INFORMATION ANALYSIS DIRECTORATE

Complaints and Compliments Received by HSC Trusts

in Northern Ireland (2018/19)

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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Reader Information

Purpose:	This publication monitors and reports the number of HSC Trust complaint issues received, by the programme of care, category, subject and specialty of the complaint issue, as well as demographic information and the time taken to provide a substantive response to complaints received. It also includes information on compliments received by HSC Trusts regarding the services they provide.
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CONTENTS

KEY POINTS

Latest Year (2018/19)

- A total of 4,473 complaints, relating to 6,049 complaint issues, were received by HSC Trusts in 2018/19 (Tables 1 & 9); equating to 86 complaints per week or 12 complaints a day.
- Almost 6 in 10 (3,626, 59.9%) complaint issues received during 2018/19 related to the 'Acute' POC (Table 2, Figure 3).
- During 2018/19, almost a third (1,920, 31.7%) of complaint issues concerned patient's 'Diagnosis/Operation/Treatment' (Table 5).
- The highest percentage of complaint issues received in 2018/19 related to the 'Accident & Emergency' (691, 11.4%) specialty (Table 7).
- Of the 4,473 complaints received in 2018/19, the median age of the patient / client was 48.0 years (Figure 8).
- On average HSC Trusts took 31.8 working days to provide a substantive response to complaints received in 2018/19 (Table 9, Figure 13).
- During 2018/19, 16,757 compliments (via card, email, feedback form, letter or social media) were received by HSC Trusts in Northern Ireland.
- Of the 16,757 compliments received, 8,489 (50.7%) related to 'Quality of Treatment & Care', 5,628 (33.6%) to 'Staff Attitude & Behaviour', 1,471 (8.8%) to 'Information & Communication', 497 (3.0%) to 'Environment', and 672 (4.0%) to 'Other' subjects.

Last Five Years (2014/15 to 2018/19)

- Since 2014/15, the number of complaints issues received by HSC Trusts decreased by 13.8% (966), from 7,015 to 6,049 in 2018/19 (Table 1, Figure 2).
- Over the last five years all HSC Trusts, with the exception of the Western HSC Trust, reported a decrease in complaint issues received; however between 2017/18 and 2018/19, the Belfast and South Eastern HSC Trusts reported increases (330, 16.3% and 129, 11.3%, respectively) in complaint issues received (Table 1, Figure 2).
- Between 2014/15 and 2018/19, the largest reduction in the number of complaint issues (563, 13.4%) was observed in the 'Acute' POC (4,189 to 3,626) (Table 3).
- Complaints handled in 2018/19 against Family Practitioner Services increased by almost a third (77, 32.1%) compared to the previous year (240 in 2017/18) and only just remained below that reported in 2014/15 (326) (Table 10, Figure 14).

SECTION 1

COMPLAINT ISSUES RECEIVED BY HSC TRUSTS

What's the Difference between a Complaint and a Complaint Issue?

A ***complaint*** is defined as an 'expression of dissatisfaction' received from or on behalf of patients, clients or other users of HSC Trust and/or Family Practitioner Services or facilities.

A single communication regarding a complaint, however, may refer to more than one issue. In such cases each individual ***complaint issue*** is recorded separately for the Programme of Care, Subject and Specialty to which it relates.

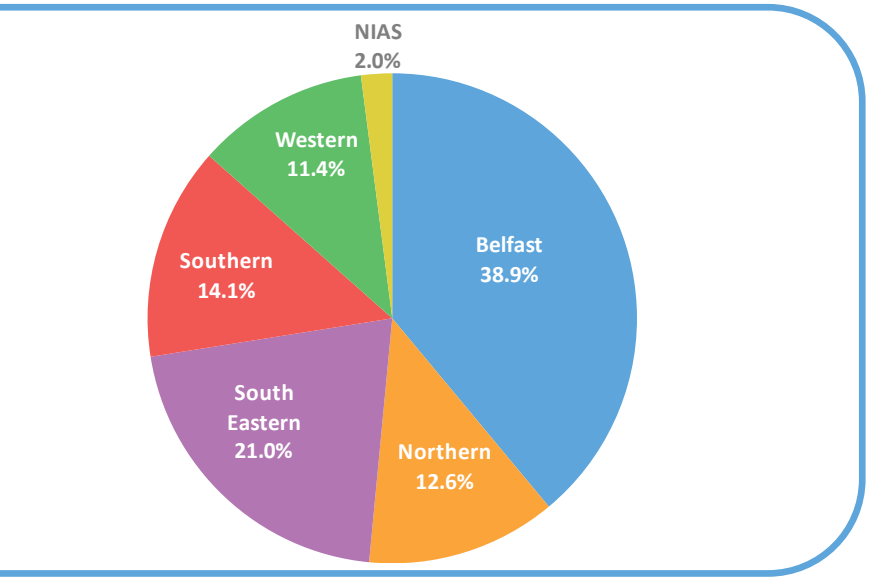
Almost two fifths of complaint issues were received by the Belfast HSC Trust

Complaint Issues Received by HSC Trusts

During 2018/19, HSC Trusts received 4,473 complaints relating to 6,049 complaint issues (Tables 1 & 9).

Of the 6,049 complaint issues, almost two fifths (2,356, 38.9%) were received by the Belfast HSC Trust, 1,269 (21.0%) by the South Eastern HSC Trust, 850 (14.1%) by the Southern HSC Trust, 760 (12.6%) by the Northern HSC Trust, 690 (11.4%) by the Western HSC Trust and 124 (2.0%) by the Northern Ireland Ambulance Service (NIAS) (Tables 1 & 2, Figure 1).

Figure 1: Complaint Issues Received by HSC Trusts (2018/19)

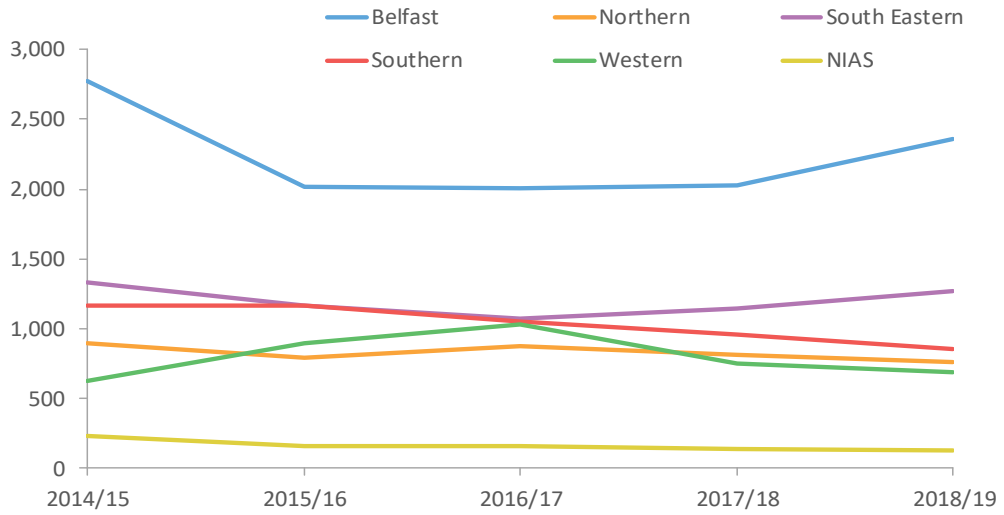


14% decrease in complaint issues received since 2014/15

During the last five years, the highest number of complaint issues received by HSC Trusts was in 2014/15 (7,015) and the lowest in 2017/18 (5,814) (Table 1, Figure 2).

Since 2014/15, the number of complaint issues received decreased in five of the six HSC Trusts, with Belfast reporting the most notable decrease (416, 15.0%), from 2,772 to 2,356 in 2018/19 (Table 1, Figure 2).

Figure 2: Complaint Issues Received by HSC Trusts (2014/15 - 2018/19)



Complaint Issues Received by Programme of Care (POC)[1]

Each complaint issue received is recorded against the POC of the patient / client to whom the complaint relates. If a complaint is made by a user of HSC Trust facilities who is not a patient / client, the complaint issue will be recorded against the POC of that service.

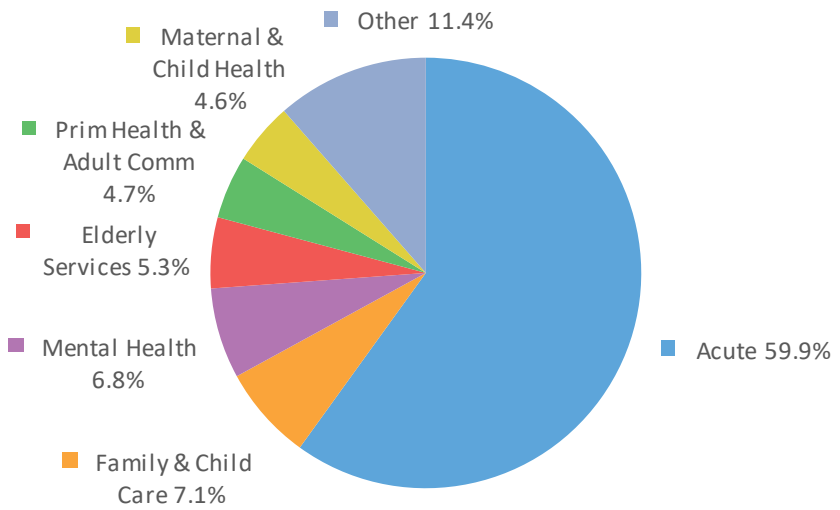
60% of complaint issues received during 2018/19 related to the Acute POC

Of the 6,049 complaint issues received by HSC Trusts in 2018/19, 6 in 10 (3,626, 59.9%) related to the Acute POC (Table 2)

Four POCs accounted for almost 80% (4,789, 79.2%) of all complaint issues received during 2018/19; the Acute POC (3,626, 59.9%), Family & Child Care POC (429, 7.1%), Mental Health POC (412, 6.8%) and Elderly Services POC (322, 5.3%) (Table 2 & Fig 3).

Since 2014/15, the number of complaint issues received by HSC Trusts relating to the Primary Health & Adult Community POC increased by 34.1% (73), from 214 to 287 (Table 3).

Figure 3: Complaint Issues by POC (2018/19)[2]



[1] Refer to Appendix 2: Definitions for full list of Programmes of Care (POCs)
[2] 'The 'Other' category includes all complaint issues not included within the six named POCs above.

