complaints (Working draft)

Authors	***Joscelyn Magennis, Corporate Complaints Officer***
Directorate Responsible	***Chief Executive's Office***
Date of Issue	
Review Date	***July 2015***

CONTENTS

SECTION ONE: INTRODUCTION, PURPOSE AND SCOPE

1.0 *Introduction to Policy*

The Policy for the Management of Complaints has been based on *Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*, which was published by the DHSSPSNI on 1st April 2009 (and updated June 2011 and June 2013). The policy also reflects the ongoing regional work with HSC to ensure best practice in the management of complaints.

A separate specific policy and procedure is in place for the management of complaints regarding services to children and young people in accordance with the *Children (NI) Order 1995 Representation and Complaint Procedure*.

1.1 *Policy Statement*

The Southern Health and Social Care Trust (hereafter referred to as the "Trust") believes that patients, relatives and carers have a right to have their views heard and acted upon. The Trust welcomes feedback on all aspects of service and recognises the value of complaints in improving service provision for patients and the public through listening, learning and improving.

1.2 *Purpose and Aims*

The Trust is committed to developing a culture of responsible openness and constructive criticism, and to encouraging all service users to contribute views on all aspects of the Trust's activities. It has introduced this policy to enable service users to raise any concerns they may have at an early stage and in the right way.

The aim of this policy is to:

- Inform staff of the Trust's processes for complaints handling; and
- Provide service users, patients and clients with the information they require to make a complaint.

1.3 *Scope of Policy*

This Policy is applicable to all services provided by the Trust with the following exception for which alternative procedures are already in place: *Children (NI) Order 1995 Representation and Complaints Procedure*.

1.4 *Legislative Compliance, Relevant Policies, Procedures and Guidance*

The *Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009* requires HSC organisations to make arrangements in accordance with the provisions of the directions for

the handling and consideration of complaints. The *Regional Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning* conform to this legislative framework.
Trust staff must also take cognisance of relevant professional standards and guidance to their own profession.

The Regulation and Quality Improvement Authority (RQIA) is the independent Health and Social Care regulatory body for Northern Ireland. In its work the RQIA encourages continued improvement in the quality of these services through a programme of inspections and reviews. RQIA have a duty to assess how Health and Social Care bodies handle complaints in light of the criteria drawn down from the standards and regulations laid down by the Department of Health, Social Services and Public Safety.

1.5 *Equality and Human Rights Consideration*

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the *Northern Ireland Act 1998*. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria; no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This policy has been considered under the terms of the *Human Rights Act 1998*, and deemed to be compatible with the *European Convention Rights* contained in that Act.

This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

1.6 *Alternative Formats*

This document is available on request in alternative formats which include large print, audio disc and in other languages to meet the needs of those who are not fluent in English. These formats can be requested from the Corporate Complaints Officer. P*lease refer to* ***Appendix 3*** *for contact details*.
We Value Your Views leaflets, which provide service users/clients with an overview of the Trust's complaints procedures and contact details, is available from the Trust Intranet in large print and other languages (http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html).

SECTION TWO: ROLES AND RESPONSIBILITES

2.0 *Role of the Chief Executive*

Our Chief Executive is responsible for ensuring that our complaints procedure is effective and that our approach ensures that appropriate investigations and actions have been completed before a response sent following the formal investigation of a complaint.

However, the responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance. The Chief Executive must maintain an overview of the issues raised in complaints and be assured that appropriate organisational learning has taken place and that action is taken in the light of the outcome of any investigation.

2.1 *Role of the Assistant Director of Clinical and Social Care Governance*

It is role of the Assistant Director of Clinical and Social Care Governance (CSCG) to work with the Trust's operational, executive and corporate Governance Leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness of changing professional, clinical and operational practice in improving the safety and quality of care, which takes due regard of evidence-based practice, lessons learned from reviews, complaints, incidents, accidents and public inquiries, and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priority areas for action.

The Assistant Director of CSCG also ensures that a 'Lessons Learned' strategy and process is in place that identifies learning from clinical and social care incidents, lead the implementation and embedding of learning through co-ordination of agreed actions and integrated support from clinical and social care governance staff and workforce development and training leads, ensuring systems are in place for effective feedback to staff where issues of concern have been raised and actions identified to address same.

2.2 *Role of Executive Directors*

It is the role of the Executive Directors to refer any professional issues, about which they have concerns to the relevant professional body.

2.3 *Role of Operational Directors, Assistant Directors and Heads of Service*

All Operational Directors are responsible and accountable for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. This responsibility also includes the prompt instigation of local investigations at an appropriate level determined by the seriousness of the complaint.

All Operational Directors will endeavour to ensure that those tasked with investigating and responding to complaints, implementing and sharing learning and improvement have the necessary resources, the co-operation of all staff and the support of senior management.

It is the responsibility of all Trust Directors, Assistant Directors, Service Heads and Senior Managers to utilize the information and trends from complaints within their governance processes to ensure learning and improvement, and to develop and monitor action and learning plans in response to issues identified from complaints.

It is the role of the Assistant Director, in complaints where concerns are raised about clinical treatment and care, to share and agree the proposed draft response to the complaint with the relevant clinician prior to it being submitted to the Director for approval.

2.4 *Role of Line Managers and Front-Line Staff*

Complaints may be made to any member of staff. Staff must be trained and empowered to deal with complaints as they arise. Appropriately trained staff will recognise the value of the complaints process and as a result will welcome complaints as a source of learning. Advice and assistance for staff regarding the handling of complaints is available from the relevant Directorate Governance Team or the Corporate Complaints Officer.

The first responsibility of a staff member who receives a complaint is to ensure that, where applicable, the service user's immediate health and social care needs are being met before taking action on the complaint. Thereafter, the complainant's concerns should be recorded and dealt with rapidly and in an informal, sensitive and confidential manner.

Some complainants may prefer to make their initial complaint to a member of staff who has not been involved in the care provided. In these circumstances, the complaint should be dealt with by an appropriate member of senior staff (i.e. line manager). The Corporate Complaints Officer and Directorate Governance Team are available to support and advise front-line staff on the handling of complaints.

Where a complainant raises a clinical or professional matter an appropriately qualified person should be asked to review it in light of the investigation and advise on accuracy and details prior to the proposed complaint response being finalised.

All staff are required to promote and maintain service user and staff confidentiality and to comply

with the requirements of legislation, for example the Data Protection Act. The need for sensitivity and confidentiality is paramount.

2.5 ***Role of Corporate Complaints Officer***

The Corporate Complaints Officer (CCO) is responsible for providing a first contact for service users, signposting the service users around the organisation, assisting them in problem solving and facilitating them to access and use the Trust's complaints process.

The CCO is also responsible for screening service user contacts and determining if these are enquiries or complaints. The CCO will facilitate either resolution of the enquiry or complaint, or they will help facilitate the complainant in their use of the Trust's formal complaints procedure by directing the complaint to the relevant Directorate Governance Team. The CCO will then update Datix with all relevant information and actions taken. The CCO will provide the same support and consideration for those enquiries and complaints from third parties, such as MLAs and the Minister's office. The CCO will alert the Directorate Governance Teams to significant issues at an early stage.

2.6 ***Role of Governance Co-ordinators and Governance Officers***

The Governance Co-ordinators will lead their Directorate Governance Team in ensuring that at each level of the Directorate staff have access to timely, high quality and appropriate information in relation to complaints, and that within each service team this information is being acted upon appropriately in order to mitigate risk, improve quality of care and patient/client safety.

The Governance Co-ordinators will co-ordinate via the Directorate Governance Team the timely and appropriate responses to complaints on behalf of the Directorate. The Co-ordinators will ensure that the complaints process is conducted in accordance with Regional and Trust complaints procedures.

The Directorate Governance Team will:

- Manage all complaints received within their respective Directorates;
- Maintain a comprehensive IT system (Datix) of all complaints received;
- Provide support and advice to staff investigating/responding to complaints;
- Take account of any corroborative evidence available relating to the complaint;
- Identify training needs of staff and ensuring that appropriate programme are organised in conjunction with line managers;
- Provide the Directorate and the organisation with analysis and intelligence on complaints received to ensure that trends are identified as well as appropriate responses to individual complaints;

- Comply with Controls Assurance Standards criteria in respect of complaint management; and
- Be aware of the availability of and advise complainants about:
  - the support available from the Patient Client Council;
  - the role and availability of conciliation, advocacy, independent experts and lay persons; and
  - the Ombudsman/Commissioner for Complaints.

SECTION THREE: MAKING A COMPLAINT

3.0 *What is a complaint?*

The Trust aims to provide the highest possible standard of care and treatment to all service users, at all times, but sometimes things do not always go according to plan. When this happens, it is important for us to put things right quickly.

A complaint is **"an expression of dissatisfaction that requires a response"**.[1] Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments which are really complaints and need to be handled as such.

3.1 *Who can complain?*

Any person can complain about care or treatment, or about issues relating to the provision of health and social care.

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

Complaints may be made by:

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

It is important to note that making a complaint does not affect the rights of the patient/client and will not result in the loss of any services the patient/client have been assessed as requiring.

[1] *Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning* (April 2009)

3.2 *Issues this guidance does not cover*

3.2.1 This Policy for the Management of Complaints does not deal with complaints about:

- private care and treatment or services, including private dental care[2] or privately supplied spectacles; or
- services not provided or funded by the Trust, for example, provision of private medical reports.

3.2.2 Complaints may be raised within the Trust which we need to address, but which do not fall within the scope of this policy. While the Policy for the Management of Complaints does not cover the issues listed below the Trust has in place procedures to ensure that such concerns are dealt with. Such issues include:

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

If any complaint received by the Trust indicates a need for referral under any of the issues above in section 3.3.2, they should immediately be passed to the relevant Directorate Governance Team for onward transmission to the appropriate department. If any aspect of the complaint is not covered by the referral it will be investigated under this Complaints Policy. In these circumstances, investigation under this Complaints Policy will only be taken forward if it does not or will not, compromise or prejudice the matter under investigation under any other process. The complainant will be informed of the need for referral.

While the Trust does not investigate complaints made regarding the Northern Ireland Ambulance Service (NIAS), any complaints received by the Trust in relation to the NIAS will be passed onto the NIAS Complaints Officer.

Complaints received by the Trust in relation to GP practices and services will be passed onto the Complaints Manager at the Health and Social Care Board (HSCB).

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

3.3 *Complaints about Regulated Establishments/Agencies and Independent Service Providers*

On occasions the Trust may make use of Regulated Establishments/Agencies and Independent Service Providers (ISP), e.g. residential nursing homes, domiciliary care providers; to provide services for patients/clients. This form of treatment and/or care is subcontracted to the Regulated Establishment/Agency or ISP and funded by the Trust.

Regulated Establishments/Agencies and ISPs are contractually obliged to have in place appropriate governance arrangements for the effective handling of, management and monitoring of all complaints. This should include the appointment of designated officers of suitable seniority to take responsibility for the management of the in-house complaints procedures, including the investigation of complaints and the production of literature, which is available and accessible to patients/clients, which outline the establishment's complaints procedure. On commissioning of the services it would be good practice if the commissioner (i.e. Trust staff) informs the patient/client and relatives/carers that the Regulated Establishment/Agency or ISP will have a complaints procedure in place.

If a patient/client or relative/carer has a concern or complaint relating to the contracted services provided by a Regulated Establishments/Agency or ISP they should raise the concern/complaint directly with the provider of care in the first instance. However, where complaints are raised with the Trust, the Trust must establish the nature of the complaint and consider how best to proceed. It may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where the complaint raises serious concerns or where the Trust deems it in the public interest to do so.

The Regulated Establishment/Agency or ISP is required to investigate the concern or complaint and provide a written response to the complainant which should be copied to the Trust. If there is a delay in responding to the complainant within the target timescales[3] the complainant will be informed and a revised date for conclusion of the investigation will be provided.

The response letter from the Regulated Establishment/Agency or ISP must advise the complainant that they can progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and who will be responsible for conducting the investigation. The Trust will work closely with the

[3] Under SHSCT complaints procedure a written response should be issued to the complaints within 20 working of the establishment's receipt of the complaint. If the establishment is unable to meet these timescales the complainant should be informed, in writing, as to the reasons why.

Regulated Establishment/Agency or ISP to enable appropriate decisions to be made.

The complainant must also be informed by the Regulated Establishment/Agency or ISP of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the Regulated Establishment/Agency or ISP without Trust participation in local resolution will be referred to the Trust for investigation and action by the Ombudsman.

The Trust has agreed arrangements in place to ensure that Regulated Establishments/Agency or ISPs provide information to annual review meetings relating to all complaints received and responded to directly by them.

It is the role of Trust staff, such as Key Workers, to ensure that patients/clients and relatives/carers are aware of the importance of raising concerns or complaint as close to the source as possible, as this allows for early resolution through discussion and negotiation. The general principle in the first instance therefore would be that the Regulated Establishment/Agency or ISP investigates and responds directly to the complainant.

Should patients/clients or relatives/carers lack confidence in the Regulated Establishments/Agencies or ISPs' complaints handling procedures or are not happy with the response they had received from the provider of care, they can refer their complaint to the Trust's Corporate Complaints Officer so that an investigation can begin. *Contact details for the Trust's Corporate Complaints Officer are listed below.*

Corporate Complaints Officer
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Portadown,
BT63 5QQ

Telephone: (028) 3861 4150

Email: complaints@southerntrust.hscni.net

The Regulation and Quality Improvement Authority (RQIA) will monitor how complaints are handled and investigated by regulated services and the Trust. *For contact details please refer to* ***Appendix 3****.*

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

Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaint's Manager if he/she does not feel able to approach immediate staff. The HSC Board has a responsibility to record and monitor the outcome of those complaints lodged with them.

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

Please refer to ***Appendix 3*** *for contact details.*

3.5 ***How can complaints be made?***
Complaints can be made to a member of Trust staff at the point of service delivery
It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation, and by following the guidance in section 4.3 of this Policy.

It is important that front-line staff are trained and supported to respond sensitively to the comments and concerns raised by service users and are able to distinguish those issues which would be better referred elsewhere. Staff across the Trust can assess the "Policy for the Management of Complaints" and "Complaints in Health and Social Care: A Need to Know Guide for Staff" through the Trust's Intranet.

Where possible complaints should be dealt with immediately and front-line staff should follow the procedures below in their handling of complaints received at point of service delivery:

1. The complaint is raised by or on behalf of the service user at the point of service delivery.

2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

Where appropriate if the member of staff attempting to resolve the matter feels it would be

beneficial to involve a patient's advocate at this stage, they should seek advice from the relevant Directorate Governance Team.

3. If a member of staff has resolved a complaint 'at point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form and return to the Corporate Complaints Officer. A *Complaints at Point of Service Delivery* form can be located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

If the person remains dissatisfied, they should be offered a copy of the Trust's 'We Value Your Views' leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

It is important that if you are in this situation, you ask your supervisor or line manager for assistance, if necessary.

3.5.1 ***Formal Letter of Complaint received at Point of Service Delivery***

If a formal letter of complaint is received by staff at a point of service delivery' it should be sent by email the same day to the Trust's Corporate Complaints Officer so that an investigation can begin. *Please refer to* ***Appendix 3*** *for contact details.*

3.5.2 ***Complaints can be made to the Corporate Complaints Officer***

Complaints may be made verbally or in writing and will also be accepted via other methods such as the telephone (including voicemail) or electronically (e.g. e-mail). It is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint. The Trust is mindful of technological advances and has in place local arrangements which ensure that there is no breach of patient/client confidentiality. Contact details for the Trust's Corporate Complaints Officer are listed below.

Corporate Complaints Officer
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Portadown,
BT63 5QQ

Telephone: (028) 3861 4150

Email: complaints@southerntrust.hscni.net

3.5.3 *What information should be included in a complaint?*

A complaint need not be long or detailed, but it should include:	
Relevant Contact Details	✓ Complainants name, address (including postcode) and telephone number ✓ If you are making this comment/complaint on behalf of another person, please provide the following details: ▪ Their name, their address (including postcode) and their date of birth (if known) ▪ And please indicate your relationship to this person
Who or what is being complained about?	✓ Department/ward/facility where the issues occurred ✓ Hospital site, e.g. Craigavon, Lurgan, Newry, etc. ✓ Include the names of staff, if known
When the events of the complaint happened	✓ Details of the issue(s) relevant to the complaint ✓ Please include dates
Where possible, what remedy is being sought	✓ Such as an apology, an explanation or changes to be made to our services

3.6 *Complaints made by a 3rd Party (including those made by MPs, MLAs and Local Councillors) and Consent*

Confidentiality must be respected at all times and complaints by a third party should be made with the written consent of the patient/client concerned. If consent does not accompany the complaint the Trust will seek consent from the patient/client concerned or their next of kin where necessary. There will be situations where it is not possible to obtain consent, such as:

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

The relevant Governance Team will be able to provide further advice and guidance in relation to this matter. Consent forms can be obtained from the Complaints and User Views section of the Southern Health and Social Trust website.
(www.southerntrust.hscni.net/pdf/Patient_Client_Consent_form_May_2012(2).pdf)

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

3.7 *Complaints made by staff*

As staff in the Southern Trust, we all have a responsibility to protect our service users, fellow members of staff, the public and the Trust. If you have a concern as a member of staff about any aspect of the quality and safety of our services, another member of staff or about any of the functions of the Trust, those concerns can be raised as per the Trust's *Whistleblowing Policy*. Staff can access the *Whistleblowing Policy* via the Trust's Intranet (http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/WhistleblowingPolicyFINALREVIEWEDonintranetMay2012.pdf).

3.8 *Anonymous Complaints*

If someone approaches the Trust with a complaint we will request their name and contact details. This will enable us to acknowledge their complaint, confirm the issues causing concern and clarify or seek further information and provide information on the outcome of our investigation.

Any request to remain anonymous will be respected as all complaints received by the Trust are treated with equal importance regardless of how they are submitted. However, complaints received with anonymity may mean that a detailed investigation may not always be possible, for example when there is a need to access medical records. Also, a complaint response cannot be issued.

All complaints submitted to the Trust, whether anonymous or not, are viewed as a significant source of learning within the organisation and help us to continue to improve the quality of our services and safeguard high standards of care and treatment. The number of complaints and trends emerging from complaints are continually monitored by each Directorate's Governance meeting and at the Patient/Client Experience Committee meetings.

3.9 *What are the timescales for making a complaint?*

A complaint should be made as soon as possible after the action giving rise to it, normally within **six months** of the event. If a complainant was not aware that there was cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is earlier.

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

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

3.10 *Support for complaints*

Some people who wish to complain do not do so because they do not know how, doubt they will be taken seriously or simply find the prospect too intimidating. Support and advocacy services are an important way of enabling people to make informed choices. These services help people gain access to the information they need, to understand the options available to them and to make their views and wishes known.

The Southern Trust's ***Patient Support Services*** is a confidential service for patients, families and carers within the **Acute Directorate**, i.e. Emergency Department, surgical wards, intensive care, etc. It provides:

- on the spot advice ;
- answers to your queries and questions ;
- information on the Trust and the services it provides ;
- information on local health services and support groups;
- support, when needed;
- information on making a complaint;
- a way for you to tell us what you think of our services so that we can improve them.

The Patient Support Services offices are located on both the Craigavon and Newry sites, with the support available at Craigavon from Monday to Friday and available on the Newry site Monday and Thursday. Contact details are listed below.

Craigavon Contact Details:
Patient Support Service
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ
Telephone: (028) 3861 2395 / 3861 4285

Email: PatientSupport.CAH@southerntrust.hscni.net

Newry Contact Details:
Patient Support Service
Daisy Hill Hospital
5 Hospital Road
Newry BT35 8DR

Telephone: (028) 3083 5070

Email: PatientSupport.DHH@southerntrust.hscni.net

Niamh (***Northern Ireland Association for Mental Health***) is the largest and longest established independent charity focusing on mental health and wellbeing services in Northern Ireland. Niamh is structured as a group consisting of three elements: Compass, beacon and Carecall. ***Beacon*** offers an independent advocacy service which is designed to listen to the compliments, concerns, problems or issues that people may be experiencing whilst using mental health services. An advocate can provide patients/clients with information in relation to the options available to them under four broad areas: clinical, legal, treatment and environment. An advocate will help patients/clients to express any concerns and to pass these on to relevant professionals. Advocates will support the individual to be heard and all discussions will be treated confidentially. *Please see below for contact details.*

80 University Street,
Belfast,
BT7 1HE

Telephone: (028) 9032 8474
Email: info@beaconwellbeing.org

In the Southern Health and Social Care Trust, ***Disability Action***'s Centre on Human Rights provides an advocacy service specifically for people with learning disabilities. This service is confidential, provided free of charge and independent. The advocate supports people with learning disabilities to understand their rights and encourages them to speak up if they are unhappy about how they have been treated. The advocate will listen to the person's issue and identify the options available to them and will support the patient/client to take action.