Complaint Issues Received by POC and HSC Trust

There is variation across HSC Trusts in the distribution of complaint issues across POCs. During 2018/19:

- Belfast HSC Trust reported the highest number of complaint issues relating to the Acute POC (1,745, 48.1%), Mental Health POC (128, 31.1%), and the Elderly Services POC (92, 28.6%) (Table 2).

- South Eastern HSC Trust reported the highest number of complaint issues relating to the Primary Health & Adult Community POC (162, 56.4%) and the Sensory Impairment & Physical Disability POC (16, 27.6%). The South Eastern HSC Trust, the sole provider of Prison Healthcare in Northern Ireland, reported 39 complaint issues in relation to this POC (Table 2).

- Southern HSC Trust reported the highest number of complaint issues relating to the Family & Child Care POC (104, 24.2%) and the Learning Disability POC (22, 23.7%) (Table 2).

- The Western HSC Trust reported the highest number of complaint issues relating to the Maternal & Child Health POC (66, 23.5%) (Table 2).

74%
of complaint issues received in the Belfast HSC Trust related to the Acute POC

Complaint Issues Received by Category

The category of each complaint issue is based on the subject[3] which best describes the nature of the patient's / client's concern. To enable the category of the complaint issue to be presented, the subject area of each complaint issue has been grouped into one of 15 main categories[4].

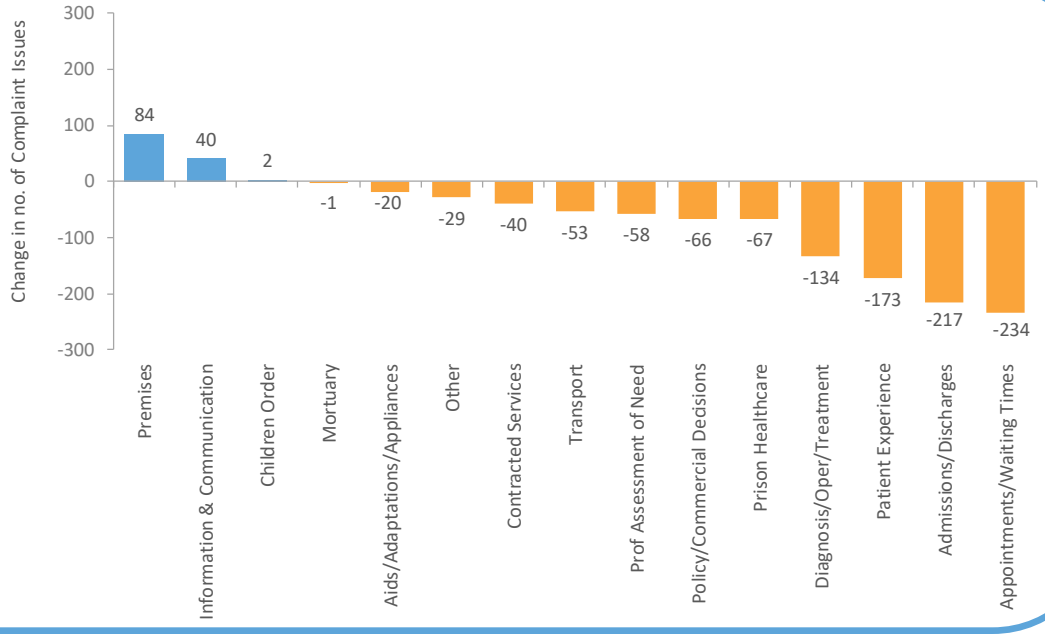
During 2018/19, HSC Trusts reported that the highest number of complaint issues related to 'Diagnosis/Operation/Treatment' (1,920, 31.7%), 'Information & Communication' (1,075, 17.8%), 'Patient Experience' (1,068, 17.7%) and 'Appointments/Waiting Times' (711, 11.8%) (Table 5, Figure 4).

63% reduction in Prison Healthcare related complaint issues received

Between 2014/15 and 2018/19, three categories reported increases in the number of complaint issues received, the 'Premises' category increased by 36.1% from 233 to 317, 'Information & Communication' by 3.9% from 1,035 to 1,075 and 'Children Order' from 0 to 2 (Figure 4, Table 5).

The 'Appointments/Waiting Times' and 'Admissions/Discharges' categories reported the largest decrease in the number of complaint issues received, 234 (24.8%) and 217 (38.4%), respectively (Figure 4, Table 5).

Figure 4: Change in the Number of Complaint Issues Received, by Category of Complaint (2014/15 - 2018/19)



[3] A complete list of complaint issue subjects is detailed in Appendix 3, whilst an analysis of complaint issues by subject can be found in Table 5.
[4] A list of complaint issue subjects grouped by general category is detailed in Appendix 4.

Complaint Issues Received by Category and HSC Trust

During 2018/19:

- In the Belfast HSC Trust, a third (787, 33.4%) of complaint issues related to the 'Diagnosis/Operation/Treatment' category. The next largest categories were 'Appointments/Waiting Times' (371, 15.7%), 'Patient Experience' (365, 15.5%) and 'Information & Communication' (363, 15.4%) (Figure 5, Table 6).

- In the Northern HSC Trust, the largest category of complaint issues related to 'Diagnosis/Operation/Treatment' (278, 36.6%). The second largest category was 'Patient Experience' (152, 20.0%) (Figure 5, Table 6).

- The 'Diagnosis/Operation/Treatment' category accounted for the largest number (354, 27.9%) of complaint issues received in the South Eastern HSC Trust followed by 'Information & Communication' (283, 22.3%) and Patient Experience (228, 18.0%) (Figure 5, Table 6).

- In the Southern HSC Trust, the largest number (197, 23.2%) of complaint issues were related to the 'Information & Communication' category. The next largest categories were 'Diagnosis/Operation/Treatment' (166, 19.55) and 'Patient Experience' (146, 17.2%) (Figure 5, Table 6).

- Over two fifths (308, 44.6%) of complaint issues received by the Western HSC Trust related to 'Diagnosis/Operation/Treatment'. The next largest categories were 'Information & Communication' (141, 20.4%) and 'Patient Experience' (131, 19.0%) (Figure 5, Table 6).

- NIAS received 46 (37.1%) complaint issues regarding 'Patient Experience' and 45 (36.3%) relating to 'Transport' issues (Table 6).

Figure 5 below presents a summary of the four largest categories, accounting for 78.9% (4,774) of complaint issues received during 2018/19 for each HSC Trust. In the charts below complaint issues not in the four largest categories are referred to as 'Other'.

Almost 2,000 complaint issues related to Diagnosis/Operation/ Treatment

Figure 5: Main Category of Complaint Issues Received by HSC Trusts (2018/19)[5]

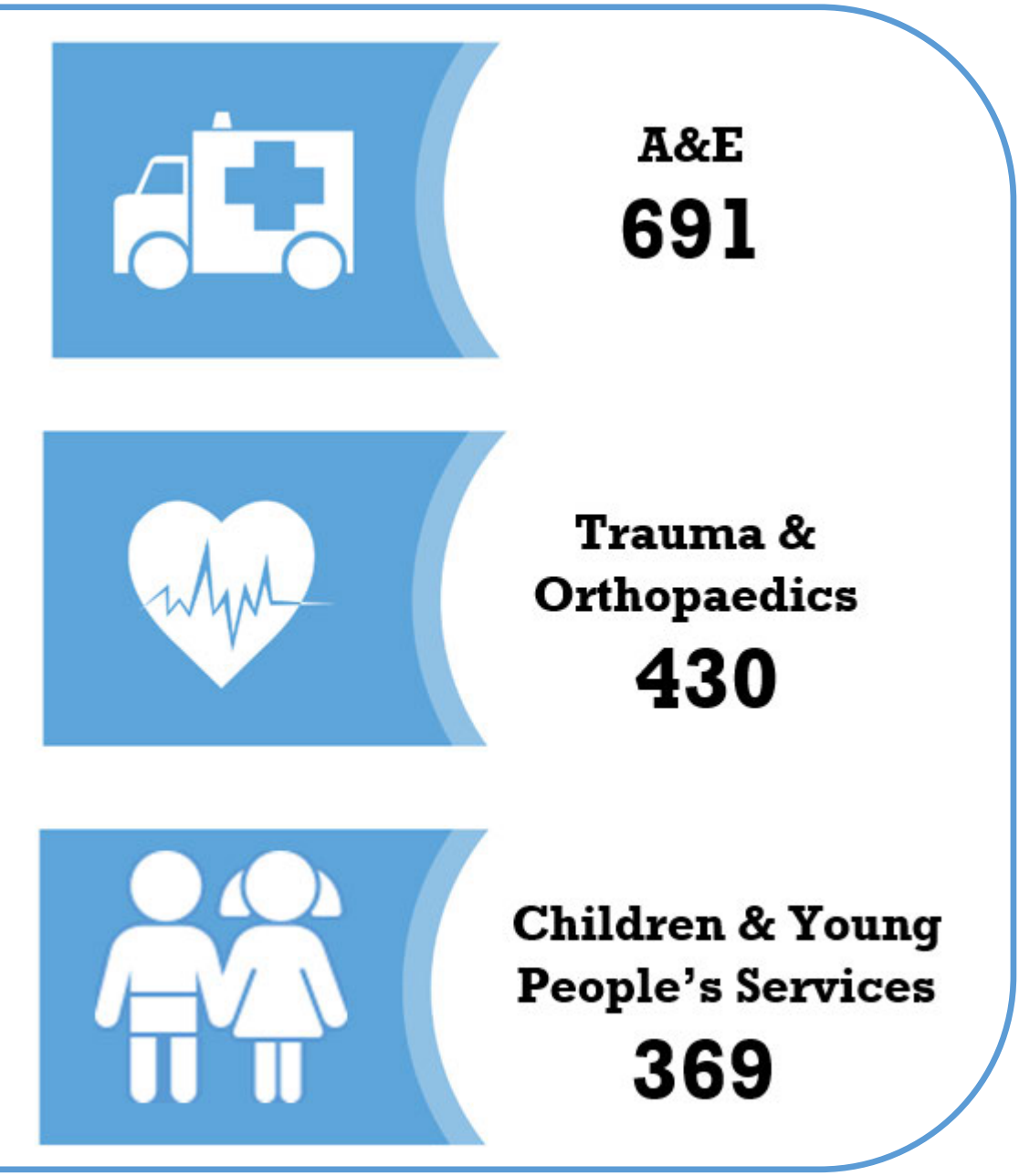
[5] Information for Northern Ireland includes complaint issues received by all HSC Trusts including the NIAS.

Complaint Issues Received by Specialty

During 2018/19, HSC Trusts reported that the highest number of complaint issues received related to the 'Accident & Emergency' (691, 11.4%), 'Trauma & Orthopaedics' (430, 7.1%) and Children & Young People's Services' (369, 6.1%) specialties (Table 7).

These three specialties accounted for a quarter (1,490, 24.6%) of all complaint issues received during this time (Table 7).

Figure 6: Top 3 Complaint Issues Received by Specialty



SECTION 2

COMPLAINTS RECEIVED BY HSC TRUSTS

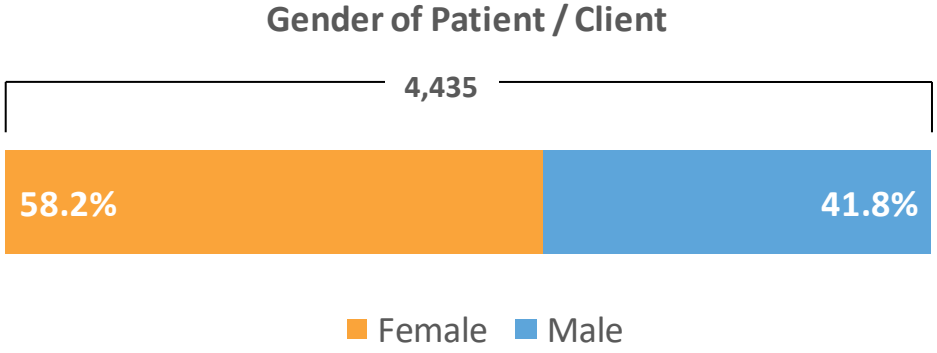
During 2018/19, HSC Trusts received 4,473 complaints relating to 6,049 complaint issues. Section 2 presents a summary of information relating to these 4,473 complaints. Further information on the difference between a complaint and a complaint issue is detailed on page 5.

Age and Gender of Patient / Client

During 2018/19, the gender of the patient / client was recorded in 4,435 (99.2%) of the complaints received by HSC Trusts (Figure 7).

Of those complaints where the gender of the patient / client was recorded, 2,579 (58.2%) were for females and 1,856 (41.8%) for males (Figure 7).

Figure 7: Gender of Patient / Client (2018/19)



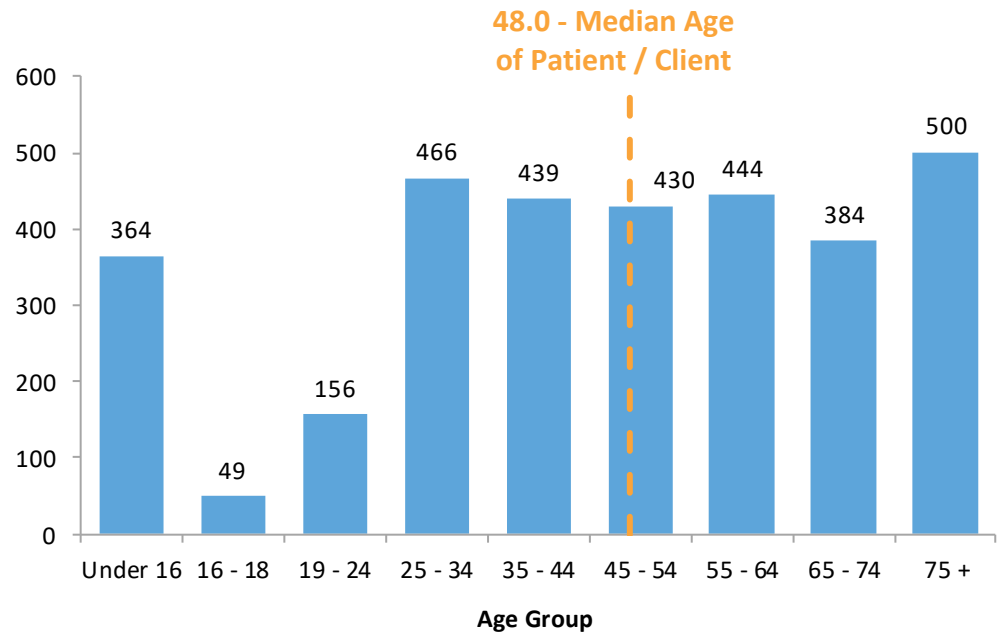
During 2018/19, both the age and gender of the patient / client was recorded in 3,232 (72.3%) of the complaints received by HSC Trusts.

48 years
the median age of patient / client complaints received in 2018/19

For those complaints where the age and gender of the patient / client was recorded, 500 (15.5%) related to patients / clients aged 75 & over and 364 (11.3%) to those aged under 16 (Figure 8).

Of the complaints received by HSC Trusts during 2018/19, the median age of the patient / client was 48.0 years (Figure 8).

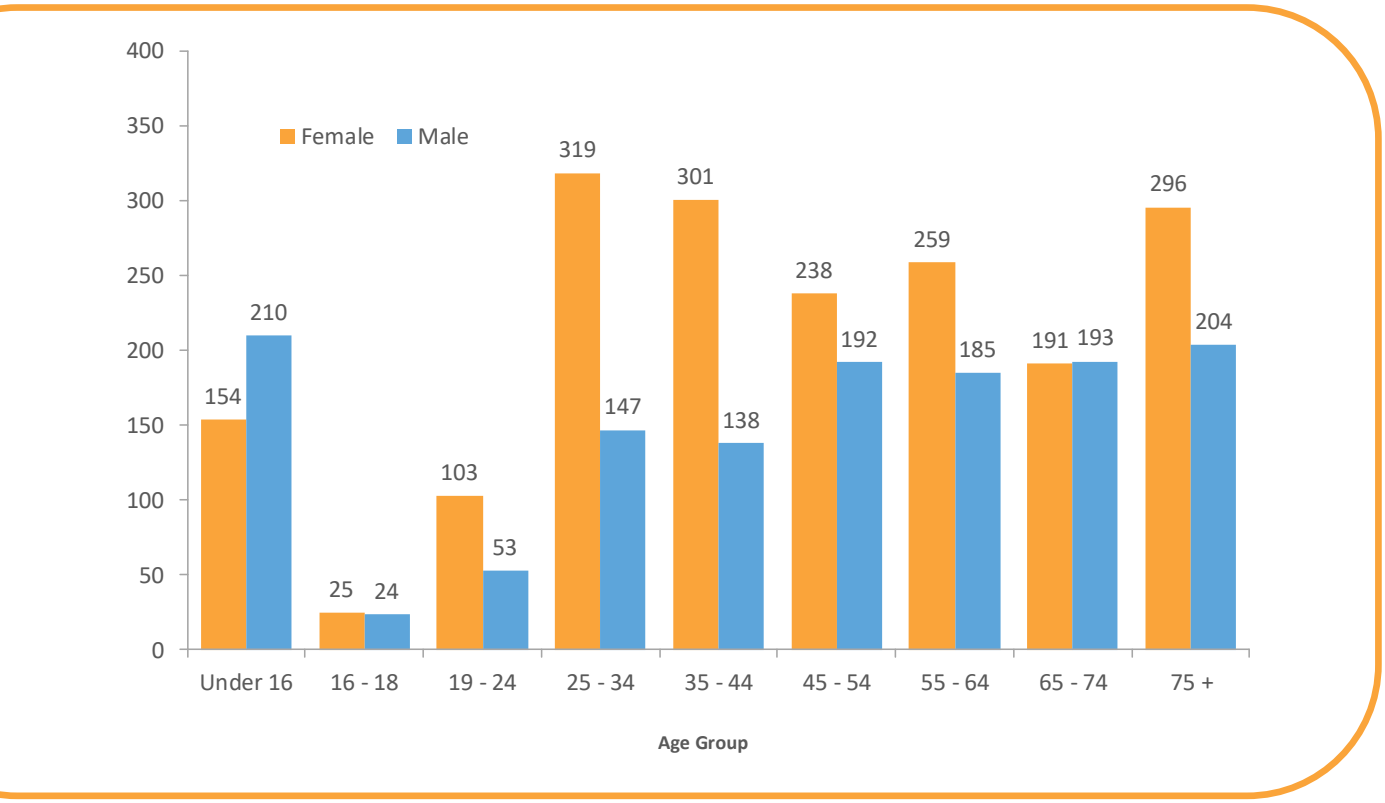
Figure 8: Complaints Received by Age Group of Patient / Client (2018/19)



Of the 3,232 complaints where the age and gender of the patient / client was recorded, 1,886 (58.4%) were females and 1,346 (41.6%) were males (Table 8, Figure 9).

There were over twice as many complaints received relating to females than males in the 25-34 and 35-44 age groups (Table 8, Figure 9).