The advocate also provides non-instructured advocacy, when a patient/client cannot give a clear indication of their views or wishes in a specific situation, e.g. when a person has a profound learning disability. In these cases, the advocate works to uphold the person's rights, ensure fair and equal treatment and access to services and make certain that decisions are taken with due consideration for the patient/client's individual preferences and perspectives. Please see below for contact details.

Human Rights Advocate,
Disability Action's Centre on Human Rights,
Disability Action,
Portside Business Park,
189 Airport Road West,
Belfast,
BT3 9ED

Telephone: (028) 9029 7880
Textphone: (028) 9029 7882
Email: humanrights@disabilityaction.org

VOYPIC (***Voice of Young People in Care***) offers advocacy for children and young people with care experience aged 25 and under. This is a confidential and independent service where children and young people can get advice, information and support outside of Social Services. The service can:

- provide you with information and advice on your rights;
- Go to meetings with a child or young person;
- Help children/young people ask for a service;
- Help children/young people speak out about decisions that affect you; and
- Help children/young people make a complaint.

Please see below for contact details.

Voice of Young People In Care
Flat 12, Mount Zion House
Edward Street
Lurgan
BT66 6DB

Telephone: (028) 3831 3380
Website: www.voypic.org

The **Northern Ireland Commissioner for Children and Young People**'s (**NICCY**) Legal and Investigations team deal with queries and complaints from children, young people, their carers and relevant professionals about the services they receive from public bodies. This team can:

- investigate complaints against public bodies (schools, hospitals, etc) on behalf of children and young people;
- help a child or young person bring their complaint to a public body; and
- help children and young people in legal proceedings against public bodies.

Please see below contact details.

Legal and Investigations Team
Northern Ireland Commissioner for Children and Young People
Equality House
7-9 Shaftesbury Square
Belfast
BT2 7DP

Telephone: (028) 9031 1616
(Monday – Friday: 9:00am to 5:00pm)
Email: listening2u@niccy.org
Website: www.niccy.org

The ***Age NI*** Advice and Advocacy Service offer free, independent and confidential support to older people, their families and carers. The Age NI team provides advocacy support to people experiencing difficulties:

- negotiating the health and social care system
- accessing appropriate levels of community care
- dealing with issues relating to residential and nursing care
- those who have experienced or are at risk of abuse.

Please see below for contact details.

Age NI
3 Lower Crescent
Belfast
BT7 1NR

Telephone: 0808 808 7575
(8:00am to 7:00pm, 7 days a week)
Email: advice@ageni.org
Website: www.ageni.org/advice

The ***Patient Client Council*** (PCC) is an independent non-departmental public body and its functions include:

- representing the interests of the public;
- promoting involvement of the public; and
- providing assistance to individuals making or intending to make a complaint.

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

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

All advice, information and assistance with complaints is provided free of charge and is confidential. *Please see below for contact details.*

Quaker Buildings,
High Street,
Lurgan,
BT66 8BB

Telephone: 0800 917 0222
Email: info.pcc@hscni.net

Website: www.patientclientcouncil@hscni.net

The Trust's Corporate Complaints Officer and Directorate Governance Teams will also be able to offer advice and support complainants and explain the Trust's complaints procedure, as well as attempt to resolve the complaint. *For contact details of these services please refer to* ***Appendix 3****.*

3.11 *Making a compliment*

The staff who provide services do their best to meet your individual expectations and are often working in difficult circumstances. Therefore we are always keen to know when things have worked out well for our patients/clients and what aspect has made a positive experience for them.

Those patients/clients wishing to make a compliment can do so by completing a *We Value Your Views* leaflet and returned to the Trust's Corporate Complaints Officer. Alternatively, you can contact the Corporate Complaints Officer directly to make your compliment. (*Contact details can be found in* ***Appendix 3***) These compliments, which highlight good practice, will be forwarded to the relevant staff and departments.

SECTION 4: HANDLING COMPLAINTS

4.0 *Accountability*

Accountability for the handling and consideration of complaints rests with the Chief Executive. The Assistant Director of Clinical and Social Care Governance is the Trust's designated senior person within the organisation who takes responsibility for the local complaints procedure and to ensure compliance with the regulations and that action is taken in light of the outcome of any investigation. All staff within the Trust are made aware off and must comply with the requirement of this complaints procedure. These arrangements ensure the integration of complaints management into the Trust's governance arrangements.

4.1 *Co-operation*

Arrangements are in place within the Trust to ensure a comprehensive response to the complainant and to that end there is necessary co-operation in the handling of complaints and the consideration of complaints between:

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

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

4.2 *Actions on receipt of a complaint*

All complaints received by the Trust are treated with equal importance regardless of how they are submitted. Complainants are encouraged to speak openly and freely about their concerns and are reassured that whatever they have to say will be treated with appropriate confidence and sensitivity. Complainants will be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. On receipt of a complaint the first responsibility of Trust staff is to ensure that the service user's immediate care needs are being met.

The Trust will involve the complainant throughout the consideration of their complaint as this provides for a more flexible approach to the resolution of the complaint. An early provision of information and explanation of what to expect is provided by the Trust to the complainant at the outset to ensure they are informed about the process and of the support that is available.

Each complaint received by the Trust is taken on its own merit and responded to appropriately. It

may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive manner.

4.2.1 *Informal Complaint*

It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation.

Staff across the Trust can access 'Complaints in Health and Social Care: A Need to Know Guide for Staff' via the Trust's Intranet.

Point of Service Delivery

When a complaint is raised at the point of service delivery staff should follow the procedures laid out below.

1. The complaint is raised by or on behalf of the service user at the point of service delivery.
2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

   Where appropriate if the member of staff attempting to resolve the matter feels it would be beneficial to involve a patient's advocate at this stage, they should contact the advocate directly with the patient/client's consent or seek advice from the relevant Directorate Governance Team.
3. If a member of staff has resolved a complaint 'at the point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

   If the person remains dissatisfied, they should be offered a copy of the Trust's **'We Value Your Views'** leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

   It is important that staff in this situation ask their supervisor or line manager for assistance, if necessary.

Complaints made directly to the Trust's Corporate Complaints Officer

The Corporate Complaints Officer will facilitate either resolution of the complaint or they will facilitate the service user in accessing the Trust's formal complaints procedure.

4.2.2 ***Formal Complaints***

This is the starting point for anyone is dissatisfied with attempts to resolve their complaint at the point of service delivery or any complainant who expects to receive a written (or alternative format) response from the Trust. The complainant should receive a full response within **20 working days** of the Trust's receipt of the formal complaint.

Acknowledgement

1. The Corporate Complaints Officer is to forward the complaint to the relevant Governance Co-ordinator's office within **1 working day**.

2. The relevant Governance Team should clarify the details of the complaint raised directly with the complainant if required and acknowledge their receipt of the complaint within **2 working days**. This acknowledgement should express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the matter to the attention of the Trust. A copy of the regional "*What Happens Next?*" leaflet should be included with the acknowledgment letter.

3. If a complaint is made by a third party (including those made by MPs, MLAs and local councillors) and it refers to an individual's care the matter of knowledgeable and informed consent must be considered.

If consent is required it should be sought from the patient at this point. Investigation of the complaint should be initiated without delay, however a response to specific issues will not be provided unless the consent of the patient is received. (*The 20 working days only starts in these instances on the day in which the consent is received*.)

4. All complaints which occur in the Trust are graded in a standardised manner using the Trust's *Risk Management Strategy*.

5. In the case of complaints which are applicable to more than one directorate, it is best practice for the Governance Team in the directorate where the complaint has first arisen to handle the complaint and seek input from other Directorate Teams where appropriate.

Investigation

1. By **day 2**, Investigating Officer(s) should be given detail of the complaint and advised that they are expected to provide their draft response as well as their action and learning plans, where actions are required following investigation of the complaint, by **day 10**. The names of the staff involved in the complaint, when identified, should be provided to the appropriate Directorate Governance Team.

A copy of the complaint should be forwarded to the Assistant Director responsible for the service area. Where serious governance issues are identified on receipt of the complaint it must be shared with the relevant Director.

Investigating staff can reference the Trust's 'Investigating Complaints Advice Sheet' for best practice guidance on investigations, which can be accessed via the Trust's Intranet.

Service Managers should bear in mind that staff will often require support if a complaint is received. Support is available from the following sources:

- line management support;
- occupational health;
- Care Call; and
- the relevant Governance Team.

2. The draft response to the complainant is to be validated by the Investigating Directorate Governance Team and then forwarded to the appropriate Assistant Director by **day 15** for approval/amendment.

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

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong – staff should refer to the *Ombudsman's Guidance on Issuing an Apology* (May 2011) which can be found here: http://www.ni-ombudsman.org.uk/niombudsmanSite/files/2d/2dfa3d4d-2b55-4bcb-8670-bd99f76eba4e.pdf
- report the action taken or proposals to prevent recurrence, where the need for such actions have been identified following investigation of the complaint;
- indicate that a named member of staff is available to clarify any aspect of the letter; and
- advise of their right to make a complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

3. Where a complaint involves clinical/professional issues, the draft response must be shared by the Assistant Director with the relevant clinicians/professionals to ensure the factual accuracy of the response and to ensure those staff agree with and support the draft response. The relevant Assistant Director is required to approve and return to the relevant Governance Co-ordinator by **day 17**. The Assistant Director is to indicate if they are satisfied with the content of any action and learning plans, the details of which will be captured on the Datix system.

   Should further work be required on the action and learning plan it is the responsibility of the Assistant Director to initiate this within their division and report back to the relevant Governance Co-ordinator.

4. All final responses are to be forwarded to the relevant Lead Director for approval by **day 18**.

   The Lead Director's office is required to issue the response to the complainant by **day 20**, sending the Directorate Governance Team copy of the final signed response. The exception to this are those complaint responses being sent to Elected Representations whereby the Chief Executive will, following approval by the Director, sign the final response and send a signed copy to the Lead Director and relevant Governance Team within **10 working days**. **Responses should not be issued to the complainant electronically.**

5. There is some flexibility built into the above internal timescales to allow investigating officers to complete complex complaint issues and to give the Director signing off more than 24 hours to sign if required. Where there are difficulties in gaining a response from the investigating officer the Governance Co-ordinator will escalate any breaches of the timeframes to the appropriate line manager for further action.

4.3 *Acknowledgement of delays*

Complainants must be given a written explanation of any reason for delay in responding to a complaint and this should happen as soon as it becomes apparent that the Trust will be unable to meet the 20 working days timescale. The relevant Director should be informed of any delay at this stage also.

4.4 *Further Local Resolution beyond 20 working days*

Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain consideration needs to be given to how the remaining issue(s) can be resolved. All complainants will be advised that if they remain unhappy with the Trust's response they should

contact the relevant Governance Team in the first instance to discuss options available or refer their complaint to the Ombudsman. (Please refer to **Appendix 3** for contact details) At this point all complainants should be asked to state clearly which aspect(s) of their complaint remains unresolved. On receipt of this documentation, options may include one or a number of the following:

- Further written response to outstanding issues;
- Meeting with the complainant;
- Local resolution investigation by a second team;
- Conciliation;
- Use of Lay people to assist;
- Use of independent experts.

4.4.1 *Further written response to outstanding issues*

Complainants will be advised in the first response that they should contact the organisation **within 3 months** of the Trust's response if they are dissatisfied with the response or require further clarity. There is discretion for the Governance Co-ordinator to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

The first step of further local resolution should then be that of an offer of a further response to the complainant. This may be in the form of a further written response signed off by the Director(s). This response should be issued **within 20 days** of the complaint being re-opened.

4.4.2 *Meeting with the Complainant*

Offer of facilitation of a meeting with the relevant staff. This will be taken forward by the existing investigation team and chaired by the Head of Service. The relevant Director(s) should be advised of the outcome of the meeting. The notes of the meeting should be agreed upon by all that were present and issued to the complainant. This meeting should take place within **30 days** of a second response being issued.

4.5 *Additional Measures*

In extreme cases where a complainant cannot be satisfied with the response provided along with the facilitation of a meeting and where the Trust has provided further information there are a number of other options available. The decision on which option to be used will be agreed by the lead Director responsible for the management of the complaint and the relevant Governance Co-ordinator, with specific terms of reference and timescales also being agreed. Complainants may wish to include the involvement of the Patient and Client Council in this process and contact

details of this service can be found in ***Appendix 3***. Once agreement is reached upon which option is to be used the decision should be acknowledged with the complainant and additional information should be provided on the option to be used. Options include the following:

- Local resolution investigation by a second team
- Conciliation
- Involvement of Lay Persons
- Involvement of Independent Experts
- Review by an Independent Panel

4.5.1 *Local resolution investigation by a second team*

Local resolution investigation by a second team should examine the initial complaint, response to it and all information gathered in formulating that response. The decision to progress to this option will be taken by the relevant Director(s) in conjunction with the relevant Governance Co-ordinator(s). The local resolution team should be chaired and led by a Manager/Clinician from another service area within the Directorate and have a Manager/Clinician from another Directorate as well as the relevant Governance Co-ordinator. This membership will provide a more detailed response with a measure of independence in responding to the complainant and make best use of Trust resources.

If the complaint progresses to this stage, the following guidelines should be adhered to as best practice.

1. A draft report on findings should be forwarded to the Assistant Director responsible for the service area within **20 days** of the decision to use this option. A copy should be provided to the relevant Governance Co-ordinator.
2. By **day 25** the Assistant Director should have discussed the content of the draft report with the relevant Director and Governance Co-ordinator.
3. A final copy of the findings of the second complaint review team will be sent by the relevant Governance Co-ordinator to the Director for issue to the complainant by **day 30** of the decision to use this option.

4.5.2 *Conciliation*

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to achieve a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but may be helpful in situations where staff feel the relationship with the complainant is difficult and trust has broken down as well as at times where there are ongoing healthcare issues where it is important to

maintain relationships or when there are misunderstandings with relatives during the treatment of a patient.

4.5.3 *Involvement of Lay Persons*

Lay Persons may be beneficial in providing an independent perspective of non-clinical or technical issues within the local resolution process. They are not intended to as act as advocates, conciliators or investigators, and neither do they act on behalf of the Trust or the complainant. The Lay Person's involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. Input from a Lay Person is valuable when testing issues such as communication, quality of written documents, attitudes and behaviours and access arrangements. The relevant Governance Co-ordinator will provide advice regarding the use of Lay Persons should the need arise.

4.5.4 *Involvement of Independent Experts*

The use of an independent expert in the resolution of a complaint may be requested by the complainant at any time; however the Trust reserves the right to accept/decline this request. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution. Input will normally only be required in cases where there are major clinical issues or concerns, but the use of the option may be helpful when it is indicated there may be a risk to patient or public safety or a serious breakdown in relationships which would threaten public confidence in services and damage the Trust's reputation. The relevant Governance Co-ordinator will provide advice regarding the use of Independent Experts should the need arise.

4.5.5 *Review by Independent Panel*

In a small number of cases where complainant is not satisfied with the Trust's response, the Trust may wish to use an independent panel as a final attempt to resolve the complainant issue. This will only be used in extreme cases. An independent panel should be chaired by an operational Assistant Director with the support of an internal independent person (for example professional governance lead, clinical expert, social care expert, etc.) and an external layperson. The panel would be supported by the relevant Governance Co-ordinator.

The panel would be given clear terms of reference and provided with all the relevant information. They may wish to meet with the complainant or individual members of staff to discuss the complaint in detail and to clarify issues raised.

The panel would provide a draft report and action plan to the relevant Director(s) for discussion and issue to the complainant.

The panel may also wish to comment on other issues as they arise. For example, Trust policies and procedures, team practices, line management arrangements, etc. A separate report should be provided to the Director(s) highlighting areas of concern for further action by the Director(s).

4.5.6 *Northern Ireland Commissioner for Complaints (Ombudsman)*

Once all options available to the Trust under local resolution have been exhausted and the complainant remains unsatisfied, the complainant should be advised of the role of the Ombudsman and provided with contact details for same. It is for the Ombudsman to determine whether or not a case falls within that Office's jurisdiction. *For contact details please refer to* ***Appendix 3****.*

4.6 *Joint Complaint Investigations*

Where a complaint relates to the actions of more than one HSC organisation, the *Health and Social Care Trusts Interim Memorandum of Understanding Joint Working Processes for Handling Complaints* should be referred to. The relevant Governance Co-ordinator will advise on this process.

4.7 *Out of Area Complaints*

Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. The Governance Co-ordinator will advise on this process.

HSC contracts include entitlement, by the Trust, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

4.8 *Confidentiality*

Trust staff are aware of their legal and ethical duty to protect the confidentiality of the patient/client's information. The legal requirements are set out in the *Data Protection Act 1998* and the *Human Rights Act 1998*. The common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required of

their personal information is to be disclosed but more detailed information can be found in the HSC guidance entitled *Code Practice on Protecting the Confidentiality of Service User Information*.

When using a patient's personal information for the purpose if investigating a complaint it is not necessary to obtain the patient's express consent. However, care must be taken throughout the process to ensure that patient confidentiality is maintained (particularly when a complaint is made on behalf of another/when contributing to a response lead by another organisation) and any information disclosed is confined to that which is relevant to the investigation and only disclosed to those who have a demonstrable need to know for the purpose of the investigation. Where a complaint relates to the actions of more than one HSC organisation the complainant's consent must be obtained before sharing the details of the complaint across HSC organisation.

Complaint investigations will be conducted with appropriate consideration of the confidentiality due to the staff involved in the complaint.

4.9 *Support and advice for Trust Staff*

Support and advice should be provided to any member of Trust staff involved in either informal or formal complaints by their Supervisor and/or Line Manager at any stage of the process.

Advice and assistance is available to Trust staff at any stage in the complaints process from the Trust's Directorate Governance Teams. *For contact details please refer to* ***Appendix 3****.*

The Trust has selected Carecall as an independent source of support for staff. Carecall staff are trained to listen and can offer support, guidance and a fresh outlook on not only issues at work but also personal problems. This service is free to Trust staff and Carecall are committed to protecting your confidentiality and anonymity. Carecall is available 24 hours a day, 7 days a week, and 365 days a year, please refer to the contact details below.

CARECALL

For free, confidential and immediate support call:

Telephone: 0808 800 002

For further information about the service:
Website: www.carecallwellbeing.com

SECTION FIVE: POLICY FOR HANDLING UNREASONABLE, VEXATIOUS OR ABUSIVE COMPLAINANTS

5.0 *Introduction*

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

This policy aims:

- to make it clear to all complainants, both at initial contact and throughout their dealings with the Trust, what the Trust can or cannot do in relation to their complaint. The Trust aims to be open and not raise hopes or expectations that cannot be met;
- to deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered to be unacceptable. All complainants have the right to be heard, understood and respected, as do Southern Trust staff;
- to provide a service that is accessible to all complainants. However, the Trust retains the right, where it considers the actions of a complainant to be unacceptable, to restrict or change access to the service;
- and to ensure that other complainants and Trust staff do not suffer any disadvantage from complainants who are unreasonable, vexatious and/or abusive manner.

5.1 *Unacceptable Actions*

The Trust defines unacceptable action as the following:

5.1.1 *Aggressive or abusive behaviour*

The Trust understands that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards Trust staff, it will be considered unacceptable. **Any violence or abuse towards Trust staff will not be tolerated**.

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

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

5.1.2 *Unreasonable demands*

The Trust considers these demands become unacceptable when they start to (or when complying with the demand would) impact substantially upon the work of the organisation. An example of such impact would be that the demand takes up an excessive amount of staff time and in doing so disadvantages other complainants. Examples of unreasonable demands include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; or
- repeatedly changing the substance of a complaint or raising unrelated concerns.

5.1.3 *Unreasonable levels of contact*

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

5.1.4 *Unreasonable persistence*

It is recognised that some complainants will not or cannot accept that the Trust is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the Trust persistently about the same issue. Examples of unreasonable persistence include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the Trust can or cannot do and continuing to pursue a complaint without presenting any new information. The war in which these complainants approach the Trust may be entirely reasonable, but it is their persistent behaviour in continuing to do that is not. The Trust consider the actions of persistent complainants to be unacceptable when they take up what the Trust regards as being a disproportionate amount of time and resources.

5.1.5 ***Unreasonable use of the complaints process***

Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about the Trust, with which they have a continuing relationship, if subsequent incidents occur. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the Trust from pursuing a legitimate aim or implementing a legitimate decision. The Trust considers access to a complaints system to be important and it will only be in exceptional circumstances that it would consider such repeated use is unacceptable – but the Trust reserves the right to do so in those exceptional circumstances.

5.2 ***How the Trust manages aggressive or abusive behaviour***

The threat or us of physical violent, verbal abuse or harassment towards Trust staff is likely to result in a termination of all direct contact with the complainant. Trust staff will directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the Trust are only taken after careful consideration by a more senior member staff. Wherever possible, the Trust will give the complainant the opportunity to change their behaviour or action before a decision is taken.

All incidents of verbal and physical abuse will be reported to the police.

The Trust will not accept any correspondence (letter, fax or e-mail) that is abusive to staff or contains allegations that lack substantive evidence. If such correspondence is received by the Trust, we will inform the complainant that we consider their language to be offensive, unnecessary and unhelpful and will request that they refrain from using such language. The Trust will not respond the correspondence if the action or behaviour continues.

Trust staff will end telephone calls if they consider the caller to be aggressive, abusive or offensive. All staff members taking such calls have the right to make this decision.

In extreme situations, the Trust will inform the complainant in writing that their name is on a “no personal contact” list. This means that the Trust will limit contact with the complainant to either written communication or through a third party.

5.3 ***Managing other unacceptable actions***

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

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

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

Where the Trust considers correspondence on a wide range of issues to be excessive, we may inform the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly. In exceptional cases, the Trust will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further. *The Trust will always inform the complainant of what action it is taking and why.*

5.4 ***How the Trust lets people know of its decision to restrict contact***

When a Trust member of staff makes an immediate decision in response to unreasonable behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[4] why a decision has been made to restrict future contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

5.5 ***Appealing a decision to restrict contact***

The Trust believes that it is important that a decision can be reconsiders and it is on this basis that a complainant can appeal a decision to restrict contact. The Trust will only consider arguments that relate to the restriction and **not** to either the complaint made to the Trust or its decision to

[4] This can be supplemented if written communications are not the most appropriate form for the individual.

close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable; or that they will adversely impact on the individual because of personal circumstances. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They will advise the complainant in writing[5] that either the restricted contact arrangements will apply or a different course of action has been agreed.

5.6 ***How the Trust records and reviews decisions to restrict contact***

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

[5] This can be supplemented if written communications are not the most appropriate form for the individual.

SECTION 6: LEARNING FROM COMPLAINTS

6.0 *Reporting and Monitoring*

The Trust has a legal duty to operate a complaints procedure and is required to monitor how we, or those providing care on our behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with the Trust's Governance arrangements and continually monitoring the effectiveness of the Trust's complaints procedures. To ensure good practice the Trust:

- regularly reviews its policies and procedures to ensure they are effective;
- monitors the nature and volume of complaints;
- seeks feedback from service users and staff to improve our services and performance; and
- ensuring that lessons are learnt from complaints and using these to improve services and performance.

The volume of complaints received is regularly monitored within the Trust through the following methods:

- Complaints figures are routinely discussed at Directorate Governance meetings/fora, SMT, the Governance Committee and at the Patient and Client Experience Committee meetings.
- Closed complaints figures are regularly sent to the Health and Social Care Board (HSCB) for consideration.
- A Trust complaints report is compiled annually and details how complaints were received and handled, and what lessons were learnt.

6.1 *Learning*

The Trust aims to manage all complaints received effectively and ensures that appropriate action is taken to address the issues highlighted by complaints. We make sure that lessons are learnt from all complaints so as to ensure the same mistakes do not re-occur within the Trust. Learning takes place at different levels within the Trust, with the individual, the team and the organisation as a whole.

Each Directorate within the Trust is provided with analysis and intelligence on the complaints received to ensure that trends are identified and acted upon.

The Trust will use issues raised through the complaints process as an important source of information for safety and quality improvement. This information will inform learning and development and will feed into the Trust's Governance systems as well as being directly fed back to the staff involved.

Within the Trust it is the responsibility of all Trust Directors, Assistant Directors, Heads of Service

and Senior Managers to utilise the information and trends from their complaints to ensure learning and development and to develop and monitor actions and learning plans.

An annual report is presented to Trust Board, which summarises the complaints we have received, how they were handled, the outcomes and lessons learnt. This is published to the public on the Trust website (www.southerntrust.hscni.net).

Learning is a critical part of the Trust Complaints Procedure and the Trust values complaints and comments as an opportunity to improve services for our patients and clients. It is for this reasons that the Trust continually contributes to and learns from regional, national and international quality improvement and patient safety initiatives, and shares intelligence gained through complaints with other HSC organisations in Northern Ireland, the RQIA and the Ombudsman.

SECTION SEVEN: REVIEW AND IMPLEMENTATION

7.0 *Consultation*

During development, this policy was considered in draft form by the Trust's Governance Co-ordinators and Officers from Acute Services, Older Persons and Primary Care, Children and Young Persons Services and Mental Health and Disability.

The Review of the Policy for the Management of Complaints was informed by focus groups held for service users and Trust staff. These discussions ensured that the reviewed Policy reflected the needs of Trust staff and service users.

7.1 *Approval*

The Policy for the Management of Complaints was presented in final draft and approved by SMT on…

7.2 *Review*

The Trust is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.
The Policy for the Management of Complaints will be reviewed bi-annually.

7.3 *Policy Implementation*

Following approval this policy will be circulated to all Trust staff via Global email.
A copy of the Policy for the Management of Complaints will be placed on the Trust's intranet.

7.3.1 Training and Education

All Trust managers must ensure that their staff have access to this policy, understand its content, and are aware of its aims and purpose immediately upon its release.

Complaints at Point of Service

Complaint is raised by or on behalf of a service

Member of staff who first learns of complaint should respond immediately & directly in an attempt to resolve the matter informally, speedily & appropriately.

IS THE MATTER **RESOLVED**?

YES

If a member of staff has resolved a complaint 'at point of service delivery' they should complete and return all sections on the *Complaints at Point of Source Delivery form.*
(Trust Intranet >Policies & Procedures>Clinical & Social Care Governance)

NO

Formal Complaints Process

The **Formal Complaints** process is instigated. This is also the starting point for anyone who approaches the Corporate Complaints Office directly with their complaint.
The Corporate Complaints Officer will aim to de-escalate and resolve all complaints/enquires at first point of contact with the Corporate Complaints Office.

The Corporate Complaints Officer, Southern Health & Social Care Trust, Trust Headquarters, Craigavon Area Hospital, Portadown, BT63 5QQ
Telephone: 028 3861 4150

Email: complaints@southerntrust.hscni.net

DAY 1: Complaint is sent to the relevant Governance Co-ordinator's office.

DAY 2: Governance Co-ordinator's office to send **ACKNOWLEDGEMENT** of the complaint to the complainant.

INVESTIGATION

DAY 20: Governance Co-ordinator will issue a **RESPONSE** to the complainant.

Complainant Satisfied?

YES

Complaint file is closed.

NO

Assistant Director to consider the following measures: ***Further written response*** to outstanding issues (within 20 days of complaint being re-opened); ***meeting with the complaint*** (within 30 days); enhanced local resolution ***investigation by a second team***; c***onciliation***; use of ***Lay people to assist***; or the use of ***independent experts***.

Complainant Satisfied?

YES

Complaint file is closed.

NO

Where the Trust has exhausted all options available to it and there is no resolution to a complaint the complainant is advised of the procedures for contacting the ***Ombudsman's office.***

Appendix 2

Frequently Asked Questions

"Will my services/care be hindered in making a complaint?"	*No, making a complaint does not affect your rights and will not result in the loss of any services you have been assessed as requiring.*
"Who can make a complaint?"	*Any person can complain about any matter connected with the provision of Trust services. Complaints may be made by:* • *a patient or client;* • *former patients, clients or visitors using Trust services and facilities;* • *someone acting on behalf of existing or former patients/clients (providing they have obtained the patient/client's consent;* • *parents (or persons with parental responsibility) on behalf of a child; and* • *any appropriate person in respect of a patient/client unable by reason of physical or mental capacity to make the complainant himself or who has died, e.g. next of kin.*
"How can I make a complaint?"	*For the Trust it is important that we work closely with service users to find an early resolution to complaints when they arise.* *Initially you may wish to express your concerns to the person who is providing the care/services, or to other members of staff, such as receptionists, clinical/care staff. Every opportunity will be taken to resolve a complaint as close to the source as possible through discussion and negotiation.* *If you do this and are still not satisfied you may wish to express your concerns to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, the Trust advises complainants to address their complaint to the Trust's Corporate Complaints Officer. Complaints may be made verbally or in writing, and will also be accepted via other methods, for example the telephone or electronically (e-mail).*

	Corporate Complaints Officer, ***Southern Health & Social Care Trust,*** ***Trust Headquarter,*** ***Craigavon Area Hospital,*** ***Portadown,*** ***BT63 5QQ*** ***Telephone: 028 3861 4150*** ***Email: complaints@southerntrust.hscni.net*** *When making a complaint it is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint.*
"Why is consent needed?"	*By law confidentiality must be respected at all times and it is for this reason that complaints made by a third party require the consent of the individual involved. Consent is required as the response to the complainant will include personal details about the individual involved.*
"How long does it take until I receive a response to my complaint?"	*The relevant Governance Office will acknowledge receipt of the complaint within 2 working days. This acknowledgement will express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the Trust's attention to the issue.* *After an investigation has been carried out by the relevant Directorate the Trust aims to issue a final response to the complainant within 20 working days of the Trust's receipt of the complaint.* *In the event of the Trust being unable to meet the 20 working day target, which can be due to the complexity of a complaint, the Trust will issue a holding letter to the complainant. If this happens the Trust will remain in contact with the complainant and advise them as to when they should expect a final response in regards to the investigation of their complaint.*

"Who will investigate my complaint?"	*The complaint will be investigated by an investigating team made up of members of staff from within the Directorate where the complaint arose.*
"What if I am not satisfied with my response?"	*Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain, consideration needs to be given to providing enhanced local resolution where practicable. All complainants will be advised that if they should be advised that if they remain unhappy with the Trust's response they should contact the relevant Governance Office to discuss options available. At this point all complainants should be asked to state clearly which aspect(s) of their complaint that they feel remain unresolved. On receipt of this documentation, options may include one or a number of the following:* • *Further written response to outstanding issues;* • *Meeting with the complainant;* • *Enhanced local resolution investigation by a second team;* • *Conciliation;* • *Use of Lay people to assist;* • *Use of independent experts.* *If you are not happy with our response to your complaint, you can contact us again. We will discuss the options available which may assist in resolving any outstanding issues.* *If after this you remain unhappy, you can refer your complaint to the Northern Ireland Commissioner for Complaints (the Ombudsman). The Ombudsman will consider your complaint to determine whether it warrants investigation by the Ombudsman's office.* ***The Ombudsman,*** ***Freepost BEL 1478,*** ***Belfast,*** ***BT1 6BR*** ***Telephone: 0800 34 34 24*** ***Email: ombudsman@ni-ombudsman.org.uk*** ***Website: www.ni-ombudsman.org.uk***

"What if I don't want to make a formal complaint?"	*The Southern Trust is committed to providing a high quality service to all its users. You can help us improve our services by telling us of your experiences. Your views are much appreciated and will be treated in confidence.* *If you do not wish to make a formal complaint you can also make a comment or suggestion, which can be done by completing the 'We Value Your Views' leaflet.* *An Informal complaint can also be made by speaking to a member of staff at the point of service delivery, or by speaking to the Trust's Corporate Complaints Officer.* ***Corporate Complaints Officer,*** ***Southern Health & Social Care Trust,*** ***Trust Headquarters,*** ***Craigavon Area Hospital,*** ***Portadown,*** ***BT63 5QQ*** ***Telephone: 028 3861 4150*** ***Email: complaints@southerntrust.hscni.net***

Appendix 3

Useful Contacts

Southern Trust Contacts	
Corporate Complaints Officer	**Southern Health and Social Care Trust,** **Trust Headquarters,** **Craigavon Area Hospital,** **Portadown,** **BT63 5QQ** **Telephone: (028) 3861 4150** **Email:complaints@southerntrust.hscni.net**
Acute Services Clinical & Social Care Governance Office	**Telephone: (028) 3861 2987**
Children & Young People's Services Clinical & Social Care Governance Office	**Telephone: (028) 3839 8345**
Mental Health & Disability Directorate Clinical & Social Care Governance Office	**Telephone: (028) 3883 3366**
Older People & Primary Care Directorate Clinical & Social Care Governance Office	**Telephone: (028) 3883 3365**
Support & Advocacy Services	
Southern Trust Patient Support Service (Acute Directorate)	**Patient Support Service** **Craigavon Area Hospital** **68 Lurgan Road** **Portadown BT63 5QQ** **Telephone: (028) 3861 2395 / 4285** **Email:PatientSupport.CAH@southerntrust.hscni.net**

	Patient Support Service **Daisy Hill Hospital** **5 Hospital Road** **Newry BT35 8DR** **Telephone: (028) 3083 5070** **Email:PatientSupport.DHH@southerntrust.hscni.net**
Disability Action	**Human Rights Advocate,** **Disability Action's Centre on Human Rights,** **Disability Action,** **Portside Business Park,** **189 Airport Road West,** **Belfast,** **BT3 9ED** **Telephone: (028) 9029 7880** **Textphone: (028) 9029 7882** **Email:humanrights@disabilityaction.org**
Niamh (Northern Ireland Association for Mental Health)	**80 University Street,** **Belfast,** **BT7 1HE** **Telephone: (028) 9032 8474** **Email: info@beaconwellbeing.org**
VOYPIC	**Voice of Young People In Care** **Flat 12, Mount Zion House** **Edward Street** **Lurgan** **BT66 6DB** **Telephone: (028) 3831 3380** **Website: www.voypic.org**
NICCY (Northern Ireland Commissioner for Children and Young People)	**Legal and Investigations Team** **NICCY** **Equality House** **7-9 Shaftesbury Square**

	Belfast **BT2 7DP** **Telephone: (028) 9031 1616** (Monday – Friday: 9:00am to 5:00pm) **Email: listening2u@niccy.org** **Website: www.niccy.org**
Age NI	**Age NI** **3 Lower Crescent** **Belfast** **BT7 1NR** **Telephone: 0808 808 7575** (8:00am to 7:00pm, 7 days a week) **Email: advice@ageni.org** **Website: www.ageni.org/advice**
Patient & Client Council	**Telephone: 0800 917 0222** **Website:www.patientclientcouncil.hscni.net**
Carecall (*Mental Wellbeing at Work*)	**Telephone: 0808 800 002** **Website: www.carecallwellbeing.com**
What to do if you're still not happy?	
Northern Ireland Commissioner for Complaints (the Ombudsman)	**The Ombudsman,** **Freepost BEL 1478,** **Belfast,** **BT1 6BR** **Telephone: 0800 34 34 24** **Email: ombudsman@ni-ombudsman.org.uk** **Website: www.ni-ombudsman.org.uk**
Complaints about Regulated Establishments	
The Regulation & Quality	**The Regulation & Improvement Authority,**

Improvement Authority (RQIA)	**9th Floor Riverside Tower,** **5 Lanyon Place,** **Belfast,** **BT1 3BT** **Telephone: (028) 9051 7500** **Fax: (028) 9051 7501** **Email: info@rqia.org.uk** **Website: www.rqia.org.uk**
Complaints about Family Practitioner Services **(family doctors, dentists, pharmacists, opticians)**	
HSC Board **Complaints Manager**	**Southern LCG,** **Tower Hill,** **Armagh,** **BT61 9DR** **Email: Complaints.hscb@hscni.net**

Southern Health and Social Care Trust

Policy Checklist

Name of Policy:	Policy for the Management of Complaints
Purpose of Policy:	To ensure that Trust staff are informed and aware off the Trust's complaints handling process and to provide service users, patients and clients with the information they require to make a complaint.
Directorate responsible for Policy	Medical Directorate
Name & Title of Author:	Margaret Marshall, Assistant Director, Clinical and Social Care Governance
Does this meet criteria of a Policy?	Yes/
Trade Union consultation?	Not Applicable
Equality Screened by:	Stephen Wallace
Date Policy submitted to Policy Scrutiny Committee:	9th July 2018
Members of Policy Scrutiny Committee in Attendance:	
Policy Approved/Rejected/ Amended	
Policy Implementation Plan included?	
Any other comments:	
Date presented to SMT	
Director Responsible	
SMT Approved/Rejected/Amended	
SMT Comments	
Date received by Employee Engagement & Relations for database/Intranet/Internet	
Date for further review	2 year default

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Policy for the Management of Complaints Version: Reference number/document name:
Supersedes	Supersedes: Policy for the Management of Complaints, June 2013 Description of Amendments(s)/Previous Policy or Version: Reviewed and updated in-line with changes to the Governance structures within the Trust and to ensure continuing compliance with regional complaints procedures.
Originator	Name of Author: Margaret Marshall Title: Assistant Director Clinical and Social Care Governance
Scrutiny Committee & SMT approval	Referred for approval by: Date of Referral: Scrutiny Policy Committee Approval (Date) SMT approval (Date)
Circulation	Issue Date: Circulated By: Issued To: As per circulation List (details below)
Review	Review Date: Responsibility of (Name): Title:

Southern Health and Social Care Trust

Quality Care - for you, with you

Policy for the Management of Complaints

Authors	***Margaret Marshall, Assistant Director Clinical and Social Care Governance***
Directorate Responsible	***Medical Directorate***
Date of Issue	
Review Date	***July 2020***

CONTENTS

SECTION ONE: INTRODUCTION, PURPOSE AND SCOPE

1.0 *Introduction to Policy*

The Policy for the Management of Complaints has been based on *Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*, which was published by the DHSSPSNI on 1st April 2009 (and updated October 2013). The policy also reflects the ongoing regional work with HSC to ensure best practice in the management of complaints.

A separate specific policy and procedure is in place for the management of complaints regarding services to children and young people in accordance with the *Children (NI) Order 1995 Representation and Complaint Procedure*.

1.1 *Policy Statement*

The Southern Health and Social Care Trust (hereafter referred to as the "Trust") believes that patients, relatives and carers have a right to have their views heard and acted upon. The Trust welcomes feedback on all aspects of service and recognises the value of complaints in improving service provision for patients and the public through listening, learning and improving.

1.2 *Purpose and Aims*

The Trust is committed to developing a culture of responsible openness and constructive criticism, and to encouraging all service users to contribute views on all aspects of the Trust's activities. It has introduced this policy to enable service users to raise any concerns they may have at an early stage and in the right way.

The aim of this policy is to:

- Inform staff of the Trust's processes for complaints handling; and
- Provide service users, patients and clients with the information they require to make a complaint.

1.3 *Scope of Policy*

This Policy is applicable to all services provided by the Trust with the following exception for which alternative procedures are already in place: *Children (NI) Order 1995 Representation and Complaints Procedure*.

1.4 *Legislative Compliance, Relevant Policies, Procedures and Guidance*

The *Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009* requires HSC organisations to make arrangements in accordance with the provisions of the directions for

the handling and consideration of complaints. The *Regional Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning* conform to this legislative framework. Trust staff must also take cognisance of relevant professional standards and guidance to their own profession.

The Regulation and Quality Improvement Authority (RQIA) is the independent Health and Social Care regulatory body for Northern Ireland. In its work the RQIA encourages continued improvement in the quality of these services through a programme of inspections and reviews. RQIA have a duty to assess how Health and Social Care bodies handle complaints in light of the criteria drawn down from the standards and regulations laid down by the Department of Health, Social Services and Public Safety.

1.5 *Equality and Human Rights Consideration*

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the *Northern Ireland Act 1998*. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria; no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This policy has been considered under the terms of the *Human Rights Act 1998*, and deemed to be compatible with the *European Convention Rights* contained in that Act.