Figure 9: Complaints Received by Age Group and Gender of Patient / Client (2018/19)



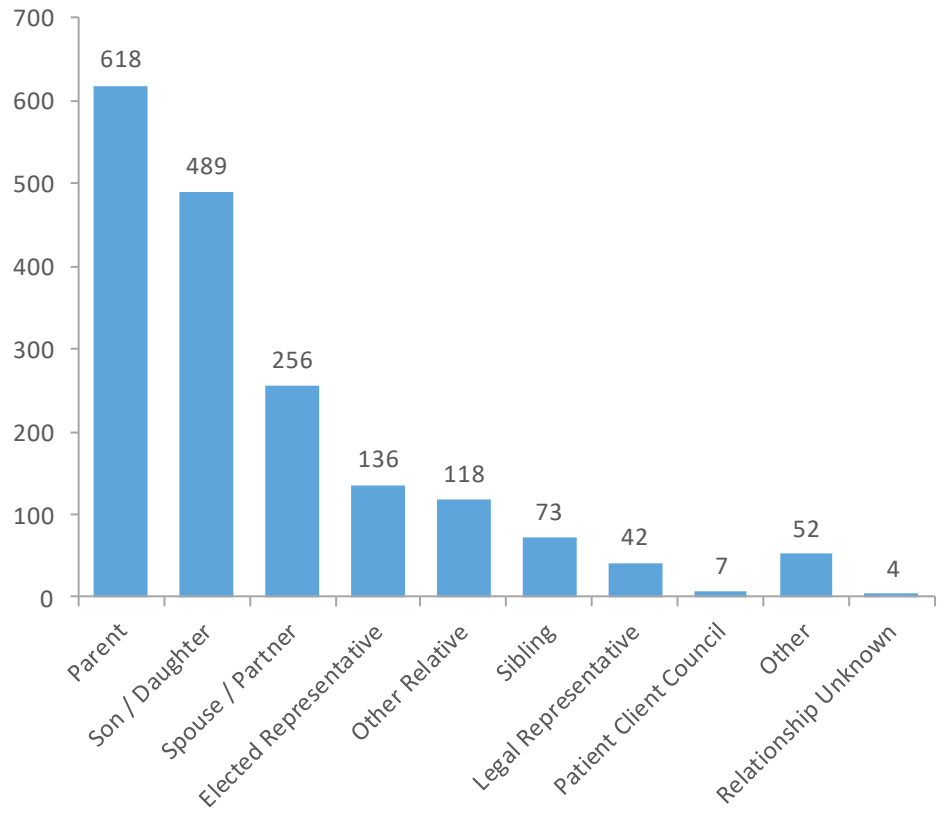
Relationship of Complainant to Patient / Client

Three fifths (2,678, 59.9%) of all complaints received in 2018/19 were from the patient / client, with 1,789 (40.0%) complaints from persons acting on behalf of the patient / client and 6 (0.1%) complaints where no particular patient / client was identified.

60%
of complaints were received from the patients / clients themselves in 2018/19

Of the 1,789 complaints received from persons acting on behalf of the patient / client, over a third (618, 34.5%) were from the parents of the patient / client, 489 (27.3%) from the son / daughter, 256 (14.3%) from a spouse / partner and 136 (7.6%) from an elected representative (Figure 10).

Figure 10: Complaints Received by Relationship of Complainant (2018/19)

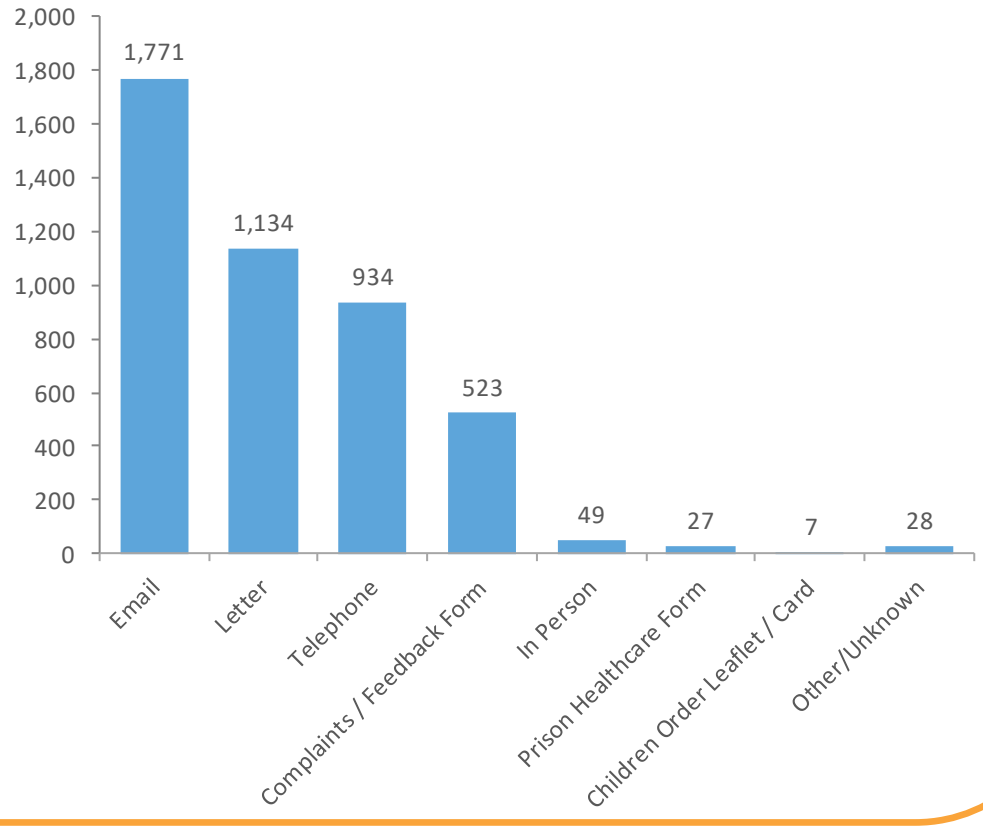


Method of Complaint

Of the 4,473 complaints received during 2018/19, two fifths (1,771, 39.6%) were sent by email, 1,134 (25.4%) by letter and 934 (20.9%) by telephone. These three methods accounted for over four fifths (85.8%, 3,839) of all complaints received during the year (Figure 11).

40%
of complaints received were sent by email in 2018/19

Figure 11: Complaints Received by Method of Complaint (2018/19)



SECTION 3

TIME TAKEN TO PROVIDE A SUBSTANTIVE RESPONSE TO COMPLAINTS RECEIVED

A substantive response is defined as a communication of the outcome of the complaint to the complainant following an investigation. It should be noted that a single substantive response will be provided to a complaint which may include a number of complaint issues.

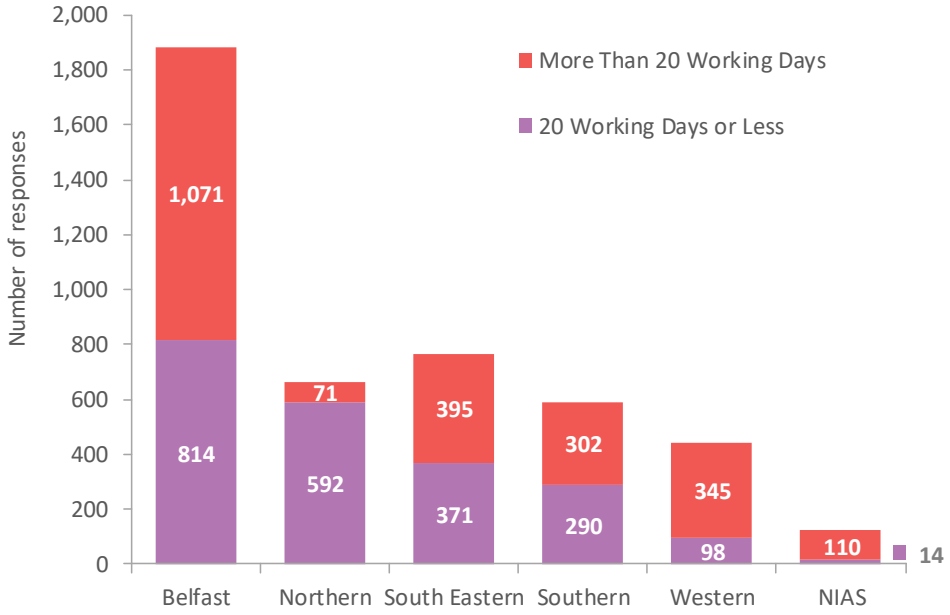
The HSC Complaints Policy requires HSC Trusts to provide a substantive response to the complainant within 20 working days of receipt of a complaint. Where this is not possible, a holding response explaining the reason for the delay is sent to the complainant. **All holding responses are issued in 20 working days or less.**

During 2018/19, just under a half (2,179, 48.7%) of substantive responses were provided by HSC Trusts within 20 working days of having received the complaint (Table 9, Figure 12).

The Northern HSC Trust provided the highest proportion of substantive responses within 20 working days (592, 89.3%) during 2018/19, whilst the NIAS provided the lowest (14, 11.3%) (Table 9, Figure 12).

49%
of complaints received a substantive response within 20 working days

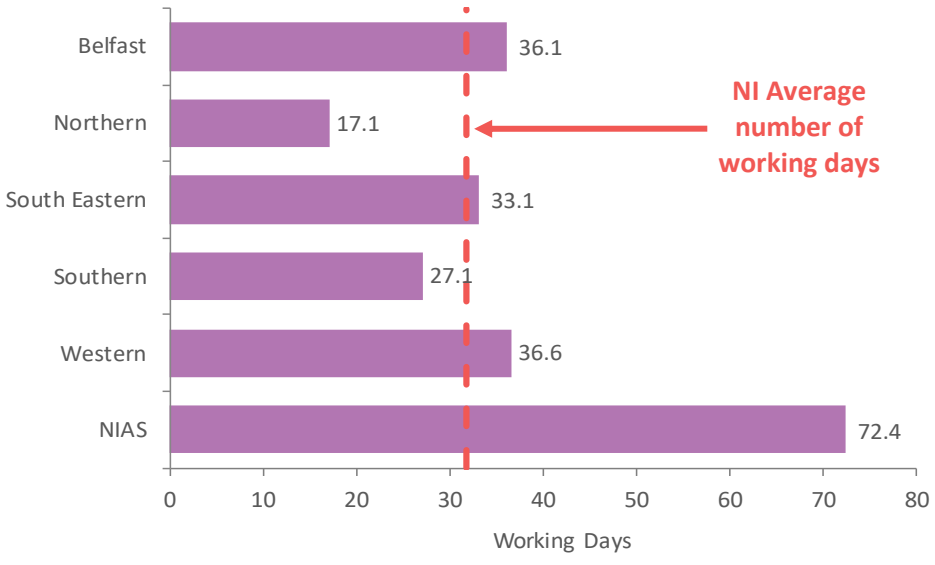
Figure 12: Time Taken to Provide a Substantive Response to Complaints Received, by HSC Trusts (2018/19)



Average Number of Working Days to Substantive Response

On average HSC Trusts took 31.8 working days to provide a substantive response to a complaint received in 2018/19 (Table 9, Figure 13)

Figure 13: Average Number of Working Days to Provide a Substantive Response to Complaints Received, by HSC Trusts (2018/19)[6]



On average substantive responses were provided within 32 working days

[6] Where it is not possible to provide a substantive response within 20 working days, a holding response explaining the reason for the delay is sent to the complainant. All holding responses are issued in 20 working days or less.