This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

1.6 *Alternative Formats*

This document is available on request in alternative formats which include large print, audio disc and in other languages to meet the needs of those who are not fluent in English. These formats can be requested from the Corporate Complaints Officer. P*lease refer to* ***Appendix 3*** *for contact details*.

We Value Your Views leaflets, which provide service users/clients with an overview of the Trust's complaints procedures and contact details, is available from the Trust Intranet in large print and other languages (http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html).

SECTION TWO: ROLES AND RESPONSIBILITES

2.0 *Role of the Medical Director*

The Trust Medical Director is responsible for ensuring that our complaints procedure is effective and that our approach ensures that appropriate investigations and actions have been completed before a response sent following the formal investigation of a complaint.

However, the responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance. The Medical Director must maintain an overview of the issues raised in complaints and be assured that appropriate organisational learning has taken place and that action is taken in the light of the outcome of any investigation.

2.1 *Role of the Assistant Director of Clinical and Social Care Governance*

It is role of the Assistant Director of Clinical and Social Care Governance (CSCG) to work with the Trust's operational, executive and corporate Governance Leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness of changing professional, clinical and operational practice in improving the safety and quality of care, which takes due regard of evidence-based practice, lessons learned from reviews, complaints, incidents, accidents and public inquiries, and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priority areas for action.

The Assistant Director of CSCG also ensures that a 'Lessons Learned' strategy and process is in place that identifies learning from clinical and social care incidents, lead the implementation and embedding of learning through co-ordination of agreed actions and integrated support from clinical and social care governance staff and workforce development and training leads, ensuring systems are in place for effective feedback to staff where issues of concern have been raised and actions identified to address same.

2.2 *Role of Executive Directors*

It is the role of the Executive Directors to refer any professional issues, about which they have concerns to the relevant professional body.

2.3 *Role of Operational Directors, Assistant Directors and Heads of Service*

All Operational Directors are responsible and accountable for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. This responsibility also includes the prompt instigation of local investigations at an appropriate level determined by the seriousness of the complaint.

All Operational Directors will endeavour to ensure that those tasked with investigating and responding to complaints, implementing and sharing learning and improvement have the necessary resources, the co-operation of all staff and the support of senior management.

It is the responsibility of all Trust Directors, Assistant Directors, Service Heads and Senior Managers to utilize the information and trends from complaints within their governance processes to ensure learning and improvement, and to develop and monitor action and learning plans in response to issues identified from complaints.

It is the role of an Assistant Director, in complaints where concerns are raised about clinical treatment and care, to share and agree the proposed draft response to the complaint with the relevant clinician prior to it being submitted to the Director for approval.

2.4 ***Role of Line Managers and Front-Line Staff***

Complaints may be made to any member of staff. Staff must be trained and empowered to deal with complaints as they arise. Appropriately trained staff will recognise the value of the complaints process and as a result will welcome complaints as a source of learning. Advice and assistance for staff regarding the handling of complaints is available from the relevant Directorate Governance Team or the Corporate Complaints Officer.

The first responsibility of a staff member who receives a complaint is to ensure that, where applicable, the service user's immediate health and social care needs are being met before taking action on the complaint. Thereafter, the complainant's concerns should be recorded and dealt with rapidly and in an informal, sensitive and confidential manner.

Some complainants may prefer to make their initial complaint to a member of staff who has not been involved in the care provided. In these circumstances, the complaint should be dealt with by an appropriate member of senior staff (i.e. line manager). The Corporate Complaints Officer and Directorate Governance Team are available to support and advise front-line staff on the handling of complaints.

Where a complainant raises a clinical or professional matter an appropriately qualified person should be asked to review it in light of the investigation and advise on accuracy and details prior to the proposed complaint response being finalised.

All staff are required to promote and maintain service user and staff confidentiality and to comply

with the requirements of legislation, for example the Data Protection Act. The need for sensitivity and confidentiality is paramount.

2.5 ***Role of Corporate Complaints Officer***

The Corporate Complaints Officer (CCO) is responsible for providing a first contact for service users, signposting the service users around the organisation, assisting them in problem solving and facilitating them to access and use the Trust's complaints process.

The CCO is also responsible for screening service user contacts and determining if these are enquiries or complaints. The CCO will facilitate either resolution of the enquiry or complaint, or they will help facilitate the complainant in their use of the Trust's formal complaints procedure by directing the complaint to the relevant Directorate Governance Team. The CCO will provide the same support and consideration for those enquiries and complaints from third parties, such as MLAs and the Minister's office. The CCO will alert the Directorate Governance Teams to significant issues at an early stage.

2.6 ***Role of Governance Co-ordinators and Governance Officers***

The Governance Co-ordinators will lead their Directorate Governance Team in ensuring that at each level of the Directorate staff have access to timely, high quality and appropriate information in relation to complaints, and that within each service team this information is being acted upon appropriately in order to mitigate risk, improve quality of care and patient/client safety.

The Governance Co-ordinators will co-ordinate via the Directorate Governance Team the timely and appropriate responses to complaints on behalf of the Directorate. The Co-ordinators will ensure that the complaints process is conducted in accordance with Regional and Trust complaints procedures.

The Directorate Governance Team will:

- Manage all complaints received within their respective Directorates;
- Maintain a comprehensive IT system (Datix) of all complaints received;
- Provide support and advice to staff investigating/responding to complaints;
- Take account of any corroborative evidence available relating to the complaint;
- Identify training needs of staff and ensuring that appropriate programme are organised in conjunction with line managers;
- Provide the Directorate and the organisation with analysis and intelligence on complaints received to ensure that trends are identified as well as appropriate responses to individual complaints;

- Comply with Controls Assurance Standards criteria in respect of complaint management; and
- Be aware of the availability of and advise complainants about:
  - the support available from the Patient Client Council;
  - the role and availability of conciliation, advocacy, independent experts and lay persons; and
  - the Ombudsman/Commissioner for Complaints.

SECTION THREE: MAKING A COMPLAINT

3.0 *What is a complaint?*

The Trust aims to provide the highest possible standard of care and treatment to all service users, at all times, but sometimes things do not always go according to plan. When this happens, it is important for us to put things right quickly.

A complaint is **"an expression of dissatisfaction that requires a response"**.[1] Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments which are really complaints and need to be handled as such.

3.1 *Who can complain?*

Any person can complain about care or treatment, or about issues relating to the provision of health and social care.

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

Complaints may be made by:

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

It is important to note that making a complaint does not affect the rights of the patient/client and will not result in the loss of any services the patient/client have been assessed as requiring.

[1] *Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning* (April 2009)

3.2 *Issues this guidance does not cover*

3.2.1 This Policy for the Management of Complaints does not deal with complaints about:

- private care and treatment or services, including private dental care[2] or privately supplied spectacles; or
- services not provided or funded by the Trust, for example, provision of private medical reports.

3.2.2 Complaints may be raised within the Trust which we need to address, but which do not fall within the scope of this policy. While the Policy for the Management of Complaints does not cover the issues listed below the Trust has in place procedures to ensure that such concerns are dealt with. Such issues include:

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

If any complaint received by the Trust indicates a need for referral under any of the issues above in section 3.3.2, they should immediately be passed to the relevant Directorate Governance Team for onward transmission to the appropriate department. If any aspect of the complaint is not covered by the referral it will be investigated under this Complaints Policy. In these circumstances, investigation under this Complaints Policy will only be taken forward if it does not or will not, compromise or prejudice the matter under investigation under any other process. The complainant will be informed of the need for referral.

While the Trust does not investigate complaints made regarding the Northern Ireland Ambulance Service (NIAS), any complaints received by the Trust in relation to the NIAS will be passed onto the NIAS Complaints Officer.

Complaints received by the Trust in relation to GP practices and services will be passed onto the Complaints Manager at the Health and Social Care Board (HSCB).

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

3.3 *Complaints about Regulated Establishments/Agencies and Independent Service Providers*

On occasions the Trust may make use of Regulated Establishments/Agencies and Independent Service Providers (ISP), e.g. residential nursing homes, domiciliary care providers; to provide services for patients/clients. This form of treatment and/or care is subcontracted to the Regulated Establishment/Agency or ISP and funded by the Trust.

Regulated Establishments/Agencies and ISPs are contractually obliged to have in place appropriate governance arrangements for the effective handling of, management and monitoring of all complaints. This should include the appointment of designated officers of suitable seniority to take responsibility for the management of the in-house complaints procedures, including the investigation of complaints and the production of literature, which is available and accessible to patients/clients, which outline the establishment's complaints procedure. On commissioning of the services it would be good practice if the commissioner (i.e. Trust staff) informs the patient/client and relatives/carers that the Regulated Establishment/Agency or ISP will have a complaints procedure in place.

If a patient/client or relative/carer has a concern or complaint relating to the contracted services provided by a Regulated Establishments/Agency or ISP they should raise the concern/complaint directly with the provider of care in the first instance. However, where complaints are raised with the Trust, the Trust must establish the nature of the complaint and consider how best to proceed. It may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where the complaint raises serious concerns or where the Trust deems it in the public interest to do so.

The Regulated Establishment/Agency or ISP is required to investigate the concern or complaint and provide a written response to the complainant which should be copied to the Trust. If there is a delay in responding to the complainant within the target timescales[3] the complainant will be informed and a revised date for conclusion of the investigation will be provided.

The response letter from the Regulated Establishment/Agency or ISP must advise the complainant that they can progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and who will be responsible for conducting the investigation. The Trust will work closely with the

[3] Under SHSCT complaints procedure a written response should be issued to the complaints within 20 working of the establishment's receipt of the complaint. If the establishment is unable to meet these timescales the complainant should be informed, in writing, as to the reasons why.

Regulated Establishment/Agency or ISP to enable appropriate decisions to be made.

The complainant must also be informed by the Regulated Establishment/Agency or ISP of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the Regulated Establishment/Agency or ISP without Trust participation in local resolution will be referred to the Trust for investigation and action by the Ombudsman.

The Trust has agreed arrangements in place to ensure that Regulated Establishments/Agency or ISPs provide information to annual review meetings relating to all complaints received and responded to directly by them.

It is the role of Trust staff, such as Key Workers, to ensure that patients/clients and relatives/carers are aware of the importance of raising concerns or complaint as close to the source as possible, as this allows for early resolution through discussion and negotiation. The general principle in the first instance therefore would be that the Regulated Establishment/Agency or ISP investigates and responds directly to the complainant.

Should patients/clients or relatives/carers lack confidence in the Regulated Establishments/Agencies or ISPs' complaints handling procedures or are not happy with the response they had received from the provider of care, they can refer their complaint to the Trust's Corporate Complaints Officer so that an investigation can begin. *Contact details for the Trust's Corporate Complaints Officer are listed below.*

Corporate Complaints Officer
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Portadown,
BT63 5QQ

Telephone:
(028) 3756 4600

Email: complaints@southerntrust.hscni.net

The Regulation and Quality Improvement Authority (RQIA) will monitor how complaints are handled and investigated by regulated services and the Trust. *For contact details please refer to* ***Appendix 3****.*

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

Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaint's Manager if he/she does not feel able to approach immediate staff. The HSC Board has a responsibility to record and monitor the outcome of those complaints lodged with them.

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

Please refer to ***Appendix 3*** *for contact details.*

3.5 ***How can complaints be made?***
Complaints can be made to a member of Trust staff at the point of service delivery
It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation, and by following the guidance in section 4.3 of this Policy.

It is important that front-line staff are trained and supported to respond sensitively to the comments and concerns raised by service users and are able to distinguish those issues which would be better referred elsewhere. Staff across the Trust can assess the "Policy for the Management of Complaints" and "Complaints in Health and Social Care: A Need to Know Guide for Staff" through the Trust's Intranet.

Where possible complaints should be dealt with immediately and front-line staff should follow the procedures below in their handling of complaints received at point of service delivery:

1. The complaint is raised by or on behalf of the service user at the point of service delivery.
2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

Where appropriate if the member of staff attempting to resolve the matter feels it would be beneficial to involve a patient's advocate at this stage, they should seek advice from the relevant Directorate Governance Team.

3. If a member of staff has resolved a complaint 'at point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form and return to the Corporate Complaints Officer. A *Complaints at Point of Service Delivery* form can be located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

If the person remains dissatisfied, they should be offered a copy of the Trust's 'We Value Your Views' leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

It is important that if you are in this situation, you ask your supervisor or line manager for assistance, if necessary.

3.5.1 ***Formal Letter of Complaint received at Point of Service Delivery***

If a formal letter of complaint is received by staff at a point of service delivery' it should be sent by email the same day to the Trust's Corporate Complaints Officer so that an investigation can begin. *Please refer to* ***Appendix 3*** *for contact details.*

3.5.2 ***Complaints can be made to the Corporate Complaints Officer***

Complaints may be made verbally or in writing and will also be accepted via other methods such as the telephone (including voicemail) or electronically (e.g. e-mail). It is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint. The Trust is mindful of technological advances and has in place local arrangements which ensure that there is no breach of patient/client confidentiality. Contact details for the Trust's Corporate Complaints Officer are listed below.

3.5.3 ***What information should be included in a complaint?***

A complaint need not be long or detailed, but it should include:	
Relevant Contact Details	✓ Complainants name, address (including postcode) and telephone number ✓ If you are making this comment/complaint on behalf of another person, please provide the following details:

	▪ Their name, their address (including postcode) and their date of birth (if known) ▪ And please indicate your relationship to this person
Who or what is being complained about?	✓ Department/ward/facility where the issues occurred ✓ Hospital site, e.g. Craigavon, Lurgan, Newry, etc. ✓ Include the names of staff, if known
When the events of the complaint happened	✓ Details of the issue(s) relevant to the complaint ✓ Please include dates
Where possible, what remedy is being sought	✓ Such as an apology, an explanation or changes to be made to our services

3.6 *Complaints made by a 3rd Party (including those made by MPs, MLAs and Local Councillors) and Consent*

Confidentiality must be respected at all times and complaints by a third party should be made with the written consent of the patient/client concerned. If consent does not accompany the complaint the Trust will seek consent from the patient/client concerned or their next of kin where necessary. There will be situations where it is not possible to obtain consent, such as:

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

The relevant Governance Team will be able to provide further advice and guidance in relation to this matter. Consent forms can be obtained from the Complaints and User Views section of the Southern Health and Social Trust website.
(www.southerntrust.hscni.net/pdf/Patient_Client_Consent_form_May_2012(2).pdf)
Third party complainants who wish to pursue their own concerns can bring these to the Trust without compromising the identity of the patient/client. The Trust will consider the matter, investigate and address, as fully as possible, any identified concerns. A response will be provided to the third party on any issues which it is possible to address without breaching the patient's/client's confidentiality.

3.7 *Complaints made by staff*

As staff in the Southern Trust, we all have a responsibility to protect our service users, fellow

members of staff, the public and the Trust. If you have a concern as a member of staff about any aspect of the quality and safety of our services, another member of staff or about any of the functions of the Trust, those concerns can be raised as per the Trust's *Whistleblowing Policy*. Staff can access the *Whistleblowing Policy* via the Trust's Intranet (http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/YOURRIGHTTORAISEACONCERNWhistleblowingFramework.pdf)

3.8 *Anonymous Complaints*

If someone approaches the Trust with a complaint we will request their name and contact details. This will enable us to acknowledge their complaint, confirm the issues causing concern and clarify or seek further information and provide information on the outcome of our investigation.

Any request to remain anonymous will be respected as all complaints received by the Trust are treated with equal importance regardless of how they are submitted. However, complaints received with anonymity may mean that a detailed investigation may not always be possible, for example when there is a need to access medical records. Also, a complaint response cannot be issued.

All complaints submitted to the Trust, whether anonymous or not, are viewed as a significant source of learning within the organisation and help us to continue to improve the quality of our services and safeguard high standards of care and treatment. The number of complaints and trends emerging from complaints are continually monitored by each Directorate's Governance meeting and at the Patient/Client Experience Committee meetings.

3.9 *What are the timescales for making a complaint?*

A complaint should be made as soon as possible after the action giving rise to it, normally within **six months** of the event. If a complainant was not aware that there was cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is earlier.
In any case where the Trust has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant will be advised of the options available to him/her to pursue this further.

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

3.10 *Support for complaints*

Some people who wish to complain do not do so because they do not know how, doubt they will be taken seriously or simply find the prospect too intimidating. Support and advocacy services are an important way of enabling people to make informed choices. These services help people gain access to the information they need, to understand the options available to them and to make their views and wishes known.

Inspire Wellbeing NI (Formally ***Northern Ireland Association for Mental Health***) is the largest and longest established independent charity focusing on mental health and wellbeing services in Northern Ireland.. ***Inspire Mental Health*** offers an independent advocacy service which is designed to listen to the compliments, concerns, problems or issues that people may be experiencing whilst using mental health services. An advocate can provide patients/clients with information in relation to the options available to them under four broad areas: clinical, legal, treatment and environment. An advocate will help patients/clients to express any concerns and to pass these on to relevant professionals. Advocates will support the individual to be heard and all discussions will be treated confidentially. *Please see below for contact details.*

Inspire
Central Office
Lombard House
10-20 Lombard Street
Belfast
BT1 1RD
Telephone: (028) 9032 8474
Email: hello@inspirewellbeing.org

In the Southern Health and Social Care Trust, ***Disability Action***'s Centre on Human Rights provides an advocacy service specifically for people with learning disabilities. This service is confidential, provided free of charge and independent. The advocate supports people with learning disabilities to understand their rights and encourages them to speak up if they are unhappy about how they have been treated. The advocate will listen to the person's issue and identify the options available to them and will support the patient/client to take action.

The advocate also provides non-instructured advocacy, when a patient/client cannot give a clear indication of their views or wishes in a specific situation, e.g. when a person has a profound learning disability. In these cases, the advocate works to uphold the person's rights, ensure fair

and equal treatment and access to services and make certain that decisions are taken with due consideration for the patient/client's individual preferences and perspectives. Please see below for contact details.

Human Rights Advocate,
Disability Action's Centre on Human Rights,
Disability Action,
Portside Business Park,
189 Airport Road West,
Belfast,
BT3 9ED

Telephone: (028) 9029 7880
Textphone: (028) 9029 7882
Email: humanrights@disabilityaction.org

VOYPIC (***Voice of Young People in Care***) offers advocacy for children and young people with care experience aged 25 and under. This is a confidential and independent service where children and young people can get advice, information and support outside of Social Services. The service can:

- provide you with information and advice on your rights;
- Go to meetings with a child or young person;
- Help children/young people ask for a service;
- Help children/young people speak out about decisions that affect you; and
- Help children/young people make a complaint.

Please see below for contact details.

Voice of Young People In Care
Flat 12, Mount Zion House
Edward Street
Lurgan
BT66 6DB

Telephone: (028) 3831 3380
Website: www.voypic.org

The **Northern Ireland Commissioner for Children and Young People**'s (**NICCY**) Legal and Investigations team deal with queries and complaints from children, young people, their carers and relevant professionals about the services they receive from public bodies. This team can:

- investigate complaints against public bodies (schools, hospitals, etc) on behalf of children and young people;
- help a child or young person bring their complaint to a public body; and
- help children and young people in legal proceedings against public bodies.

Please see below contact details.

Legal and Investigations Team
Northern Ireland Commissioner for Children and Young People
Equality House
7-9 Shaftesbury Square
Belfast
BT2 7DP

Telephone: (028) 9031 1616
(Monday – Friday: 9:00am to 5:00pm)
Email: listening2u@niccy.org
Website: www.niccy.org

The ***Age NI*** Advice and Advocacy Service offer free, independent and confidential support to older people, their families and carers. The Age NI team provides advocacy support to people experiencing difficulties:

- negotiating the health and social care system
- accessing appropriate levels of community care
- dealing with issues relating to residential and nursing care
- those who have experienced or are at risk of abuse.

Please see below for contact details.

Age NI
3 Lower Crescent
Belfast

BT7 1NR

Telephone: 0808 808 7575
(8:00am to 7:00pm, 7 days a week)
Email: advice@ageni.org
Website: www.ageni.org/advice

The ***Patient Client Council*** (PCC) is an independent non-departmental public body and its functions include:

- representing the interests of the public;
- promoting involvement of the public; and
- providing assistance to individuals making or intending to make a complaint.

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

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

All advice, information and assistance with complaints is provided free of charge and is confidential. *Please see below for contact details.*

Quaker Buildings,
High Street,
Lurgan,
BT66 8BB

Telephone: 0800 917 0222
Email: info.pcc@hscni.net
Website: www.patientclientcouncil@hscni.net

The Trust's Corporate Complaints Officer and Directorate Governance Teams will also be able to offer advice and support complainants and explain the Trust's complaints procedure, as well as attempt to resolve the complaint. *For contact details of these services please refer to* ***Appendix 3****.*

3.11 *Making a compliment*

The staff who provide services do their best to meet your individual expectations and are often working in difficult circumstances. Therefore we are always keen to know when things have worked out well for our patients/clients and what aspect has made a positive experience for them.

Those patients/clients wishing to make a compliment can do so by completing a *We Value Your Views* leaflet and returned to the Trust's Corporate Complaints Officer. Alternatively, you can contact the Corporate Complaints Officer directly to make your compliment. (*Contact details can be found in* ***Appendix 3***) These compliments, which highlight good practice, will be forwarded to the relevant staff and departments.

SECTION 4: HANDLING COMPLAINTS

4.0 *Accountability*

Accountability for the handling and consideration of complaints rests with the Medical Director. The Assistant Director of Clinical and Social Care Governance is the Trust's designated senior person within the organisation who takes responsibility for the local complaints procedure and to ensure compliance with the regulations and that action is taken in light of the outcome of any investigation. All staff within the Trust are made aware off and must comply with the requirement of this complaints procedure. These arrangements ensure the integration of complaints management into the Trust's governance arrangements.

4.1 *Co-operation*

Arrangements are in place within the Trust to ensure a comprehensive response to the complainant and to that end there is necessary co-operation in the handling of complaints and the consideration of complaints between:

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

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

4.2 *Actions on receipt of a complaint*

All complaints received by the Trust are treated with equal importance regardless of how they are submitted. Complainants are encouraged to speak openly and freely about their concerns and are reassured that whatever they have to say will be treated with appropriate confidence and sensitivity. Complainants will be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. On receipt of a complaint the first responsibility of Trust staff is to ensure that the service user's immediate care needs are being met.

The Trust will involve the complainant throughout the consideration of their complaint as this provides for a more flexible approach to the resolution of the complaint. An early provision of information and explanation of what to expect is provided by the Trust to the complainant at the outset to ensure they are informed about the process and of the support that is available.

Each complaint received by the Trust is taken on its own merit and responded to appropriately. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive manner.

4.2.1 *Informal Complaint*

It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation.

Staff across the Trust can access 'Complaints in Health and Social Care: A Need to Know Guide

for Staff' via the Trust's Intranet.

Point of Service Delivery

When a complaint is raised at the point of service delivery staff should follow the procedures laid out below.

1. The complaint is raised by or on behalf of the service user at the point of service delivery.
2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

   Where appropriate if the member of staff attempting to resolve the matter feels it would be beneficial to involve a patient's advocate at this stage, they should contact the advocate directly with the patient/client's consent or seek advice from the relevant Directorate Governance Team.
3. If a member of staff has resolved a complaint 'at the point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

   If the person remains dissatisfied, they should be offered a copy of the Trust's **'We Value Your Views'** leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

   It is important that staff in this situation ask their supervisor or line manager for assistance, if necessary.

Complaints made directly to the Trust's Corporate Complaints Officer

The Corporate Complaints Officer will facilitate either resolution of the complaint or they will facilitate the service user in accessing the Trust's formal complaints procedure.

4.2.2 ***Formal Complaints***

This is the starting point for anyone is dissatisfied with attempts to resolve their complaint at the point of service delivery or any complainant who expects to receive a written (or alternative format) response from the Trust. The complainant should receive a full response within **20 working days** of the Trust's receipt of the formal complaint.

Acknowledgement

1. The Corporate Complaints Officer is to forward the complaint to the relevant Governance Co-ordinator's office within **1 working day**.

2. The relevant Governance Team should clarify the details of the complaint raised directly with the complainant if required and acknowledge their receipt of the complaint within **2 working days**. This acknowledgement should express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the matter to the attention of the Trust. A copy of the regional "*What Happens Next?*" leaflet should be included with the acknowledgment letter.

3. If a complaint is made by a third party (including those made by MPs, MLAs and local councillors) and it refers to an individual's care the matter of knowledgeable and informed consent must be considered.

If consent is required it should be sought from the patient at this point. Investigation of the complaint should be initiated without delay, however a response to specific issues will not be provided unless the consent of the patient is received. (*The 20 working days only starts in these instances on the day in which the consent is received*.)

4. All complaints which occur in the Trust are graded in a standardised manner using the Trust's *Risk Management Strategy*.

5. In the case of complaints which are applicable to more than one directorate, it is best practice for the Governance Team in the directorate where the complaint has first arisen to handle the complaint and seek input from other Directorate Teams where appropriate.

Investigation

1. By **day 2**, Investigating Officer(s) should be given detail of the complaint and advised that they are expected to provide their draft response as well as their action and learning plans, where actions are required following investigation of the complaint, by **day 10**. The names of the staff involved in the complaint, when identified, should be provided to the appropriate Directorate Governance Team.

A copy of the complaint should be forwarded to the Assistant Director responsible for the service area. Where serious governance issues are identified on receipt of the complaint it

must be shared with the relevant Director.

Investigating staff can reference the Trust's 'Investigating Complaints Advice Sheet' for best practice guidance on investigations, which can be accessed via the Trust's Intranet.

Service Managers should bear in mind that staff will often require support if a complaint is received. Support is available from the following sources:

- line management support;
- occupational health;
- Care Call; and
- the relevant Governance Team.

2. The draft response to the complainant is to be validated by the Investigating Directorate Governance Team and then forwarded to the appropriate Assistant Director by **day 15** for approval/amendment.

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

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong – staff should refer to the *Ombudsman's Guidance on Issuing an Apology* (June 2016) which can be found here:
- https://nipso.org.uk/nipso/publications/services-we-offer/n14c-a4-nipso-guidance-on-issuing-an-apology-june-2016/
- report the action taken or proposals to prevent recurrence, where the need for such actions have been identified following investigation of the complaint;
- indicate that a named member of staff is available to clarify any aspect of the letter; and
- advise of their right to make a complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

3. Where a complaint involves clinical/professional issues, the draft response must be shared by the Assistant Director with the relevant clinicians/professionals to ensure the factual accuracy of the response and to ensure those staff agree with and support the draft response. The relevant Assistant Director is required to approve and return to the relevant Governance Co-ordinator by **day 17**. The Assistant Director is to indicate if they are satisfied with the content of any action and learning plans, the details of which will be captured on the Datix system.

Should further work be required on the action and learning plan it is the responsibility of the Assistant Director to initiate this within their division and report back to the relevant

Governance Co-ordinator.

4. All final responses are to be forwarded to the relevant Lead Director for approval by **day 18**.

The Lead Director's office is required to issue the response to the complainant by **day 20**, sending the Directorate Governance Team copy of the final signed response. The exception to this are those complaint responses being sent to Elected Representations whereby the Chief Executive will, following approval by the Director, sign the final response and send a signed copy to the Lead Director and relevant Governance Team within **10 working days**. **Responses should not be issued to the complainant electronically.**

5. There is some flexibility built into the above internal timescales to allow investigating officers to complete complex complaint issues and to give the Director signing off more than 24 hours to sign if required. Where there are difficulties in gaining a response from the investigating officer the Governance Co-ordinator will escalate any breaches of the timeframes to the appropriate line manager for further action.

4.3 *Acknowledgement of delays*

Complainants must be given a written explanation of any reason for delay in responding to a complaint and this should happen as soon as it becomes apparent that the Trust will be unable to meet the 20 working days timescale. The relevant Director should be informed of any delay at this stage also.

4.4 *Further Local Resolution beyond 20 working days*

Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain consideration needs to be given to how the remaining issue(s) can be resolved. All complainants will be advised that if they remain unhappy with the Trust's response they should contact the relevant Governance Team in the first instance to discuss options available or refer their complaint to the Ombudsman. (Please refer to **Appendix 3** for contact details) At this point all complainants should be asked to state clearly which aspect(s) of their complaint remains unresolved. On receipt of this documentation, options may include one or a number of the following:

- Further written response to outstanding issues;
- Meeting with the complainant;
- Local resolution investigation by a second team;
- Conciliation;
- Use of Lay people to assist;

- Use of independent experts.

4.4.1 *Further written response to outstanding issues*

Complainants will be advised in the first response that they should contact the organisation **within 3 months** of the Trust's response if they are dissatisfied with the response or require further clarity. There is discretion for the Governance Co-ordinator to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

The first step of further local resolution should then be that of an offer of a further response to the complainant. This may be in the form of a further written response signed off by the Director(s). This response should be issued **within 20 days** of the complaint being re-opened.

4.4.2 *Meeting with the Complainant*

Offer of facilitation of a meeting with the relevant staff. This will be taken forward by the existing investigation team and chaired by the Head of Service. The relevant Director(s) should be advised of the outcome of the meeting. The notes of the meeting should be agreed upon by all that were present and issued to the complainant. This meeting should take place within **30 days** of a second response being issued.

4.5 *Additional Measures*

In extreme cases where a complainant cannot be satisfied with the response provided along with the facilitation of a meeting and where the Trust has provided further information there are a number of other options available. The decision on which option to be used will be agreed by the lead Director responsible for the management of the complaint and the relevant Governance Co-ordinator, with specific terms of reference and timescales also being agreed. Complainants may wish to include the involvement of the Patient and Client Council in this process and contact details of this service can be found in ***Appendix 3***. Once agreement is reached upon which option is to be used the decision should be acknowledged with the complainant and additional information should be provided on the option to be used. Options include the following:

- Local resolution investigation by a second team
- Conciliation
- Involvement of Lay Persons
- Involvement of Independent Experts
- Review by an Independent Panel

4.5.1 *Local resolution investigation by a second team*

Local resolution investigation by a second team should examine the initial complaint, response to it and all information gathered in formulating that response. The decision to progress to this option will be taken by the relevant Director(s) in conjunction with the relevant Governance Co-ordinator(s). The local resolution team should be chaired and led by a Manager/Clinician from another service area within the Directorate and have a Manager/Clinician from another Directorate as well as the relevant Governance Co-ordinator. This membership will provide a more detailed response with a measure of independence in responding to the complainant and make best use of Trust resources.

If the complaint progresses to this stage, the following guidelines should be adhered to as best practice.

1. A draft report on findings should be forwarded to the Assistant Director responsible for the service area within **20 days** of the decision to use this option. A copy should be provided to the relevant Governance Co-ordinator.
2. By **day 25** the Assistant Director should have discussed the content of the draft report with the relevant Director and Governance Co-ordinator.
3. A final copy of the findings of the second complaint review team will be sent by the relevant Governance Co-ordinator to the Director for issue to the complainant by **day 30** of the decision to use this option.

4.5.2 *Conciliation*

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to achieve a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but may be helpful in situations where staff feel the relationship with the complainant is difficult and trust has broken down as well as at times where there are ongoing healthcare issues where it is important to maintain relationships or when there are misunderstandings with relatives during the treatment of a patient.

4.5.3 *Involvement of Lay Persons*

Lay Persons may be beneficial in providing an independent perspective of non-clinical or technical issues within the local resolution process. They are not intended to as act as advocates, conciliators or investigators, and neither do they act on behalf of the Trust or the complainant. The Lay Person's involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. Input from a Lay Person is valuable when testing issues such as communication, quality of written

documents, attitudes and behaviours and access arrangements. The relevant Governance Co-ordinator will provide advice regarding the use of Lay Persons should the need arise.

4.5.4 *Involvement of Independent Experts*

The use of an independent expert in the resolution of a complaint may be requested by the complainant at any time; however the Trust reserves the right to accept/decline this request. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution. Input will normally only be required in cases where there are major clinical issues or concerns, but the use of the option may be helpful when it is indicated there may be a risk to patient or public safety or a serious breakdown in relationships which would threaten public confidence in services and damage the Trust's reputation. The relevant Governance Co-ordinator will provide advice regarding the use of Independent Experts should the need arise.

4.5.5 *Review by Independent Panel*

In a small number of cases where complainant is not satisfied with the Trust's response, the Trust may wish to use an independent panel as a final attempt to resolve the complainant issue. This will only be used in extreme cases. An independent panel should be chaired by an operational Assistant Director with the support of an internal independent person (for example professional governance lead, clinical expert, social care expert, etc.) and an external layperson. The panel would be supported by the relevant Governance Co-ordinator.

The panel would be given clear terms of reference and provided with all the relevant information. They may wish to meet with the complainant or individual members of staff to discuss the complaint in detail and to clarify issues raised.

The panel would provide a draft report and action plan to the relevant Director(s) for discussion and issue to the complainant.

The panel may also wish to comment on other issues as they arise. For example, Trust policies and procedures, team practices, line management arrangements, etc. A separate report should be provided to the Director(s) highlighting areas of concern for further action by the Director(s).

4.5.6 *Northern Ireland Commissioner for Complaints (Ombudsman)*

Once all options available to the Trust under local resolution have been exhausted and the complainant remains unsatisfied, the complainant should be advised of the role of the

Ombudsman and provided with contact details for same. It is for the Ombudsman to determine whether or not a case falls within that Office's jurisdiction. *For contact details please refer to* ***Appendix 3****.*

4.6 *Joint Complaint Investigations*

Where a complaint relates to the actions of more than one HSC organisation, the *Health and Social Care Trusts Interim Memorandum of Understanding Joint Working Processes for Handling Complaints* should be referred to. The relevant Governance Co-ordinator will advise on this process.

4.7 *Out of Area Complaints*

Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. The Governance Co-ordinator will advise on this process.

HSC contracts include entitlement, by the Trust, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

4.8 *Confidentiality*

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

When using a patient's personal information for the purpose if investigating a complaint it is not necessary to obtain the patient's express consent. However, care must be taken throughout the process to ensure that patient confidentiality is maintained (particularly when a complaint is made on behalf of another/when contributing to a response lead by another organisation) and any information disclosed is confined to that which is relevant to the investigation and only disclosed to those who have a demonstrable need to know for the purpose of the investigation. Where a complaint relates to the actions of more than one HSC organisation the complainant's consent must be obtained before sharing the details of the complaint across HSC organisation.

Complaint investigations will be conducted with appropriate consideration of the confidentiality due to the staff involved in the complaint.

4.9 *Support and advice for Trust Staff*

Support and advice should be provided to any member of Trust staff involved in either informal or formal complaints by their Supervisor and/or Line Manager at any stage of the process.

Advice and assistance is available to Trust staff at any stage in the complaints process from the Trust's Directorate Governance Teams. *For contact details please refer to* ***Appendix 3****.*

The Trust has selected Inspire Workplaces as an independent source of support for staff. Inspire Workplaces staff are trained to listen and can offer support, guidance and a fresh outlook on not only issues at work but also personal problems. This service is free to Trust staff and Inspire Workplaces are committed to protecting your confidentiality and anonymity. Carecall is available 24 hours a day, 7 days a week, and 365 days a year, please refer to the contact details below.

Inspire Workplaces

For free, confidential and immediate support call:

Telephone: 0808 800 002

For further information about the service:
Website: https://www.inspirewellbeing.org/our-services/inspire-workplaces

SECTION FIVE: POLICY FOR HANDLING UNREASONABLE, VEXATIOUS OR ABUSIVE COMPLAINANTS

5.0 *Introduction*

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

This policy aims:

- to make it clear to all complainants, both at initial contact and throughout their dealings with the Trust, what the Trust can or cannot do in relation to their complaint. The Trust aims to be open and not raise hopes or expectations that cannot be met;
- to deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered to be unacceptable. All complainants have the right to be heard, understood and respected, as do Southern Trust staff;
- to provide a service that is accessible to all complainants. However, the Trust retains the right, where it considers the actions of a complainant to be unacceptable, to restrict or change access to the service;
- and to ensure that other complainants and Trust staff do not suffer any disadvantage from complainants who are unreasonable, vexatious and/or abusive manner.

5.1 *Unacceptable Actions*

The Trust defines unacceptable action as the following:

5.1.1 *Aggressive or abusive behaviour*

The Trust understands that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards Trust staff, it will be considered unacceptable. **Any violence or abuse towards Trust staff will not be tolerated**.

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

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

5.1.2 *Unreasonable demands*

The Trust considers these demands become unacceptable when they start to (or when complying with the demand would) impact substantially upon the work of the organisation. An example of such impact would be that the demand takes up an excessive amount of staff time and in doing so

disadvantages other complainants. Examples of unreasonable demands include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; or
- repeatedly changing the substance of a complaint or raising unrelated concerns.

5.1.3 *Unreasonable levels of contact*

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

5.1.4 *Unreasonable persistence*

It is recognised that some complainants will not or cannot accept that the Trust is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the Trust persistently about the same issue. Examples of unreasonable persistence include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the Trust can or cannot do and continuing to pursue a complaint without presenting any new information. The war in which these complainants approach the Trust may be entirely reasonable, but it is their persistent behaviour in continuing to do that is not. The Trust consider the actions of persistent complainants to be unacceptable when they take up what the Trust regards as being a disproportionate amount of time and resources.

5.1.5 *Unreasonable use of the complaints process*

Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about the Trust, with which they have a continuing relationship, if subsequent incidents occur. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the Trust from pursuing a legitimate aim or implementing a legitimate decision. The Trust considers access to a complaints system to be important and it will only be in exceptional circumstances that it would consider such repeated use is unacceptable – but the Trust reserves the right to do so in those exceptional circumstances.

5.2 ***How the Trust manages aggressive or abusive behaviour***

The threat or us of physical violent, verbal abuse or harassment towards Trust staff is likely to result in a termination of all direct contact with the complainant. Trust staff will directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the Trust are only taken after careful consideration by a more senior member staff. Wherever possible, the Trust will give the complainant the opportunity to change their behaviour or action before a decision is taken.

All incidents of verbal and physical abuse will be reported to the police.

The Trust will not accept any correspondence (letter, fax or e-mail) that is abusive to staff or contains allegations that lack substantive evidence. If such correspondence is received by the Trust, we will inform the complainant that we consider their language to be offensive, unnecessary and unhelpful and will request that they refrain from using such language. The Trust will not respond the correspondence if the action or behaviour continues.

Trust staff will end telephone calls if they consider the caller to be aggressive, abusive or offensive. All staff members taking such calls have the right to make this decision.

In extreme situations, the Trust will inform the complainant in writing that their name is on a “no personal contact” list. This means that the Trust will limit contact with the complainant to either written communication or through a third party.

5.3 ***Managing other unacceptable actions***

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

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

- limit contact or telephone calls from the complainant at set times on set days;

- restrict contact to a nominated member of Trust staff who will deal with the future telephone calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact form the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; or
- take any other action which the Trust considers appropriate.

Where the Trust considers correspondence on a wide range of issues to be excessive, we may inform the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly. In exceptional cases, the Trust will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further. *The Trust will always inform the complainant of what action it is taking and why.*

5.4 ***How the Trust lets people know of its decision to restrict contact***

When a Trust member of staff makes an immediate decision in response to unreasonable behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[4] why a decision has been made to restrict future contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

5.5 ***Appealing a decision to restrict contact***

The Trust believes that it is important that a decision can be reconsiders and it is on this basis that a complainant can appeal a decision to restrict contact. The Trust will only consider arguments that relate to the restriction and **not** to either the complaint made to the Trust or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable; or that they will adversely impact on the individual because of personal circumstances. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They will advise the complainant in writing[5] that either the restricted contact arrangements will apply or a different course of action has been agreed.

5.6 ***How the Trust records and reviews decisions to restrict contact***

[4] This can be supplemented if written communications are not the most appropriate form for the individual.
[5] This can be supplemented if written communications are not the most appropriate form for the individual.

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

SECTION 6: LEARNING FROM COMPLAINTS

6.0 *Reporting and Monitoring*

The Trust has a legal duty to operate a complaints procedure and is required to monitor how we, or those providing care on our behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with the Trust's Governance arrangements and continually monitoring the effectiveness of the Trust's complaints procedures. To ensure good practice the Trust:

- regularly reviews its policies and procedures to ensure they are effective;
- monitors the nature and volume of complaints;
- seeks feedback from service users and staff to improve our services and performance; and
- ensuring that lessons are learnt from complaints and using these to improve services and performance.