SECTION 4

FAMILY PRACTITIONER SERVICE (FPS) COMPLAINTS

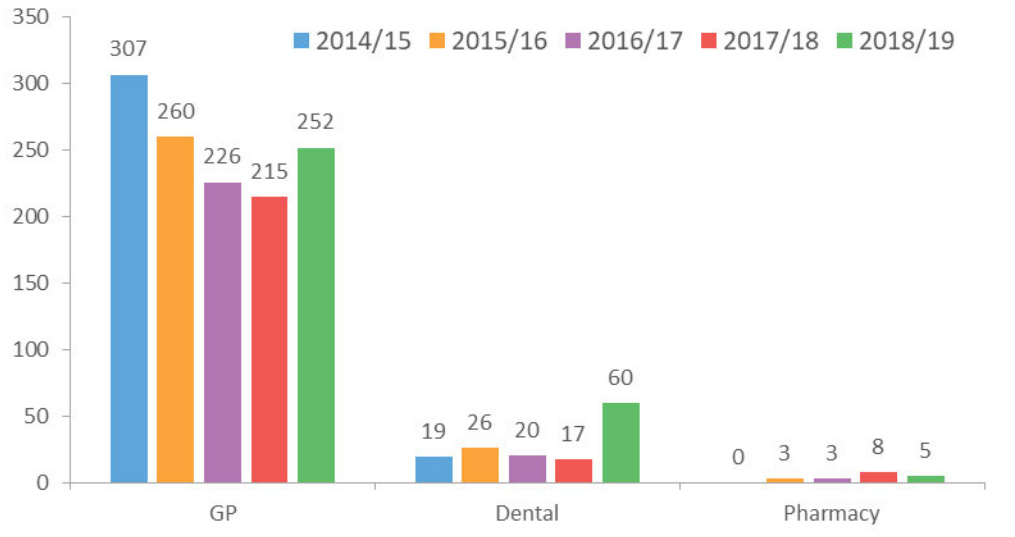
Information in this section refers to complaints received by the HSCB[7] regarding FPS practices in Northern Ireland.

There are over 1,500 FPS practices across Northern Ireland encompassing general practitioners, dental practitioners, pharmacists and optometrists. Under HSC Complaints Procedure all FPS practices are required to forward to the HSC Board anonymised copies of each letter of complaint received along with the subsequent response, within 3 working days of this being issued.

Although the five-year period has seen a small reduction of 2.8% in the number of complaints made against FPS practices in Northern Ireland, from 326 in 2014/15 to 317 in 2018/19 (Table 10, Figure 14), the figures for 2018/19 show an increase of 32.1% (77) on the previous year.

32% increase in FPS complaints in the last year

Figure 14: FPS Complaints Handled (2014/15 - 2018/19)[8]



[7] Refer to Appendix 5 for further details.
[8] There have been no ophthalmic complaints handled over the last 5 years.

Local resolution

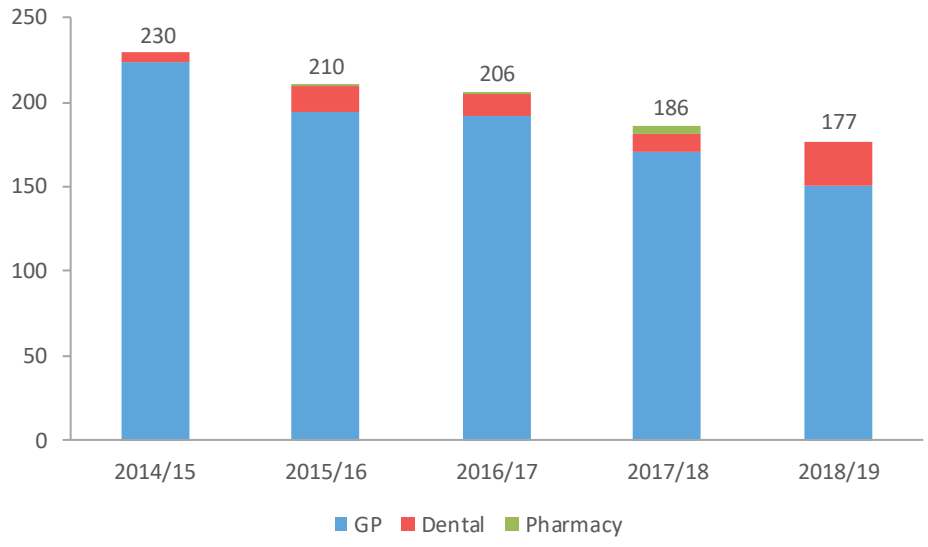
The first stage of the HSC Complaints Procedure is known as 'local resolution'. The purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint. In the case of FPS practices, local resolution involves a practitioner seeking to resolve the complaint through discussion and negotiation.

85%
of complaints handled under Local Resolution related to GPs in 2018/19

Of the 317 complaints received by the HSCB regarding FPS practices in 2018/19, 177 (55.8%) were handled under Local Resolution and the HSCB acted as an Honest Broker in 140 (44.2%) (Tables 11 – 14, Figures 15 & 17).

Between 2014/15 and 2018/19, the number of complaints handled under local resolution decreased year on year, from 230 in 2014/15 to 177 in 2018/19 (Table 11, Figure 15).

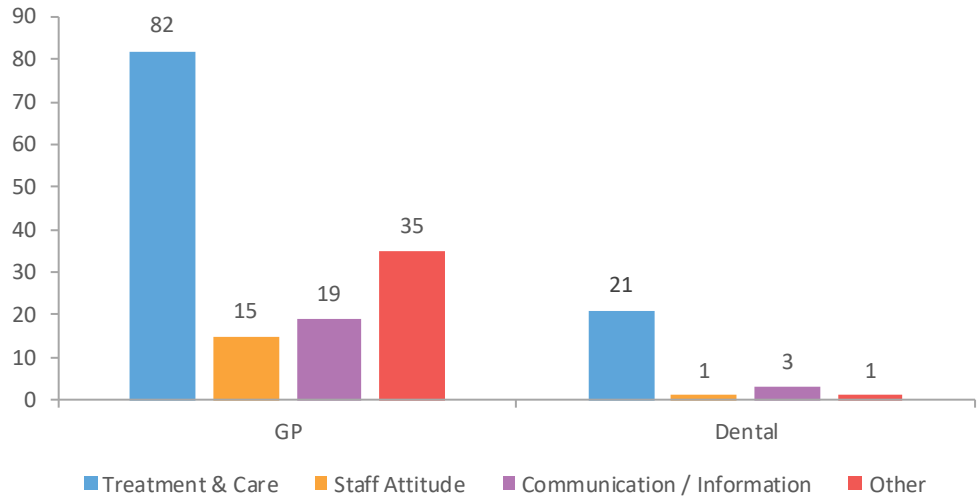
Figure 15: FPS Complaints Handled Under Local Resolution, by Year and Practice Type (2014/15 - 2018/19)[9]



[9] There have been no ophthalmic complaints handled over the last 5 years.

During 2018/19, 'Treatment & Care' accounted for 58.2% (103) of all complaints handled under local resolution, 30 (41.1%) more than in the previous year (Table 12, Figure 16).

Figure 16: FPS Complaints Handled Under Local Resolution by Subject (2018/19)[10]



Honest Broker

Where a complainant does not wish to approach the FPS practice directly, HSC Board Complaints staff, with the agreement of both the practice and complainant, may act as an intermediary or 'honest broker' with the aim of assisting in the local resolution of the complaint.

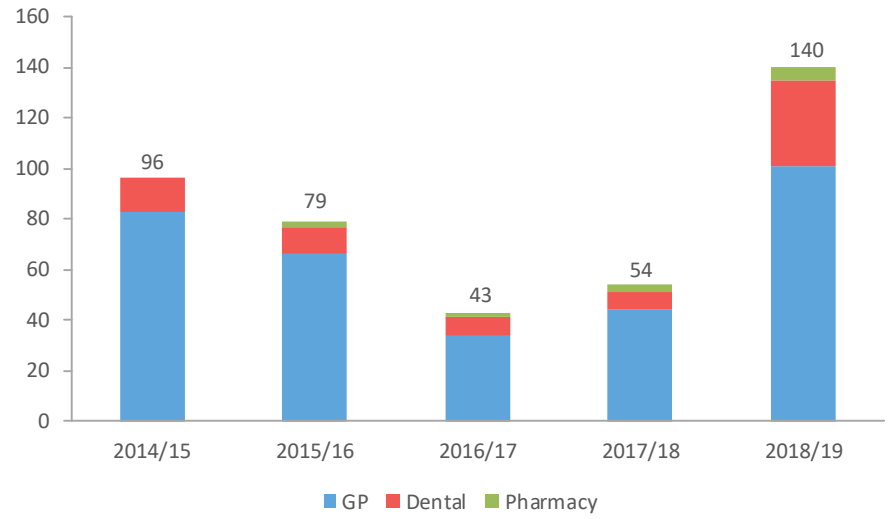
The number of complaints where the HSC Board acted as an honest broker increased, from 54 in 2017/18 to 140 in 2018/19 (Table 13, Figure 17), the highest it has been in the past five years.

72%

of complaints, where the HSCB acted as an Honest Broker, related to GPs in 2018/19

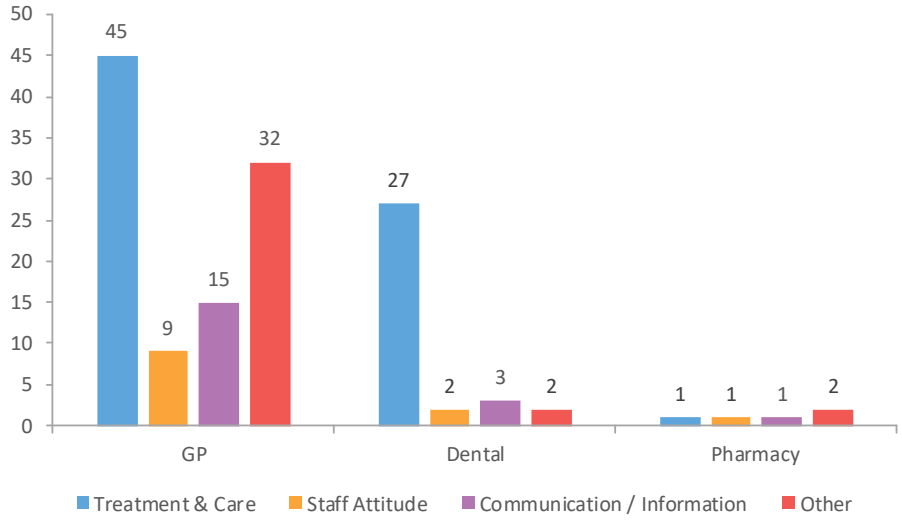
[10] There were no ophthalmic or pharmacy complaints handled under local resolution.

Figure 17: FPS Complaints where the HSC Board Acted as an Honest Broker (2014/15 - 2018/19)[11]



'Treatment & Care' accounted for over half (52.1%, 73), of all complaints in which the HSC Board acted as an honest broker during 2018/19 (Table 14, Figure 18).

Figure 18: FPS Complaints where the HSC Board Acted as an Honest Broker by Subject (2018/19)[12]



[11] There were no ophthalmic complaints handled over the last 5 years.

SECTION 5

COMPLIMENTS

A statistical information return to collate information on compliments received by HSC Trusts was introduced in December 2017[12], followed by a pilot collection for the quarter ending 31st March 2018.

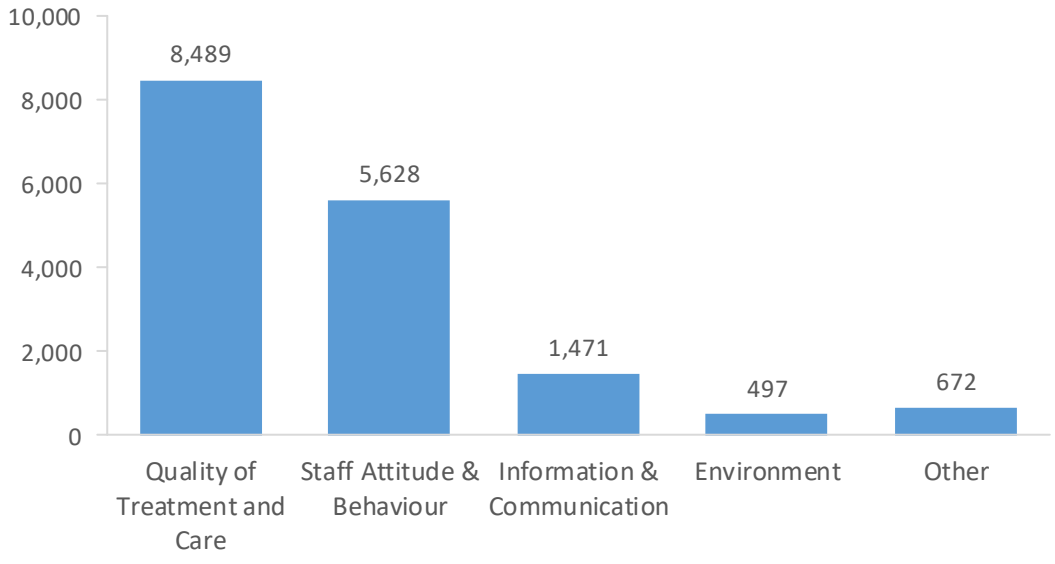
For the purposes of this statistical collection, a compliment may be understood as 'an expression of praise, commendation or admiration'. In addition, only compliments received by: Card, Email, Feedback Form, Letter or Social Media (Facebook & Twitter only) should be included.

Almost
17,000
Compliments received by HSC Trusts in 2018/19

Subject of Compliment Received

Figure 19 below presents information on the number of compliments received by HSC Trusts between 1st April 2018 and 31st March 2019, by the subject of the compliment.

Figure 19: Compliments Received by HSC Trusts (2018/19) [12]



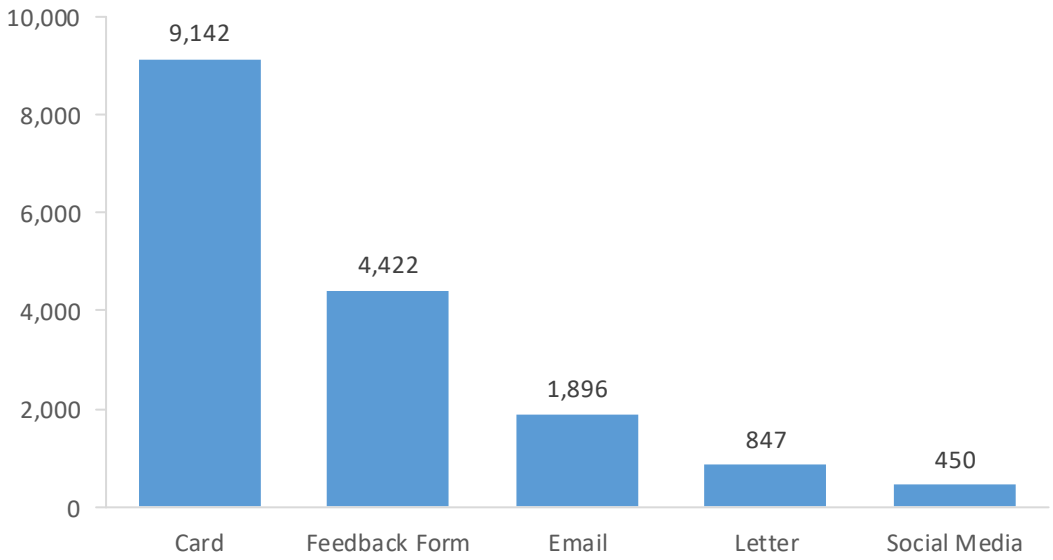
[12] Additional information on the compliments information collection is detailed in Appendix 1 & 6.

During 2018/19, almost 17,000 compliments were received by HSC Trusts in Northern Ireland, of which 8,489 (50.7%) related to 'Quality of Treatment & Care', 5,628 (33.6%) to 'Staff Attitude & Behaviour', 1,471 (8.8%) to 'Information & Communication', 497 (3.0%) to 'Environment', and 672 (4.0%) to 'Other' subjects (Figure 19).

Method of Compliment

Figure 20 below presents a summary of the methods by which compliments were received by HSC Trusts during 2018/19.

Figure 20: Compliments received by HSC Trusts by Method (2018/19)



Over half (9,142, 54.6%) of compliments received during 2018/19 were made by card, 4,422 (26.4%) by feedback form, 1,896 (11.3%) by email, 847 (5.1%) by letter and 450 (2.7%) by social media[13] (Figure 20).

[13] Only Facebook posts / Tweets linked to the Official organisational Facebook / Twitter accounts are included as social media compliments.

SECTION 6

ADDITIONAL TABLES

Table 1: Complaint Issues Received by HSC Trusts (2014/15 - 2018/19)

HSC Trust	2014/15	2015/16	2016/17	2017/18	2018/19
Belfast	2,772	2,019	2,007	2,026	2,356
Northern	890	786	869	814	760
South Eastern	1,332	1,161	1,076	1,140	1,269
Southern	1,166	1,163	1,046	955	850
Western	629	892	1,030	746	690
NIAS	226	160	161	133	124
Northern Ireland	**7,015**	**6,181**	**6,189**	**5,814**	**6,049**

Table 2: Complaint Issues Received by HSC Trusts, by POC (2018/19)[14]

Programme of Care	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Total
Acute	1,745	368	700	428	385	0	**3,626**
Maternal & Child Health	46	63	51	55	66	0	**281**
Family & Child Care	93	76	91	104	65	0	**429**
Elderly Services	92	86	37	76	31	0	**322**
Mental Health	128	81	72	89	42	0	**412**
Learning Disability	18	16	16	22	21	0	**93**
Sens Impair & Phys Dis	9	11	16	13	9	0	**58**
Health Prom & Disease Prev	1	0	0	1	2	0	**4**
Prim Health & Adult Comm	5	22	162	61	37	0	**287**
Prison Healthcare			39				**39**
None (No POC assigned)	219	37	85	1	32	124	**498**
Total	2,356	760	1,269	850	690	124	**6,049**

[14] The South Eastern HSC Trust is the sole provider of Prison Healthcare in Northern Ireland.

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Table 3: Complaint Issues Received by HSC Trusts, by POC (2014/15 - 2018/19)[15]

Programme of Care	2014/15	2015/16	2016/17	2017/18	2018/19
Acute	4,189	3,666	3,703	3,371	3,626
Maternal & Child Health	399	272	354	361	281
Family & Child Care	495	496	459	466	429
Elderly Services	457	439	378	370	322
Mental Health	366	440	431	390	412
Learning Disability	160	166	134	119	93
Sens Imp & Phys Disability	114	77	61	73	58
Health Prom & Disease Prev	0	1	5	2	4
Prim Health & Adult Comm	214	194	167	190	287
Prison Healthcare	109	62	46	51	39
None (No POC assigned)	512	368	451	421	498
Total	**7,015**	**6,181**	**6,189**	**5,814**	**6,049**

[15] Prison Healthcare was previously included within 'None (No POC assigned)' but from 2014/15 this information is now recorded separately.