The volume of complaints received is regularly monitored within the Trust through the following methods:

- Complaints figures are routinely discussed at Directorate Governance meetings/fora, SMT, the Governance Committee and at the Patient and Client Experience Committee meetings.

- Closed complaints figures are regularly sent to the Health and Social Care Board (HSCB) for consideration.
- A Trust complaints report is compiled annually and details how complaints were received and handled, and what lessons were learnt.

6.1 *Learning*

The Trust aims to manage all complaints received effectively and ensures that appropriate action is taken to address the issues highlighted by complaints. We make sure that lessons are learnt from all complaints so as to ensure the same mistakes do not re-occur within the Trust. Learning takes place at different levels within the Trust, with the individual, the team and the organisation as a whole.

Each Directorate within the Trust is provided with analysis and intelligence on the complaints received to ensure that trends are identified and acted upon.
The Trust will use issues raised through the complaints process as an important source of information for safety and quality improvement. This information will inform learning and development and will feed into the Trust's Governance systems as well as being directly fed back to the staff involved.
Within the Trust it is the responsibility of all Trust Directors, Assistant Directors, Heads of Service and Senior Managers to utilise the information and trends from their complaints to ensure learning and development and to develop and monitor actions and learning plans.

An annual report is presented to Trust Board, which summarises the complaints we have received, how they were handled, the outcomes and lessons learnt. This is published to the public on the Trust website (www.southerntrust.hscni.net).

Learning is a critical part of the Trust Complaints Procedure and the Trust values complaints and comments as an opportunity to improve services for our patients and clients. It is for this reasons that the Trust continually contributes to and learns from regional, national and international quality improvement and patient safety initiatives, and shares intelligence gained through complaints with other HSC organisations in Northern Ireland, the RQIA and the Ombudsman.

SECTION SEVEN: REVIEW AND IMPLEMENTATION

7.0 *Consultation*

During development, this policy was considered in draft form by the Trust's Governance Co-ordinators and Officers from Acute Services, Older Persons and Primary Care, Children and Young Persons Services and Mental Health and Disability.

The Review of the Policy for the Management of Complaints was informed by focus groups held for service users and Trust staff. These discussions ensured that the reviewed Policy reflected the needs of Trust staff and service users.

7.1 *Approval*

The Policy for the Management of Complaints was presented in final draft and approved by SMT on TBC

7.2 *Review*

The Trust is committed to ensuring that all policies are kept under review to ensure that they

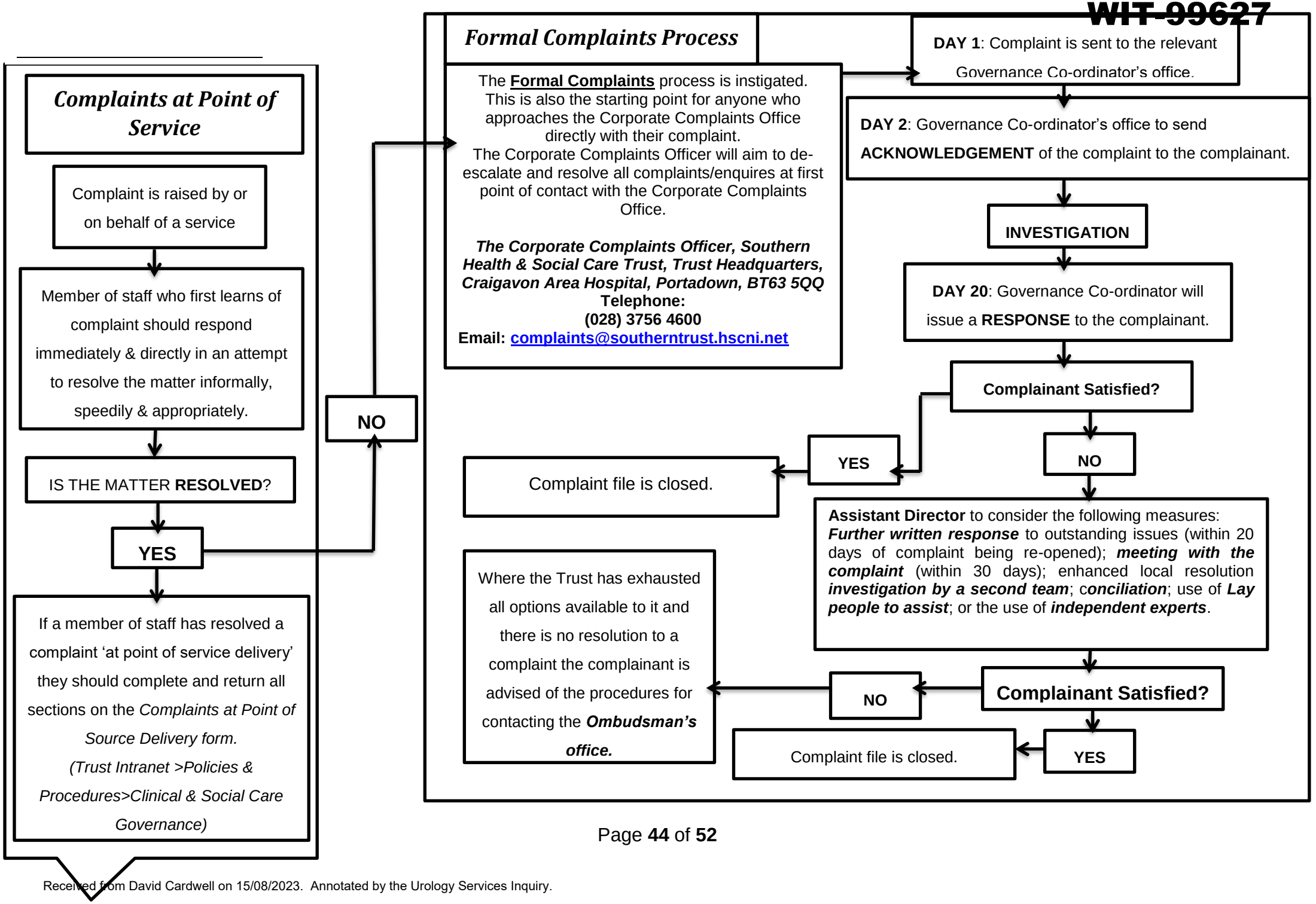
remain compliant with relevant legislation.
The Policy for the Management of Complaints will be reviewed bi-annually.

7.3 *Policy Implementation*

Following approval this policy will be circulated to all Trust staff via Global email.
A copy of the Policy for the Management of Complaints will be placed on the Trust's intranet.

7.3.1 Training and Education

All Trust managers must ensure that their staff have access to this policy, understand its content, and are aware of its aims and purpose immediately upon its release.



Appendix 2

Frequently Asked Questions

"Will my services/care be hindered in making a complaint?"	*No, making a complaint does not affect your rights and will not result in the loss of any services you have been assessed as requiring.*
"Who can make a complaint?"	*Any person can complain about any matter connected with the provision of Trust services. Complaints may be made by:* • *a patient or client;* • *former patients, clients or visitors using Trust services and facilities;* • *someone acting on behalf of existing or former patients/clients (providing they have obtained the patient/client's consent;* • *parents (or persons with parental responsibility) on behalf of a child; and* • *any appropriate person in respect of a patient/client unable by reason of physical or mental capacity to make the complainant himself or who has died, e.g. next of kin.*
"How can I make a complaint?"	*For the Trust it is important that we work closely with service users to find an early resolution to complaints when they arise.* *Initially you may wish to express your concerns to the person who is providing the care/services, or to other members of staff, such as receptionists, clinical/care staff. Every opportunity will be taken to resolve a complaint as close to the source as possible through discussion and negotiation.* *If you do this and are still not satisfied you may wish to express your concerns to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, the Trust advises complainants to address their complaint to the Trust's Corporate Complaints Officer. Complaints may be made verbally or in writing, and will also be accepted via other methods, for example the telephone or electronically (e-mail).*

	Corporate Complaints Officer, ***Southern Health & Social Care Trust,*** ***Trust Headquarter,*** ***Craigavon Area Hospital,*** ***Portadown,*** ***BT63 5QQ*** ***Telephone:*** ***(028) 3756 4600*** ***Email: complaints@southerntrust.hscni.net*** *When making a complaint it is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint.*
"Why is consent needed?"	*By law confidentiality must be respected at all times and it is for this reason that complaints made by a third party require the consent of the individual involved. Consent is required as the response to the complainant will include personal details about the individual involved.*
"How long does it take until I receive a response to my complaint?"	*The relevant Governance Office will acknowledge receipt of the complaint within 2 working days. This acknowledgement will express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the Trust's attention to the issue.* *After an investigation has been carried out by the relevant Directorate the Trust aims to issue a final response to the complainant within 20 working days of the Trust's receipt of the complaint.* *In the event of the Trust being unable to meet the 20 working day target, which can be due to the complexity of a complaint, the Trust will issue a holding letter to the complainant. If this happens the Trust will remain in contact with the complainant and advise them as to when they should expect a final response in regards to the investigation of their complaint.*

"Who will investigate my complaint?"	*The complaint will be investigated by an investigating team made up of members of staff from within the Directorate where the complaint arose.*
"What if I am not satisfied with my response?"	*Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain, consideration needs to be given to providing enhanced local resolution where practicable. All complainants will be advised that if they should be advised that if they remain unhappy with the Trust's response they should contact the relevant Governance Office to discuss options available. At this point all complainants should be asked to state clearly which aspect(s) of their complaint that they feel remain unresolved. On receipt of this documentation, options may include one or a number of the following:* • *Further written response to outstanding issues;* • *Meeting with the complainant;* • *Enhanced local resolution investigation by a second team;* • *Conciliation;* • *Use of Lay people to assist;* • *Use of independent experts.* *If you are not happy with our response to your complaint, you can contact us again. We will discuss the options available which may assist in resolving any outstanding issues.* *If after this you remain unhappy, you can refer your complaint to the Northern Ireland Commissioner for Complaints (the Ombudsman). The Ombudsman will consider your complaint to determine whether it warrants investigation by the Ombudsman's office.* ***The Ombudsman,*** ***Freepost BEL 1478,*** ***Belfast,*** ***BT1 6BR*** ***Telephone: 0800 34 34 24*** ***Email: ombudsman@ni-ombudsman.org.uk*** ***Website: www.ni-ombudsman.org.uk***

"What if I don't want to make a formal complaint?"	*The Southern Trust is committed to providing a high quality service to all its users. You can help us improve our services by telling us of your experiences. Your views are much appreciated and will be treated in confidence.* *If you do not wish to make a formal complaint you can also make a comment or suggestion, which can be done by completing the 'We Value Your Views' leaflet.* *An Informal complaint can also be made by speaking to a member of staff at the point of service delivery, or by speaking to the Trust's Corporate Complaints Officer.* ***Corporate Complaints Officer,*** ***Southern Health & Social Care Trust,*** ***Trust Headquarters,*** ***Craigavon Area Hospital,*** ***Portadown,*** ***BT63 5QQ*** ***Telephone:*** ***(028) 3756 4600*** ***Email: complaints@southerntrust.hscni.net***

Appendix 3

Useful Contacts

Southern Trust Contacts	
Corporate Complaints Officer	**Southern Health and Social Care Trust,** **Trust Headquarters,** **Craigavon Area Hospital,** **Portadown,** **BT63 5QQ** **Telephone:** **(028) 3756 4600** **Email:complaints@southerntrust.hscni.net**
Acute Services Clinical & Social Care Governance Office	**Telephone: (028) 3756 1056**
Children & Young People's Services Clinical & Social Care Governance Office	**Telephone: (028) 3756 3345**
Mental Health & Disability Directorate Clinical & Social Care Governance Office	**Telephone: (028) 3756 3366**
Older People & Primary Care Directorate Clinical & Social Care Governance Office	**Telephone: (028) 3756 3367**
Support & Advocacy Services	
Disability Action	**Human Rights Advocate,** **Disability Action's Centre on Human Rights,** **Disability Action,** **Portside Business Park,** **189 Airport Road West,** **Belfast,**

	BT3 9ED **Telephone: (028) 9029 7880** **Textphone: (028) 9029 7882** **Email:humanrights@disabilityaction.org**
Inspire NI	Central Office Lombard House 10-20 Lombard Street Belfast BT1 1RD **Telephone:** (028) 9032 8474 **Email:** hello@inspirewellbeing.org
VOYPIC	**Voice of Young People In Care** **Flat 12, Mount Zion House** **Edward Street** **Lurgan** **BT66 6DB** **Telephone: (028) 3831 3380** **Website: www.voypic.org**
NICCY (Northern Ireland Commissioner for Children and Young People)	**Legal and Investigations Team** **NICCY** **Equality House** **7-9 Shaftesbury Square** **Belfast** **BT2 7DP** **Telephone: (028) 9031 1616** (Monday – Friday: 9:00am to 5:00pm) **Email: listening2u@niccy.org** **Website: www.niccy.org**
Age NI	**Age NI** **3 Lower Crescent** **Belfast** **BT7 1NR**

	Telephone: 0808 808 7575 (8:00am to 7:00pm, 7 days a week) **Email: advice@ageni.org** **Website: www.ageni.org/advice**
Patient & Client Council	**Telephone: 0800 917 0222** **Website:www.patientclientcouncil.hscni.net**
Carecall (*Mental Wellbeing at Work*)	**Telephone: 0808 800 002** **Website: www.carecallwellbeing.com**
What to do if you're still not happy?	
Northern Ireland Commissioner for Complaints (the Ombudsman)	**The Ombudsman,** **Freepost BEL 1478,** **Belfast,** **BT1 6BR** **Telephone: 0800 34 34 24** **Email: ombudsman@ni-ombudsman.org.uk** **Website: www.ni-ombudsman.org.uk**
Complaints about Regulated Establishments	
The Regulation & Quality Improvement Authority (RQIA)	**The Regulation & Improvement Authority,** **9th Floor Riverside Tower,** **5 Lanyon Place,** **Belfast,** **BT1 3BT** **Telephone: (028) 9051 7500** **Fax: (028) 9051 7501** **Email: info@rqia.org.uk** **Website: www.rqia.org.uk**

Complaints about Family Practitioner Services **(family doctors, dentists, pharmacists, opticians)**	
HSC Board **Complaints Manager**	**Southern LCG,** **Tower Hill,** **Armagh,** **BT61 9DR** **Email: Complaints.hscb@hscni.net**

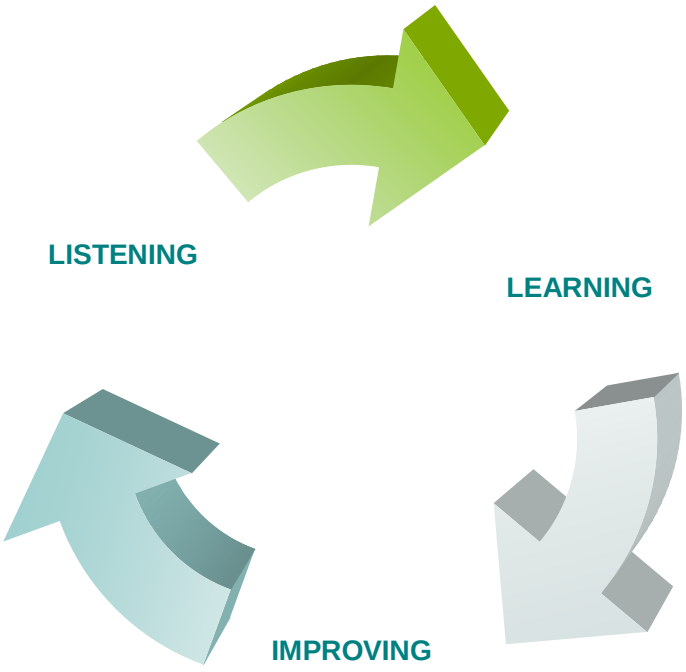
Southern Health and Social Care Trust

Quality Care - for you, with you

Investigating Complaints – Advice Sheet

When something has gone wrong, it is vital to establish the facts about what happened in a systematic way. For serious complaints, it may be necessary to involve an independent investigator, but most complaints will be looked into by someone from the Trust.

Anyone who carries out an investigation should be appropriately trained. This advice sheet sets out some of the issues you might want to consider if you are involved in investigating a complaint.



BE CLEAR ABOUT YOUR ROLE

The role of the investigator is to ascertain the facts relating to a complaint, assess the evidence and report their findings. You may also be asked to make recommendations. As an investigator, you should always aim to be impartial and examine the facts and evidence logically. It is essential to remember that an investigator is neither an advocate for the complainant, nor a spokesperson for the organisation.

BE CLEAR ABOUT WHAT YOU ARE INVESTIGATING

It is important to be clear from the start about what exactly you are investigating.

The following questions can help you define the task:

a) What should have been provided?
   What was expected?
b) What was provided?
   What actually happened?
c) Is there a difference between a) and b)?
d) If the answer to c) is yes, why?
e) What was the impact of d)?
f) What should be done to put things right?
g) What should be done to avoid a recurrence?

UNDERSTAND THINGS FROM THE COMPLAINANT'S PERSPECTIVE

It is important that the Trust understands, things from the complainant's perspective. If appropriate, it is a good idea to talk to the complainant as soon as possible and this is normally done by the Patient/Client Liaison Manager.

An early conversation can:

- Help define the investigation by understanding, from the complainant's perspective, the gap between what happened and what should have happened
- Provide an opportunity to clarify what the complainant would like to see happen and to manage any unrealistic expectations
- Help to obtain any additional information or documentation needed.

CAN YOU REACH ROBUST CONCLUSIONS?

A key question to ask yourself before beginning any investigation is whether you will be able to reach any robust conclusions. For example, if a complaint is solely about something said in a conversation, and there is no record of it or witnesses, reaching a robust conclusion is unlikely. If this is the case you should have a conversation with the Patient/Client Liaison Manager who can advise on alternative investigatory options.

It may also be useful to ask yourself some of the following questions:

- Is the complaint based on a reasonable assessment of what should have been provided by the organisation?
- Will it be possible to establish relevant facts?
- Can an investigation and any subsequent actions achieve what the complainant wants?
- Could any immediate action be taken to resolve the complaint?

PUT IN PLACE A GOOD PLAN

The key to a good investigation is a good plan. A plan will help you to focus on the key issues and highlight any problems early on that may need to be addressed.

Things to consider when making a plan include:

- The three key questions that define your investigation: What happened? What should have happened? What are the differences between those two things?
- The background information essential for understanding the complaint, which included arrangements for gathering and reviewing all information.
- Sorting and mapping the information into an easily understood format, e.g., timeline.
- Identification of problems and analysis.
- Preparation of recommendations and action plan.

TIPS ON OBTAINING EVIDENCE

Documentary evidence is usually the main source of information for an investigator.

When analysing this information, it is a good idea to check whether the evidence is complete, relevant and understandable. If you have any doubts about the above, put the onus on the supplier of the evidence to prove completeness, assure relevance and provide an explanation.

When you do get evidence, it is important to acknowledge the fact, log it and keep it secure.

Almost always, it will be necessary to conduct interviews to get the evidence you need.

To conduct a successful interview, it is important to:

- Understand the needs of the person and the background to the complaint
- Know the questions you want to ask in advance
- Know when specialist support is needed
- Let the interviewee know in advance what you are likely to ask, so they can prepare and explain that you would like to record the conversation with their permission
- Give the interviewee the option of having a witness of their choice present
- Hold the interview in a private place and avoid interruptions

Sometimes a proper understanding of the issues will require a visit to the location(s) in question. Site visits can be a useful way to understand and put into context the other forms of evidence, don't forget to make a note of the visit and any interviews/discussions carried out.

PINPOINT THE AREAS OF DISAGREEMENT

Once you have all the evidence, you can review it to identify all points of agreement and disagreement. It can be useful to summarise these for everyone concerned.

It can be very helpful to the process and constructive to issue a statement of agreement early on. This lets all parties know that there is a basis of agreement to build on. This then allows all attention and resources to be focused on the areas of outstanding disagreement.

When areas of contention have been found, most investigators have three basic choices:

1. To uphold the view of one party because this is clearly supported by the evidence
2. To request additional information to explore the matter further
3. To decide that the available evidence will never be conclusive

The investigation normally works through all the points of contention until they have reached a considered view on every aspect of the complaint.

REACH A CONCLUSION AND MAKE RECOMMENDATIONS

When reaching a conclusion, it is a good idea to run through the questions you used to define the investigation.