Table 4: Subject of Complaint Issues by Trust (2018/19)

Subject	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Total
Access to Premises	99	4	43	10	2	0	**158**
Aids/Adaptations/Appliances	19	4	7	16	5	0	**51**
Children Order Complaints	0	0	1	0	1	0	**2**
Clinical Diagnosis	111	31	58	6	41	0	**247**
Communication/Information	335	69	245	175	128	0	**952**
Complaints Handling	1	0	5	3	0	0	**9**
Confidentiality	16	7	10	9	7	1	**50**
Consent to Treatment/Care	3	0	3	2	0	0	**8**
Contracted Regulated Domiciliary Services	0	7	2	0	0	0	**0**
Contracted Regulated Residential Nursing	12	8	12	4	0	0	**36**
Contracted Independent Hospital Services	12	0	0	0	0	0	**12**
Other Contratced Services	2	3	0	1	0	0	**6**
Delay/Cancellation for Inpatients	0	1	8	0	5	0	**14**
Delayed Admission from A&E	0	0	2	0	0	0	**2**
Discharge/Transfer Arrangements	37	17	19	19	12	0	**104**
Discrimination	3	4	6	1	1	0	**15**
Environmental	38	15	23	8	6	0	**90**
Hotel/Support/Security Services (Excludes Contracted Services)	22	23	7	6	2	0	**60**
Infection Control	1	4	3	0	1	0	**9**
Mortuary & Post-Mortem	0	1	1	0	0	0	**2**
Policy/Commercial Decisions	6	41	22	30	0	0	**99**
Privacy/Dignity	5	5	18	9	10	2	**49**
Professional Assessment of Need	7	23	16	130	17	1	**194**
Property/Expenses/Finances	28	12	12	12	5	0	**69**
Records/Record Keeping	11	14	28	10	6	0	**69**
Staff Attitude/Behaviour	329	131	195	124	115	44	**938**
Transport, Late or Non-arrival/Journey Time	3	1	7	1	0	44	**56**
Transport, Suitability of Vehicle/Equipment	1	0	0	1	0	1	**3**
Quality of Treatment & Care	526	233	297	144	209	26	**1,435**
Quantity of Treatment & Care	147	13	14	14	53	1	**242**
Waiting List, Delay/Cancellation Community Based Appointments	15	19	22	6	13	0	**75**
Waiting List, Delay/Cancellation Outpatient Appointments	295	35	65	34	8	0	**437**
Waiting List, Delay/Cancellation Planned Admission to Hospital	180	10	20	23	9	0	**242**
Waiting Times, A&E Departments	19	10	18	25	9	0	**81**
Waiting Times, Community Services	6	4	20	6	1	0	**37**
Waiting Times, Outpatient Departments	36	3	18	18	8	0	**83**
Other	31	8	42	3	16	4	**104**
Total Number of Complaint Issues	**2,356**	**760**	**1,269**	**850**	**690**	**124**	**6,049**

Table 5: Category of Complaint Issue (2014/15 - 2018/19)

Category of Complaint Issue	2014/15		2015/16		2016/17		2017/18		2018/19	
	No.	%	No.	%	No.	%	No.	%	No.	%
Admissions/Discharges	565	8.1%	442	7.2%	429	6.9%	374	6.4%	348	5.8%
Aids/Adaptations/Appliances	71	1.0%	83	1.3%	72	1.2%	62	1.1%	51	0.8%
Appointments/Waiting Times	945	13.5%	785	12.7%	896	14.5%	737	12.7%	711	11.8%
Children Order	0	0.0%	4	0.1%	8	0.1%	5	0.1%	2	0.0%
Contracted Services	103	1.5%	59	1.0%	69	1.1%	64	1.1%	63	1.0%
Diagnosis/Oper/Treatment	2,054	29.3%	1,905	30.8%	1,775	28.7%	1,733	29.8%	1,920	31.7%
Information & Communication	1,035	14.8%	939	15.2%	1,007	16.3%	1,035	17.8%	1,075	17.8%
Mortuary	3	0.0%	1	0.0%	1	0.0%	0	0.0%	2	0.0%
Patient Experience	1,241	17.7%	1,108	17.9%	1,080	17.5%	1,030	17.7%	1,068	17.7%
Policy/Commercial Decisions	165	2.4%	127	2.1%	125	2.0%	111	1.9%	99	1.6%
Premises	233	3.3%	182	2.9%	214	3.5%	238	4.1%	317	5.2%
Prison Healthcare	106	1.5%	59	1.0%	46	0.7%	51	0.9%	39	0.6%
Prof Assessment of Need	249	3.5%	280	4.5%	275	4.4%	237	4.1%	191	3.2%
Transport	112	1.6%	91	1.5%	78	1.3%	61	1.0%	59	1.0%
Other	133	1.9%	116	1.9%	114	1.8%	76	1.3%	104	1.7%
Total	**7,015**	100.0%	**6,181**	100.0%	**6,189**	100.0%	**5,814**	100.0%	**6,049**	100.0%

Table 6: Category of Complaint Issue by Trust (2018/19)[16]

Category of Complaint Issue	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Northern Ireland
Admissions/Discharges	217	27	41	42	21	-	**348**
Aids/Adaptations/Appliances	19	4	7	16	5	-	**51**
Appointments/Waiting Times	371	71	141	89	39	-	**711**
Children Order	-	-	1	-	1	-	**2**
Contracted Services	26	18	14	5	-	-	**63**
Diagnosis/Operation/Treatment	787	278	354	166	308	27	**1,920**
Information & Communication	363	90	283	197	141	1	**1,075**
Mortuary	-	1	1	-	-	-	**2**
Patient Experience	365	152	228	146	131	46	**1,068**
Policy/Commercial Decisions	6	41	22	30	-	-	**99**
Premises	160	46	76	24	11	-	**317**
Prison Healthcare			39				**39**
Professional Assessment of Need	7	23	13	130	17	1	**191**
Transport	4	1	7	2	-	45	**59**
Other	31	8	42	3	16	4	**104**
Total	**2,356**	**760**	**1,269**	**850**	**690**	**124**	**6,049**

[16] The South Eastern HSC Trust is the sole provider of Prison Healthcare in Northern Ireland.

Table 7: Specialty of Complaint Issues by Trust (2018/19)

Specialty	Belfast	Northern	South Eastern	Southern	Western	NIAS	Total
Accident & Emergency	165	97	137	111	101	80	**691**
Allied Health Professions	63	38	61	40	22	0	**224**
Anaesthetics & Pain Management	15	6	30	9	10	0	**70**
Burns Plastic and Maxillofacial Surgery	3	0	19	0	2	0	**24**
Cardiology	29	9	19	15	4	0	**76**
Child & Adolescent Psychiatry	21	2	0	5	12	0	**40**
Children & Young Peoples Services	72	72	104	59	62	0	**369**
Community Nursing/Midwives	0	8	0	17	7	0	**32**
Community Paediatrics	18	7	1	3	2	0	**31**
Dentistry	25	3	0	1	0	0	**29**
Dermatology	9	2	8	6	13	0	**38**
Domicillary Services	16	9	2	17	7	0	**51**
ENT	0	4	31	5	19	0	**59**
General Medicine	85	40	105	51	48	0	**329**
General Surgery	62	53	40	52	68	0	**275**
Geriatric Medicine	50	23	17	0	7	0	**97**
Gynaecology	93	18	37	26	17	0	**191**
Joint Consultant Clinics	0	33	0	0	0	0	**33**
Learning Disability	13	16	14	22	12	0	**77**
Mental Health Acute	117	26	19	37	19	0	**218**
Mental Health Community	2	36	44	48	15	0	**145**
Neurology	338	0	10	3	10	0	**361**
Obstetrics	63	30	68	64	31	0	**256**
Old Age Psychiatry	0	16	12	4	1	0	**33**
Oncology	39	5	7	2	10	0	**63**
Ophthalmology	81	0	3	3	15	0	**102**
Other	443	170	367	143	61	44	**1,228**
Paediatrics	95	14	18	14	19	0	**160**
Physical Disability/ Sensory Support	9	1	11	13	3	0	**37**
Radiology	45	12	25	27	15	0	**124**
Residential Care	4	6	13	9	13	0	**45**
Trauma & Orthopaedics	318	4	35	27	46	0	**430**
Urology	35	0	12	17	19	0	**83**
Vascular	28	0	0	0	0	0	**28**
Total Number of Complaint Issues	**2,356**	**760**	**1,269**	**850**	**690**	**124**	**6,049**

Table 8: Complaints by Age Group and Gender of Patient / Client (2018/19)

Age Group	Female	Male	Total
Under 16	154	210	**364**
16 - 18	25	24	**49**
19 - 24	103	53	**156**
25 - 34	319	147	**466**
35 - 44	301	138	**439**
45 - 54	238	192	**430**
55 - 64	259	185	**444**
65 - 74	191	193	**384**
75 +	296	204	**500**
Total	**1,886**	**1,346**	**3,232**

Table 9: Time Taken to Provide a Substantive Response to Complaints Received, by HSC Trust (2018/19)

HSC Trust	20 Working Days or Less		More Than 20 Working Days		Total No.	Mean No. of Working Days
	No.	%	No.	%		
Belfast	814	*43.2%*	1,071	*56.8%*	**1,885**	36.1
Northern	592	*89.3%*	71	*10.7%*	**663**	17.1
South Eastern	371	*48.4%*	395	*51.6%*	**766**	33.1
Southern	290	*49.0%*	302	*51.0%*	**592**	27.1
Western	98	*22.1%*	345	*77.9%*	**443**	36.6
NIAS	14	*11.3%*	110	*88.7%*	**124**	72.4
Northern Ireland	**2,179**	*48.7%*	**2,294**	*51.3%*	**4,473**	**31.8**

Table 10: FPS Complaints Handled (2014/15 - 2018/19)

FPS Complaints	2014/15	2015/16	2016/17	2017/18	2018/19
GP	307	260	226	215	252
Dental	19	26	20	17	60
Pharmacy	0	3	3	8	5
Ophthalmic	0	0	0	0	0
Total	**326**	**289**	**249**	**240**	**317**

Table 11: FPS Complaints Handled Under Local Resolution (2014/15 - 2018/19)

Local Resolution	2014/15	2015/16	2016/17	2017/18	2018/19
GP	224	194	192	171	151
Dental	6	15	13	10	26
Pharmacy	0	1	1	5	0
Ophthalmic	0	0	0	0	0
Total	**230**	**210**	**206**	**186**	**177**

Table 12: FPS Complaints Handled Under Local Resolution, by Subject (2018/19)

Local Resolution	GP	Dental	Ophthalmic & Pharmacy	Total
Treatment & Care	82	21	0	**103**
Staff Attitude	15	1	0	**16**
Communication / Information	19	3	0	**22**
Other	35	1	0	**36**
Total	**151**	**26**	**0**	**177**

Table 13: FPS Complaints where the HSC Board Acted as an Honest Broker (2014/15 - 2018/19)

Honest Broker	2014/15	2015/16	2016/17	2017/18	2018/19
GP	83	66	34	44	101
Dental	13	11	7	7	34
Pharmacy	0	2	2	3	5
Ophthalmic	0	0	0	0	0
Total	**96**	**79**	**43**	**54**	**140**

Table 14: FPS Complaints where the HSC Board Acted as an Honest Broker, by Subject (2018/19)

Honest Broker	GP	Dental	Pharmacy	Total
Treatment & Care	45	27	1	**73**
Staff Attitude	9	2	1	**12**
Communication / Information	15	3	1	**19**
Other	32	2	2	**36**
Total	**101**	**34**	**5**	**140**

APPENDIX 1: TECHNICAL NOTES

This statistical release presents information on complaint issues received by HSC Trusts in Northern Ireland. It details the number of HSC Trust complaint issues received, by the programme of care, category, subject, specialty of the complaint and the time taken to provide a substantive response.