When it comes to making any recommendations, it is essential to think about the failures that have led to the complaint. Potential failures include:

- Human error or inappropriate behaviour by a member/members of staff
- The poor application of resources eg too late, incomplete, insufficient prioritisation
- Procedural or administrative problems
- Services not able to deliver the requirement
- The organisation failing to understand or accept its responsibilities

When making recommendations, try to make them practical, proportionate and constructive.

TIPS ON PREPARING YOUR REPORT

The purpose of your report is to record and explain the conclusions you have reached. A good report is likely to be:

- **Complete:** Does the report cover all the relevant aspects of the complaint and address all the required issues?

- **Relevant:** Does everything in the report contribute to an understanding of the conclusions reached by the investigator or explain any recommendations made?

- **Logical:** Does the report present a reasoned and understandable progression from complaint to conclusion?

- **Balanced:** Does the report appear impartial, rooted in fact and measured in tone? Does the report deal with the issue from the viewpoint of the complainant but also establish the right context for the actions of the organisation?

- **Robust:** Does the report make sense and present a coherent argument in support of the investigator's conclusions and recommendation?

A report should not come as a surprise to anyone involved, so it is a good idea to be as open as possible during the investigation.

GIVE STAFF THE CHANCE TO GIVE FEEDBACK

Before the report is finalised, all staff involved should have the chance to give the investigator their views on what they have said. It is important to correct any factual inaccuracies before submission of the report to the Patient/Client Liaison Manager who will be using it to formulate the Trust's response.

COMMON INVESTIGATION PITFALLS

To help you avoid them, here is a list of common investigation pitfalls:

- Poor planning
- Unclear or unachievable objectives
- A lack of objectivity/impartiality
- A reliance on unproven assumptions and/or unsubstantiated evidence
- Not following the proper processes
- A failure to obtain all the relevant evidence available
- Poor analysis
- Poor investigation documentation and data management
- Poor communication, especially in relation to explaining the investigative process and in managing unreasonable expectations
- A failure to ensure appropriate support for the staff involved
- A failure to control unacceptable or unreasonable behaviour
- A failure to present conclusions in a clear and logical manner
- Making unrealistic recommendations

TIP FOR SUCCESS

At the heart of every successful investigation is the application of a logic that takes the reader on an understandable journey, from the complaint to the conclusion and, where appropriate, on to the recommendations.

Southern Health and Social Care Trust

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Investigating Complaints & User Views

Advice Toolkit for Staff

February 2015

LISTENING – LEARNING – IMPROVING

Complaints are a valuable source of information about how service users interact with the services we provide. The quality and type of services we provide is very important to us. We aim to continually improve in all areas and it is often people who have experienced or observed our services who can help us to learn and improve by sharing their experiences. The Trust uses issues raised through the complaints process as an important source of information for safety and quality improvement.

1. GETTING THE INITIAL CONTACT RIGHT

When someone does complain, the first contact is crucial in setting the right tone and helping to ensure that a positive outcome is reached for everyone.

Key things to take into consideration include:

- Please give your name.
- Take the person's name and use it during the conversation.
- Listen carefully and maintain eye contact.
- Find out the nature of the problem.
- Be helpful, understanding and sensitive.
- Ask yourself if there is anything you can do to help immediately, aim to help the person and resolve the issue 'at the point of service delivery'.
- Acknowledge the complainant's concern and apologise if an error has occurred.
- Ask what they would like to happen as a result of the complaint and be honest right from the outset (explaining why) if their expectations are not feasible or realistic;
- Maintain confidentiality. Don't discuss matters in front of others.
- Discuss the matter with your line manager.

TOP TIP

Make sure that your staff are equipped to know how to handle complaints and defuse challenging situations.

Please provide all staff with a copy of our Complaints & Users Views in Health and Social Care Need to Know Guide for Staff leaflet.

Available on Trust Intranet >Policies & Procedures > Clinical & Social Care Governance>Complaints

2. BE CLEAR ABOUT YOUR ROLE

The role of the investigator is to ascertain the facts relating to a complaint, assess the evidence and report their findings. You may also be asked to make recommendations. As an investigator, you should always aim to be impartial and examine the facts and evidence logically. It is essential to remember that an investigator is neither an advocate for the complainant, nor a spokesperson for the organisation.

3. BE CLEAR ABOUT WHAT YOU ARE INVESTIGATING

It is important to be clear from the start about what exactly you are investigating. The following questions can help you define the task:

a) What should have been provided?
What was expected?

b)What was provided?
What actually happened?

c)Is there a difference between a) and b)?

d)If the answer to c) is yes, why?

e)What was the impact of d)?

f)What should be done to put things right?

g)What should be done to avoid a reoccurrence?
What have we learnt from this?

Keep in mind what the complainant is looking for and what is a reasonable, achievable outcome.

4. EARLY RESOLUTION - UNDERSTAND THINGS FROM THE COMPLAINANT'S PERSPECTIVE

It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation.

Following initial investigation if you feel a formal complaint can be resolved or de-escalated prior to investigation and response please endeavour to do so.

If you have successfully resolved a complaint please remember to inform your Directorate Governance Office who will amend and close the complainants record on Datix.

5. PUT IN PLACE A GOOD PLAN

The key to a good investigation is a good plan. A plan will help you to focus on the key issues and highlight any problems early on that may need to be addressed.

Things to consider when making a plan include:

• The five key questions that define your investigation: What happened? What should have happened? What are the differences between those two things? What should be done to avoid reoccurrence? What have we learnt from this?

• The background information essential for understanding the complaint, which included arrangements for gathering and reviewing all information.

• Sorting and mapping the information into an easily understood format, e.g., timeline.

• Identification of problems and analysis.

• Preparation of recommendations and action plan.

6. BE AWARE OF TIMESCALES

For Formal HSC Complaints, each complainant should receive an acknowledgement to their complaint within 2 working days. A full response should be issued to the complainant by 20 working days.

*The Chief Executive requests that all Elected Representative correspondence be responded to within **10 working days**.*

If consent is required, your Directorate Governance Office will request this from the relevant person (e.g. patient/client/next of kin). Investigation of the complaint should be initiated without delay unless your Directorate Governance Office advises of exemptions to the HSC complaints procedure.

During your investigation if you become aware that you will be unable to meet the 20 working day timescale please inform your Directorate Governance Office so a written explanation can be issued to the complainant.

Please refer to Appendix 1 - *Complaints Handling Timeline.*

7. TIPS ON OBTAINING EVIDENCE

Documentary evidence is usually the main source of information for an investigator. When analysing this information, it is a good idea to check whether the evidence is complete, relevant and understandable. If you have any doubts about the above go back to the supplier of the evidence.

It may be necessary to conduct interviews to get the evidence you need. Interviews should be conducted promptly, before memories of the incident/event in question fade. The objective of the interview is to establish the facts and the full circumstances behind the incident/event. **Confidentiality must be maintained during the investigation process.**

To conduct a successful interview it is important to:

- Arrange a private space for interviews, set aside enough time, and make sure that there are no interruptions.
- Inform the interviewee of the areas of the complaint that you want to discuss with them
- Think about what you need to find out to establish the facts of the matter
- Plan and structure your questions – do not use closed questions
- Avoid confrontational language when devising your questions
- Be clear about the purpose of interview notes
- Remind the interviewee that they can be accompanied by an advisor
- Advise the interviewee that before the report is finalised they will have the chance to give their views on what has been said

Staff Support

Service Managers should bear in mind that staff will often require support if a complaint is received. Support is available from the following sources:

- **line management support;**
- **occupational health;**
- **Care Call; and**
- **the relevant Directorate Governance Team.**

Remember - Staff Feedback

Before the report is finalised, all staff involved should have the chance to give the investigator their views. It is important to correct any factual inaccuracies before submission to the Directorate Governance Offices.

8. REACH A CONCLUSION AND MAKE RECOMMENDATIONS

When reaching a conclusion, it is useful to review the investigation from the beginning of the journey by reconsidering the complaint issues and evaluating the evidence you have analysed.

When it comes to making any recommendations, it is essential to think about the factors that have led to the complaint. Potential factors may include:

•Human error or inappropriate behaviour by a member/members of staff
•The poor application of resources e.g. too late, incomplete, insufficient prioritisation
•Procedural or administrative problems
•Services not able to deliver the requirement

When making recommendations, try to make them practical, proportionate and constructive. Conclusions & recommendations must be supported by evidence gleaned during the investigation.

9. TIPS ON PREPARING YOUR RESPONSE

The purpose of your response is to explain the conclusions you have reached following your investigation, apologise if necessary and make the complainant aware of any recommendations or learning points.

A good response is likely to be:

- •**Complete**: Does the response cover all the relevant aspects of the complaint and address all the required issues?
- •**Relevant**: Does everything in the response contribute to an understanding of the conclusions reached by the investigator or explain any recommendations made?
- **Balanced:** Does the response appear impartial, rooted in fact and measured in tone? Does the report deal with the issue from the viewpoint of the complainant but also establish the right context for the actions of the organisation?
- **Robust:** Does the response make sense and present a coherent argument in support of the investigator's conclusions and recommendation?

A response should not come as a surprise to anyone involved, so it is a good idea to be as open as possible during the investigation.

10. WRITING A 'FIT FOR PURPOSE' RESPONSE

The response should be clear, accurate, balanced, simple and easy to understand.

It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should;

- Include an apology where things have gone wrong; consider that an apology may need to be offered to the complainant for how they felt following interaction with our services (***See below 'Offering an Apology'***).
- Briefly summarise the complaint issues in order to respond to each concern in context
- Fully address each concern expressed by the complainant point by point and show that each element has been fully and fairly investigated; If some points are not addressed, explain why
- State your conclusions of the investigation based on the evidence. Address any conflicting evidence or lack of evidence. Make sure your decision based on your investigation is clear.
- Inform the complainant of any actions you will take as a result of the complaint and of the lessons learnt.
- Indicate that a named member of staff is available to clarify any aspect of the letter; advise of their right to make a complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

Each complaint response should be individual to the complainant. Your Directorate Governance Office will advise you in respect of acknowledgement and response templates. Examples of 'Fit for Purpose' Trust Complaint Responses can be found in Appendix 2.

Offering an Apology

In many cases an apology and explanation may be a sufficient and appropriate response to a complaint. ***The value of this approach should not be underestimated.***

- **Remember an apology is not an admission of liability** (Compensation Act 2006)

A prompt acknowledgement and apology, where appropriate can often prevent the complaint escalating. It can help restore dignity and trust and can be the first step in putting things right.

Staff should refer to the Ombudsman s Guidance on Issuing an Apology (May 2011) which can be found by clicking here:

Top Tips for Investigating and Responding to Complaints

Do	Avoid
❖ Try to be sensitive as well as objective; complainants may be writing at a time of grief and shock but that doesn't make their concerns invalid or unfair as a result ❖ Aim for early resolution – if you feel a complaint can be resolved/deescalated i.e. by a telephone call or meeting please endeavour to do so ❖ Put a good plan in place; Ask yourself What happened? What should have happened? What are the differences between those two things? What should be done to avoid reoccurrence? What have we learnt from this? ❖ Keep in mind what the complainant is looking for and what is a reasonable, achievable outcome. ❖ Apologise if something went wrong or for how the complainant felt following interaction with our services ❖ Fully address each concern point by point in your response ❖ Act proportionately; for more serious complaints you might want to think about more extensive action such as involving the complainant through a meeting ❖ Challenge your colleagues' response if they are weak, inconsistent, or do not make sense	❖ Getting key facts wrong or making assumptions ❖ Being defensive ❖ Regurgitating the complainant's issues or timeline of events in your response. Complainants know why they have complained and the series of events surrounding their interaction ❖ Skating over missing information. The complainant should not have to ask further questions to be satisfied that the response is as comprehensive as it can be

Using Complaints to Drive Improvements

User feedback informs learning and development and is fed into the Trust s governance systems as well as being directly fed back to staff involved. Within the Trust it is the responsibility of all Trust staff to utilise the information and trends from their complaints to ensure learning and development and to monitor learning. Regular analysis of complaint reports are shared at Senior Management Governance meetings, Governance Committee meetings and Directorate meetings to highlight themes and trends across the Trust to ensure improvement and learning takes place.

Being honest about, and receptive to, feedback means reflecting on what improvements can be made to the services we offer. As a manager/investigator it is important to:

- **Review complaints reports for your service area**
- **Identify any patterns, themes or trends across that area**
- **Work with staff members to identify problem areas and improve quality; and**
- **Help monitor and evaluate actions implemented in response to complaints**

Clinical & Social Care Governance Contact Details

Should you have any queries please do not hesitate to contact your Directorate Governance Team

Corporate Governance Team

Tel No: [redacted]

Mental Health & Learning Disability Governance Team

Tel No: [redacted]

Older People & Primary Care Governance Team

Tel No: [redacted]

Children's & Younger Peoples Services Governance Team

Tel No: [redacted]

Acute Services Governance Team

Tel No: [redacted]

Received from David Cardwell on 15/08/2023. Annotated by the Urology Services Inquiry.

Appendix 1 - Complaints Handling Timeline

DAY 1	Corporate Complaints Officer is to forward the complaint to the relevant Governance Co-ordinator's office
DAY 2	**Directorate Governance Teams** ➢ The relevant Governance Team should clarify the details of the complaint raised directly with the complainant if required and acknowledge their receipt of the complaint. ➢ If consent is required it should be sought from the patient/client/next of kin at this point. Investigation of the complaint should be initiated without delay unless exemptions as per HSC Complaints Procedure are met. **A copy of the complaint should be forwarded to the Assistant Director responsible for the service area and copied to the Director.** **Investigating Officers** ➢ Investigating Officer(s) should be given detail of the complaint and advised that they are expected to provide their draft response as well as their action and learning plans, where actions are required following investigation of the complaint, by **day 10**. The names of the staff involved in the complaint, when identified, should be provided to the appropriate Directorate Governance Team.
DAY 15	**Directorate Governance Team** The draft response to the complainant is to be validated/amended by the relevant Directorate Governance Team and then forwarded to the appropriate Assistant Director for approval/amendment.
DAY 17	**Assistant Director** ➢ Where a complaint involves clinical/professional issues, the draft response must be shared by the Assistant Director with the relevant clinicians/professionals to ensure the factual accuracy of the response and to ensure those staff agree with and support the draft response. ➢ The relevant Assistant Director is required to approve and return the response to the relevant Governance Co-ordinator. The Assistant Director is to indicate if they are satisfied with the content of any action and learning plans, the details of which will be captured on the Datix system.
DAY 18	All responses are to be forwarded to the relevant Lead Director for final approval.
DAY 20	The Lead Director's office is required to issue the response to the complainant, sending the Directorate Governance Team a copy of the final signed response.

Minister/Elected Representatives

Directorate Governance Office will begin investigation with aim of completion within 10 working days. Once consent is received and the response has been approved by the relevant Director, the Directorate Governance Office will forward response(s) to the Chief Executive's office for approval and signature. *Letters should be appropriately addressed to those eligible to receive following consent.*

If the Chief Executive wishes to make changes the letters will be returned to the Directorate Governance office to make changes and then returned to Chief Executive for signature and release.

If the investigation requires longer than 10 days to complete the Minister/MLA/Patient will be informed by the Directorate Governance Office

Southern Health and Social Care Trust

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Appendix 2

An example of a response to family feedback

Our Ref:

<Date>

PRIVATE & CONFIDENTIAL

<Complainants Address Details>

Dear <name>

Thank you for taking the time to write to me regarding your sister and your families experience of our services during her recent admission to <location>. I apologise unreservedly that your family's experiences of our services in relation to your Sister <name> treatment and care were not of the standard which we aspire to. I appreciate the balanced feedback which you provided to me regarding your family's experience.

As a Trust we are committed to the continuous improvement and development of our services, and receiving feedback such as yours is critically important to this process. Presently within <Directorate/Service area> there are several projects ongoing which focus on improving how we care for those with <…>.

In order to ensure that experiences such as <name> and your family's are considered within these work streams we would be grateful if you would consider an invitation to a meeting with <Name & job position> to reflect on your experience further. This would also provide an opportunity for us to provide you with some assurance that areas of improvement are underway.

I would like to take this opportunity to further thank you for your honest and dignified feedback from your family experience. I am always open to receiving such valuable information to improve our services and care, and if in the future you feel that you have further feedback on your family's experience of our services, please do not hesitate to contact <insert details>

Yours sincerely

Southern Health and Social Care Trust

Quality Care - for you, with you

An example of a response following a meeting with complainant

Our Ref:

<Date>

PRIVATE & CONFIDENTIAL

<Complainants Address Details>

Dear <name>

Firstly, can I thank you again for taking time to meet with myself and <insert name> on the <date>. I appreciate the balanced feedback which you provided to me regarding your family's experiences of our services. As a Trust we are committed to the continuous improvement and development of our services, and receiving feedback such as yours is critically important to this process.

I apologise unreservedly that your experiences of our services in relation to your father's treatment and care, the support which your Mother and yourself were provided with following your fathers' discharge from hospital, and the management of your complaint were not of the standard which we aspire to. I trust you will have been somewhat assured during our discussions that areas of improvement are underway, and learning from your family's experience is being shared across the organisation.

We also discussed your variable experience of our <Service name> Service in two different settings, and I advised you of our future plans for <Service name> Services. You indicated that you would be interested in receiving a copy of our consultation document and I enclose a copy for your information. I hope that the content will provide you with some assurance that we are committed to further improving stroke services in the future.

I would like to also take this opportunity provide you with an update on the areas we had discussed at our meeting:

- Regarding the issue of nursing staff not displaying their name badges, the overlap in information sought from yourself throughout your father's admission and the mishandling of your fathers dietary requirements; I have directed <name> to ensure that all the above are discussed with the <Directorate name> Directorate Senior Management Team to ensure the learning from your family's experience is shared with frontline staff to improve services.

- You had raised concerns over the Trust handling of your complaint, particularly in relation to timescales of responses, the location of your meeting with Trust representatives and the Trust response to your concerns. You have kindly agreed that your complaint and experience could be shared in an anonymised format at a workshop planned to support and equip staff to further develop the skills required to manage complaints. I thank you for this and it is planned that the workshop will take place in October 2014.

- I have shared the relevant aspects of your complaint with <name & position>, in respect to your family's experience with your father's transportation home from hospital.

- You had also raised concerns relating to the communication and information you received from our <service/team name>; as agreed <name> has shared your experience with <name & job title>.

I would like to take this opportunity to further thank you for your honest and dignified feedback from your family experience. I am always open to receiving such valuable information to improve our services and care, and if in the future you feel that you have further feedback on your family's experience of our services, please do not hesitate to contact <name & contact details>.

Yours sincerely

Southern Health and Social Care Trust

Quality Care - for you, with you

An example of a response where a complainant has exhausted the Trusts complaints process

Our Ref:

<Date>

PRIVATE & CONFIDENTIAL

<Complainants Address Details>

Dear <name>

Thank you for your letter which I received on the <date>. I understand you met with <name & job title> on the <date> in the hope that the areas you raised in your complaint could be resolved, I regret that all of your areas of concern were not resolved at this time and in view of this, I understand that <name> has provided you with additional information and contacts for the Northern Ireland Ombudsman's Office for your consideration as a means of providing you with support and advice concerning your complaint.

I am sorry to read in your letter that you have lost confidence in our complaints department and I am disappointed that we have been unable to resolve your complaint through our Trust complaints processes. However I would like to assure you that the Trust is committed to working in partnership with the Ombudsman in order to bring you complaint to a resolution should you which to avail of the support of his office.

Can I take this opportunity to again offer you my sincere apologies that we have been unable to resolve your complaint through our Trusts complaints procedures.

Yours sincerely

Southern Health and Social Care Trust

Quality Care - for you, with you

An example of a response informing complainant of actions taken as a response to their complaint

Our Ref:

<Date>

PRIVATE & CONFIDENTIAL

<Complainants Address Details>

Dear <name>

Thank you for making contact with the Trust's Corporate Complaints Officer on <date>, during which you lodged a complaint in relation to <summary of complaint>

I can advise that your complaint has been fully investigated by <Name & Job title> and I am now in a position to provide you with a response.

I am informed that <patient's name> was admitted to <ward/clinical area> in <hospital site> with <medical condition> on <date>. On the morning of <patients name> discharge on <date>, I am advised that <patients name> was reviewed by <Name>, <job title> with the discharge plan for <patients name> to attend <Clinic name> within 6 months of discharge.

Upon investigation of your complaint I would like to apologise that it was not made clear to <job title/department> to proceed to make an appointment for <patients name> to attend <Clinic name>, as there was no note on the front of <patients name> chart to indicate that an appointment was required. I can advise that a proforma has now been developed for future referrals to <clinic name> and will avoid and future delays in the referral process.

I am advised that an appointment was made for <patients name> to attend the <clinic name> on <date & time>.

I hope that this response addresses the issues which you have raised, however if you remain dissatisfied with the trust response or have any further issues please do not hesitate to contact <Directorate Governance Office details>.

Should you remain dissatisfied at the end of the complaints process, you can then refer your complaint to the NI Commissioner for Complaints (the Ombudsman) at the following address, Freepost BEL 1478, Belfast, BT1 6BR or Freephone: 0800 34 34 24 or email ombudsman@ni-ombudsman.org.uk. Further information on the role of the NI Ombudsman can be found at www.ni-ombudsman.org.uk. Please note that the Ombudsman will not normally accept your complaint until the complaints process with the Trust has been exhausted.

Southern Health and Social Care Trust

Quality Care - for you, with you

An example of a response following resolution/de escalation

Our Ref:

<Date>

PRIVATE & CONFIDENTIAL

<Complainants Address Details>

Dear <name>

Thank you for contacting the Trust's Corporate Complaints Department on <date>, in which you raised concern about the delay in your daughter <patients name> being seen for <…> assessment. I can assure you that your complaint has been fully investigated by <Name & Job title>.

I am advised that upon receipt of your concern, <Name & Job title> made telephone contact with you on <date> to discuss your concerns and explain his assessment of <patient's name>. <Name & Job title> has advised that he has agreed to review <patient's name> in <date> to ensure that <patient's name> is otherwise well.

<Name> assured you that if there are any significant concerns at that time that he will contact the <Department name> to arrange for an urgent assessment.

I hope that this response addresses the issues which you have raised, however if you remain dissatisfied with the trust response or have any further issues please do not hesitate to contact <Directorate Governance Office details>.

Southern Health and Social Care Trust

Quality Care - for you, with you

An example of a response to a complex complaint offering complainant the opportunity of a meeting

Our Ref:

<Date>

PRIVATE & CONFIDENTIAL

<Complainants Address Details>

Dear <name>

I refer to your complaint which was received on <date> in which you expressed concern regarding your last contact with <service/department name>. Thank you for taking the time to highlight your concerns and for providing the Trust with the opportunity to address the same.

On receipt of your complaint I asked <name & job title> and <name & job title> to investigate the concerns you had raised.

I wish to apologise for the distress caused by your recent experience of the <department/service name> service and for the delay in responding to your complaint. There has been a delay as the investigation is still on-going. However, I am aware that <name & job title> has spoken with you on the telephone and listened to your concerns. I would like to assure you that the Trust is taking them very seriously.

When the investigation is concluded senior staff would be happy to meet with you to discuss the outcome of the investigation. However, if you do not wish to meet with the Trust when the investigation has concluded a written response can be posted to your home address.

I would be most grateful if you could contact <name> <Directorate Governance team name> on <contact details> to advise how you wish to proceed.

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

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

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

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

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

ARRANGEMENT OF DIRECTIONS

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

PART I

CITATION, COMMENCEMENT, INTERPRETATION AND APPLICATION

Citation and commencement

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

Interpretation

2. In these Directions —

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

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

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

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

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

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

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

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

"disciplinary proceedings" means —

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"relevant person" means—

(a) a patient or a client;

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

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

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

"relevant HSC body" means the HSC body which —

(a) provides the care;

(b) has the duty to provide the care;

(c) takes the action, omission or decision,

which is the subject of the complaint.

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

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

(a) The Northern Ireland Blood Transfusion Service.

Application of Directions

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

PART II

HANDLING AND CONSIDERATION OF COMPLAINTS BY HSC BODIES

Requirements to make arrangements

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

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

(a) that the complaints procedure is accessible;

(b) that complaints are dealt with efficiently;

(c) that complaints are properly investigated;

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

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

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

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

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

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

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

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

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

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

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

General duty to co-operate

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

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

(b) the RQIA; and

(c) the NI Commissioner for Complaints.

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

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

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

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

Responsibility for arrangements and complaints manager

6.—(1) Each HSC body must appoint—

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

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

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

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

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

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

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

No investigation of complaint

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) these Directions; or

(ii) former Directions.

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

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

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

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

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

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

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

PART III

THE INITIAL COMPLAINT

Requirement to deal with the complaint

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

(a) by a person specified in paragraph 9;

(b) in the manner specified in paragraph 10;

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

(d) within the period specified in paragraph 11.

Person who may make a complaint

9.—(1) A complaint may be made by —

(a) a relevant person; or

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

(i) has died;

(ii) is a child;

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

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

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

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

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

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

Making a complaint

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

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

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

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

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

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

Time limits

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

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

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

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

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

whichever is the sooner.

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

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

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

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

Acknowledgement and record of complaint

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

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

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

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

Investigation

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

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

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

Response

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

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

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

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

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

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

(7) Responses should not be made electronically.

PART IV

MONITORING AND PUBLICITY

Monitoring

15.—(1) For the purposes of—

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

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

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

(d) organisational learning,

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

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

(a) specify the number of complaints received;

(b) identify the subject matter of those complaints;

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

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

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

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

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

Learning

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

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

Annual Reports

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

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

(b) the Patient and Client Council;

(c) the RQIA; and

(d) the NI Commissioner for Complaints.

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

Publicity

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

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

(b) staff working for that body;

(c) the Patient and Client Council;

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

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

Training

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

PART V

TRANSITIONAL PROVISION AND REVOCATIONS

Transitional provision

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

Revocations

21. The following Directions are revoked—

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

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

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

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

[redacted]
Personal Information redacted by the USI

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

DIRECTORATE OF ACUTE SERVICES
Weekly Report on Formal Complaints - 18 October 2016

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due	Current Stage	Handler
AS120.16/17	Personal Information redacted by	SEC	Theatre	20/07/2016	03/08/2016	17/08/2016	Returned to Amie Nelson for further investigation 17.10.16.	DC
AS139.16/17	Personal Information	MUC	Male Medical	09/08/2016	23/08/2016	06/09/2016	Returned to Kay Carroll for further investigation 18.10.16.	DC
AS143.16/17	Personal Information redacted by the	MUC	Emergency Department	10/08/2016	24/08/2016	08/09/2016	To Esther Gishkori for signature 18.10.16.	DC
AS166.16/17	Personal Information redacted by the	MUC	Emergency Department	23/08/2016	07/09/2016	21/09/2016	Returned to Mary Burke for further investigation 01.10.16.	DC
AS158.16/17	Personal Information redacted	IMWH	Admissions/Assessment Unit	24/08/2016	08/09/2016	22/09/2016	Awaiting response from Sr J O'Hagan	VK
AS161.16/17	Personal Information redacted by	CCS	Audiology Clinic	24/08/2016	08/09/2016	22/09/2016	To Heather Trouton for approval 27.09.16	VK
AS167.16/17	Personal Information	IMWH	1 West Gynae	24/08/2016	08/09/2016	22/09/2016	To Heather Trouton for approval 17.10.16	VK
AS169.16/17	Personal Information redacted	MUC	2 South Stroke	26/08/2016	12/09/2016	26/09/2016	Response being drafted.	DC
AS176.16/17	Personal	SEC	Opthamology Clinic	01/09/2016	15/09/2016	29/09/2016	Awaiting response from Belfast Trust.	DC
AS188.16/17	Personal Information redacted by the	SEC	Orthopaedic Clinic	03/09/2016	15/09/2016	29/09/2016	Awaiting response from Brigeen Kelly.	DC
AS179.16/17	Personal	MUC	MAU	05/09/2016	19/09/2016	03/10/2016	Response being drafted.	DC
AS183.16/17	Personal Information redacted by the	SEC	4 North	07/09/2016	21/09/2016	05/10/2016	To Esther Gishkori for signature 17.10.16.	DC
AS189.16/17	Personal Information	SEC	3 South	08/09/2016	22/09/2016	06/10/2016	Awaiting response from Martina Corrigan.	DC
AS191.16/17	Personal Information	MUC	General Male Medical, Level 5	12/09/2016	26/09/2016	10/10/2016	Awaiting response from Sr Rooney.	DC
AS192.16/17	Personal Information	SEC	Theatre	13/09/2016	27/09/2016	11/10/2016	Awaiting response from Dr Maguire, Dr Mathers and Dr Kadhim	VK
AS193.16/17	Personal Information	MUC	Dermatology Clinic	14/09/2016	28/09/2016	12/10/2016	To Anne McVey for approval 11.10.16.	DC
AS198.16/17	Personal	MUC	1 South Medical	16/09/2016	30/09/2016	14/10/2016	To Esther Gishkori for signature 14.10.16.	DC
AS205.16/17	Personal Information redacted by	SEC	4 South	20/09/2016	04/10/2016	18/10/2016	Awaiting response from Mr Lewis, Sr McGuigan and Amie Nelson.	DC
AS206.16/17	Personal Information	SEC	3 South	20/09/2016	04/10/2016	18/10/2016	Awaiting response from Mr O'Brien, Martina Corrigan and K Robinson.	DC
AS207.16/17	Personal Information redacted	SEC	Pain Management Clinic	20/09/2016	04/10/2016	18/10/2016	Awaiting response from Mary McGeough, Dr McConaghy and W Clayton.	DC
AS212.16/17	Personal Information	CCS	X-ray	21/09/2016	05/10/2016	19/10/2016	Awaiting respopnse from J Robinson.	VK
AS214.16/17	Personal Information redacted	SEC	3 South	27/09/2016	12/10/2016	26/10/2016	Awaiting response from Martina Corrigan and Cherith Douglas	DC
AS215.16/17	Personal Information redacted by	SEC	Trauma Ward	29/09/2016	13/10/2016	27/10/2016	Awaiting response from Brigeen Kelly	DC
AS216.16/17	Personal Information redacted	MUC	Minor Injuries Unit	29/06/2016	13/10/2016	27/10/2016	To Esther Gishkori for signature 18.10.16.	DC
AS217.16/17	Personal Information	IMWH	EPPC	29/09/2016	13/10/2016	27/10/2016	Awaiting response from David Sim and Joanne McGlade	VK
AS218.16/17	Personal Information	CCS	Prosthetics	30/09/2016	14/10/2016	28/10/2016	Awaiting further details from patient	VK
AS219.16/17	Personal Information redacted by the USI	SEC	4 North	30/09/2016	14/10/2016	28/10/2016	Awaiting response from Mr Yousaf and Amie Nelson	DC
AS220.16/17	Personal Information	MUC	Emergency Department	30/09/2016	14/10/2016	28/10/2016	Awaiting response from Mr McCann, G Hampton, P Sheridan, S Rooney	DC
AS221.16/17	Personal Information redacted by	FSS	Booking Centre	04/10/2016	18/10/2016	01/11/2016	To Anita Carroll for approval 17.10.16.	VK
AS222.16/17	Personal Information redacted by the	MUC	1 North Cardiology	05/10/2016	19/10/2016	02/11/2016	Under investigation.	DC
AS223.16/17	Personal Information	MUC	Emergency Department	06/10/2016	21/10/2016	04/11/2016	Under investigation.	DC
AS224.16/17	Personal Information	SEC	3 South	06/10/2016	20/10/2016	03/11/2016	Under investigation.	DC
AS225.16/17	Personal Information redacted	FSS	Silverwood Ward	06/10/2016	20/10/2016	03/11/2016	Under investigation.	VK
AS226.16/17	Personal Information redacted	CCS	Day Procedure/Day Surgery Unit	10/10/2016	24/10/2016	07/11/2016	Under investigation.	VK
AS227.16/17	Personal Information redacted by	CCS	X-ray Dept (Radiology)	10/10/2016	24/10/2016	07/11/2016	Under investigation.	VK
AS229.16/17	Personal Information	SEC		10/10/2016	24/10/2016	07/11/2016	To Esther Gishkori for signature 14.10.16.	DC
AS231.16/17	Personal Information	FSS	Car Park	11/10/2016	25/10/2016	08/11/2016	To Esther Gishkori for signature 14.10.16.	VK
AS228.16/17	Personal Information redacted by	MUC	Winter Pressures Ward(Ramone)	12/10/2016	26/10/2016	09/11/2016	Under investigation.	DC
AS230.16/17	Personal Information	FSS	Booking Centre	12/10/2016	26/10/2016	09/11/2016	To Anita Carroll for approval 17.10.16.	VK

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

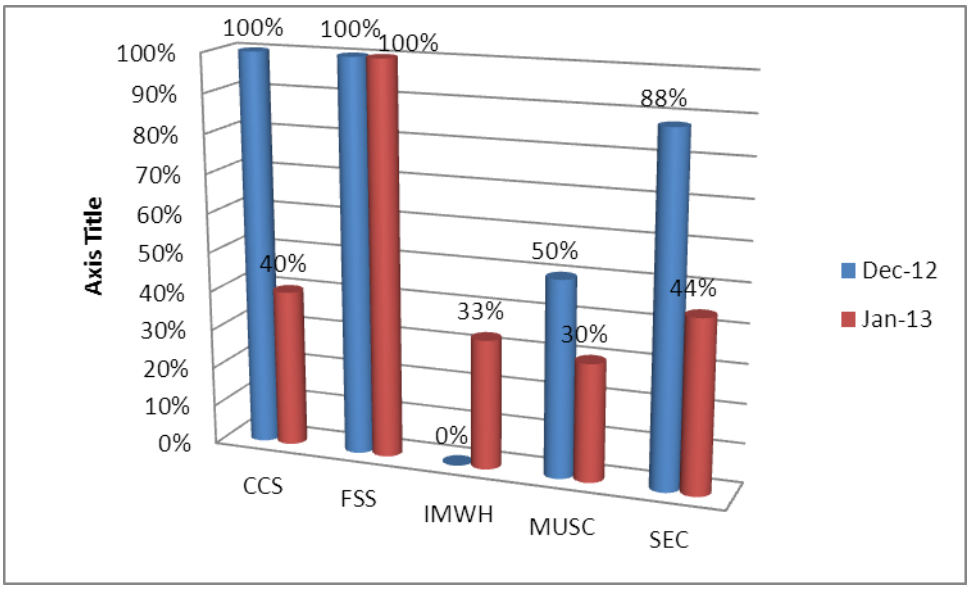
Statistical Report on Complaints – January 2013

Purpose of Report

The purpose of this report is to inform senior staff within the Directorate about the complaints activity within the Directorate in January 2013. A summary for each formal complaint is attached.

Summary

- 44 formal complaints were received, which was an increase of 17 from the previous month. These have been generated by 30 complainants.
- In addition 18 complaints/enquiries were dealt with at the point of service delivery and have been resolved.
- 100% of formal complaints have been acknowledged within 2 working days
  32% of formal complaints were responded to within 20 working days compared to 55% in the previous month and 79% in January 2012. The graph below shows the individual divisional response rate for the past two months.



115 compliments have been noted for the month compared to 709 for the previous month.

- The top 5 subjects for complaint in January 2013 are noted below.

Top 5 Subjects of Complaint	2012	2013
Treatment and care quality	9	9
Communication/Information to Patients	4	9
Discharge/Transfer arrangements	1	5
Professional Assessment of need	2	4
Staff Attitude/Behaviour	4	4

- The top 5 wards/departments which have received complaints in January 2013 are:

Top 5 Ward/Departments	2012	2013
ED CAH	7	9
1 North CAH	0	3
Day Surgery Unit DHH	0	3
4 North CAH	1	2
4 South CAH	0	2

- The top 3 professions which have been complained about in January 2013 are:

Top Profession	2012	2013
Medical and Dental	14	19
Non staff	11	13
Nursing and Midwifery	7	12

Hospital, Division, Subject	2012
Craigavon Area Hospital	**27**
MUC	**11**
Treatment and care quality	4
Patients' property/expenses/finance	2
Discharge/transfer arrangements	1
Staff attitude/behaviour	1
Waiting times, A&E department	1
Communication/information to patients	1
Patients' status/discrimination	1
IMWH	**7**
Treatment and care quality	3
Appointments, delay/cancellation (outpatients)	1
Staff attitude/behaviour	1
Communication/information to patients	1
Patients' property/expenses/finance	1
SEC	**6**
Professional assessment of need	1
Treatment and care quality	1
Theatre/operation/procedure, delay/cancellation	1
Communication/information to patients	1
Appointments, delay/cancellation (outpatients)	1
Environmental	1
FSS	**2**
Records/record keeping	1
Environmental	1
CCS	**1**
Infection control	1
Daisy Hill Hospital	**6**
IMWH	**4**
Staff attitude/behaviour	2
Treatment and care quality	1
Professional assessment of need	1
SEC	**1**
Communication/information to patients	1
MUC	**1**
Waiting times, A&E department	1
Grand Total	**33**

- **Complaints by Hospital, Division and Subject – January 2013**

Craigavon Area Hospital	**30**
CCS	**1**
Waiting times, out-patient departments	1
FSS	**1**
Access to premises	1
IMWH	**4**
Communication/information to patients	3
Waiting times, out-patient departments	1

MUC	**17**
Communication/information to patients	3
Discharge/transfer arrangements	3
Patients' privacy/dignity	3
Professional assessment of need	1
Staff attitude/behaviour	1
Treatment and care quality	4
Waiting times, A&E department	1
Waiting times, out-patient departments	1
SEC	**7**
Admission into hospital (delay cancellation) (inpatients)	1
Professional assessment of need	1
Staff attitude/behaviour	2
Treatment and care quality	3
Daisy Hill Hospital	**11**
CCS	**4**
Appointments, delay/cancellation (outpatients)	1
Communication/information to patients	2
Treatment and care quality	1
IMWH	**2**
Communication/information to patients	1
Staff attitude/behaviour	1
MUC	**5**
Discharge/transfer arrangements	2
Professional assessment of need	1
Staff attitude/behaviour	1
Treatment and care quality	1
Independent/Voluntary Sector Locations	**2**
SEC	**2**
Appointments, delay/cancellation (outpatients)	2
South Tyrone Hospital	**1**
MUC	**1**
Professional assessment of need	1
Grand Total	**44**

- **Complaints by Hospital, Division & Ward/Department – January 2013**

Craigavon Area Hospital	**30**
CCS	**1**
Oncology Clinic, Mandeville Unit	1
FSS	**1**
Car Park	1
IMWH	**4**
1 East Maternity Antenatal	2
1 West Gynae	1
Delivery Suite, CAH	1
MUC	**17**
1 North Cardiology	3
4 South	2
Dental Clinic	1
Emergency Department	9
ICU (HDU)	1
MAU	1
SEC	**7**
3 South	1
4 North	2
Orthopaedic Clinic	1
Thorndale Unit	1
Trauma Ward	1
Urology Clinic	1
Daisy Hill Hospital	**11**
CCS	**4**
Day Procedure/Day Surgery Unit	3
Pain Management Clinic	1
IMWH	**2**
Antenatal Clinic	1
Female Surgical/Gynae	1
MUC	**5**
Diabetic Cliinic	1
Emergency Department	2
Female Medical, Level 5	1
General Male Medical, Level 5	1
Independent/Voluntary Sector Locations	**2**
SEC	**2**
Non Trust premises	2
South Tyrone Hospital	**1**
MUC	**1**
Minor Injuries Unit	1
Grand Total	**44**

▪ Complaints by Profession and Subject – January 2013

Medical and Dental	**19**
Appointments, delay/cancellation (outpatients)	1
Communication/information to patients	3
Discharge/transfer arrangements	3
Professional assessment of need	3
Staff attitude/behaviour	4
Treatment and care quality	5
Non Staff	**13**
Access to premises	1
Admission into hospital (delay cancellation) (inpatients)	1
Appointments, delay/cancellation (outpatients)	2
Communication/information to patients	1
Discharge/transfer arrangements	2
Patients' privacy/dignity	1
Treatment and care quality	1
Waiting times, A&E department	1
Waiting times, out-patient departments	3
Nursing and Midwifery	**12**
Communication/information to patients	5
Patients' privacy/dignity	2
Professional assessment of need	1
Staff attitude/behaviour	1
Treatment and care quality	3
Grand Total	**44**

▪ Complaints received by Month and Year