Information is also included on the number of complaints received by the HSC Board regarding Family Practitioner Services in Northern Ireland.

Data Collection

The information presented in this statistical release derives from the Departmental CH8 Revised statistical return provided by the six HSC Trusts, (including the NIAS) in Northern Ireland. The CH8 return was originally introduced in 1998 and updated in 2007 to take account of the structural changes within the HSC system following the Review of Public Administration (RPA). In 2014, the CH8 return was redesigned to allow the collection of patient level data on all complaints received by HSC Trusts. The patient level collection was titled CH8 Revised to distinguish it from the original CH8 aggregate return. This return is submitted on a quarterly basis by HSC Trusts, in respect of the services for which they have responsibility.

Data providers are supplied with technical guidance documents outlining the methodologies that should be used in the collection, reporting and validation of each of these data returns. These documents can be accessed at the following link:

https://www.health-ni.gov.uk/publications/trust-complaints-form-ch8

Information presented on FPS complaints forwarded to the HSC Board derives from CHB statistical return. The CHB is collected on a quarterly basis by the HSC Board, in respect of the services for which they have responsibility.

Data presented on compliments is collected from the six HSC Trusts on a quarterly basis using the compliments information return which was introduced in December 2017. The compliments information return was developed in consultation with HSC Trusts to ensure regional consistency, and enable comparisons across HSC Trusts.

Rounding

Percentages have been rounded to one decimal place and as a consequence some totals may not sum to 100.

Data Quality

All information presented in this bulletin has been provided by HSC Trusts / Board and has been validated and quality assured by Hospital Information Branch (HIB) prior to release.

For the CH8 Revised information collection, HSC Trusts are given a set period of time to submit the information. Following submission, HIB carry out a series of validation checks to verify that information submitted is consistent both within and across returns.

At the end of the financial year HIB carry out a more detailed series of validations to verify that the information is consistent. Trend analyses are used to monitor annual variations and emerging trends. Queries arising from validation checks are presented to HSC Trusts for clarification and if required returns may be amended and/or re-submitted. This report incorporates all returns and amendments received up to 20th June 2019.

For the compliments information reported in section 5, information has been estimated for some Trusts as they were only able to provide a partial return for the 2018/19 year because their monitoring systems had not been fully implemented. For 2018/19, compliments data for the Southern and Western HSC Trusts were estimated as data was only provided for the periods 1st November 2018 – 30th April 2019 and 1st January – 31st March 2019 respectively.

Main Uses of Data

The main uses of these data are to monitor and report the number of HSC Trust and FPS complaint issues received during the year, to help assess performance, for corporate monitoring, to inform and monitor related policy, and to respond to assembly questions and ad-hoc queries from the public.

Contextual Information for Using Complaint Statistics

Readers should be aware that contextual information about Northern Ireland and the health services provided is available to read while using statistics from this publication.

This includes information on the current and future population, structures within the Health and Social Care system, the vision for future health services as well as targets and indicators. This information is available at the following link:

https://www.health-ni.gov.uk/publications/contextual-information-using-hospital-statistics

Contact Information

As we want to engage with users of our statistics, we invite you to feedback your comments on the publication to:

Carol Murphy

Email: [redacted]

APPENDIX 2: DEFINITIONS

Programme of care

Programmes of care are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. There are nine programmes of care as follows:

POC1 Acute
POC2 Maternity and Child Health
POC3 Family and Child Care
POC4 Elderly Services
POC5 Mental Health
POC6 Learning Disability
POC7 Sensory Impairment and Physical Disability
POC8 Health Promotion and Disease Prevention
POC9 Primary Health and Adult Community

Complaint Issues

For the purposes of the CH8 return, a complaint may be understood as 'an expression of dissatisfaction requiring a response'. This return includes information on all formal complaints only, informal complaints or communications criticising a service or the quality of care but not adjudged to require a response, are not included on this form.

A single communication regarding a complaint may refer to more than one issue. In such cases each individual complaint issue is recorded separately for Programme of Care (POC) and Subject.

Only complaints received from/on behalf of patients/clients or other 'existing or former users of a Trust's services and facilities' are included. Complaints from staff are not included.

Where separate communications in respect of a single patient / client refer to one episode, they are treated as a single complaint issue for the purposes of this publication. In other words, if two relatives complain about the same subject/episode in respect of the same patient, this will be treated as one complaint issue only. However, if two relatives complain about separate subjects/episodes but in the care of the same patient, these will be treated as separate complaint issues.

Where separate unconnected communications refer to the same episode/issue, they will be treated as separate complaint issues. In other words, if separate individuals complain about a matter they have all experienced, this would be treated as separate complaint issues, e.g. if ten clients complain individually about conditions in a day centre, these will be treated as ten separate complaint issues.

The logic of the complaints procedure is that it should afford a speedy resolution of cases of individual dissatisfaction of service. This differs from the case of petitions where the concern is primarily the collective representation of views, e.g. if a single complaint is received from a group of users, it will be treated as a single complaint issue.

Where a complainant is dissatisfied with the Trust's response to his/her complaint and enters into further communications about the same matter/s, this is not a new complaint, rather it will be the same complaint reopened. Such a complaint would only be recorded once in the CH8 Revised, i.e. in the quarter it was initially received. However, if this complainant were to then complain about a separate/different matter, this would be a new complaint.

APPENDIX 3: SUBJECT OF COMPLAINT ISSUES

1. Access to Premises

This heading includes all issues concerning ease of movement inside and outside the buildings, e.g. signage, car parking, etc. Problems of wheelchair access / disabled parking etc. should also be included under this heading, if not covered under '*Discrimination' (17).*

2. Aids / Adaptations / Appliances

This heading refers to the suitability / availability of any aids / adaptations, once they have been recommended. Complaint issues about waiting for assessment should be included under '*Waiting Lists, Delay/Cancellation Community Based Appointments'* (*32*).

3. Children Order Complaints

This heading refers to all formal complaint issues received under the Children Order Representations and Complaint Issues Procedure, irrespective of their subject or content.

4. Clinical Diagnosis

This heading covers clinical diagnosis only and is to be distinguished from '*Professional Assessment of Need'* (*24*).

5. Communication / Information

This heading includes all issues of communication and information provided to patients / clients / families / carers regarding any aspect of their contact with staff. However, this should be distinguished from complaint issues about the attitude of staff when communicating with patients / clients, which would be logged under '*Staff Attitude / Behaviour'* (*27*).

6. Complaint Handling

This refers to handling of a complaint issue at any point up to and including the conclusion of local resolution stage, e.g. a complainant complains that he/she did not receive a response within the timescale. However, a complaint issue would not be included under this heading if it obviously falls under another heading, e.g. if the complaint issue is about attitude of staff handling the complaint issue, it would be logged under '*Staff Attitude / Behaviour'* (*27*).

7. Confidentiality

This heading includes any issues of confidentiality regarding patients / clients, e.g. (i) complaint by a patient regarding a breach of confidentiality or (ii) complaint by the parents of a young adolescent who are denied information by staff on the grounds of that adolescent's right to confidentiality.

8. Consent to Treatment / care

This refers to complaint issues made regarding consent to treatment/care.

9. Contracted Regulated Children's Services

10. Contracted Regulated Domiciliary Agency

11. Contracted Regulated Residential Nursing

These three headings refer to complaints about services that are provided by Trusts via contractual / commissioned arrangements. Establishments may be children's homes, nursing or residential homes, while Agencies may be a domiciliary care agency, fostering agency or nursing agency. For a full list of Regulated Establishments and Agencies please refer to 'Quality & Improvement Regulation NI Order 2003, Article 8'.

In the first instance, the service provider is expected to deal with complaints, however, where the complainant, Trust or RQIA wishes, the matter may be investigated by the Trust under the HSC Complaint Procedure.

Examples: (i) the Trust (as the commissioner) is asked by either RQIA or a relative, to investigate a complaint about the care or treatment provided to a resident in a Residential Home; (ii) a patient / client asks the Trust (as the commissioner) to investigate a complaint about the attitude of a member of staff of a Voluntary Agency with whom the Trust has contracted a home care service (e.g. personal care).

12. Contracted Independent Hospital Services

This heading refers to complaints about services that are provided by Trusts via contractual / commissioned arrangements with independent hospitals.

13. Contracted Services – Other

This heading refers to complaint issues about services that are provided by Trusts via contractual / commissioned arrangements that are not captured in '*Contracted Regulated Children's Services/Domiciliary Agency/Residential Nursing' (9, 10 & 11).* In the first instance, the service provider is expected to deal with complaint issues, however, where the complainant or Trust wishes, the matter may be investigated by the Trust under the HSC Complaint Procedure.

Example: Attitude of a member of staff of facilities services operating under contract on Trust premises, (e.g. car clamping company or catering).

14. Delay/Cancellation for Inpatients

This heading includes all aspects of delay or cancellation of operation or procedure once the patient is in hospital, e.g. Radiology investigation cancelled, or theatre cancelled due to lack of ICU beds, theatre overrun, no anaesthetist, etc. This should be distinguished from the cancellation or delay of admission for the procedure captured under *'Waiting List, Delay/Cancellation Planned Admission to Hospital' (34*).

15. Delayed Admission from A&E

This refers to patients waiting in Accident & Emergency, following decision to 'admit', before being allocated a bed in a ward. This should be distinguished from '*Waiting Times, A&E Departments'* (*35*) and '*Waiting List, Delay/Cancellation Planned Admission to Hospital' (34).*

16. Discharge / Transfer Arrangements

This heading refers to the adequacy of arrangements and includes early discharges or delayed discharges. It does not include failure to communicate discharge arrangements, which would be included under '*Communication / Information' (5).*

17. Discrimination

This heading refers to complaint issues regarding disadvantageous treatment. It includes discrimination under the 9 Equality categories (i.e. age, gender, marital status, political opinions, religious belief, racial group, sexual orientation, persons with or without a disability, persons with or without dependents) and under the Human Rights Act (e.g. Article 1, Right to Life; Article 3, Right to Freedom from Torture, Inhuman or Degrading Treatment; Article 8, Right to Respect for Private or Family Life). Complaint issues about patient choice should also be included under this heading.

18. Environmental

Complaint issues referring to the general condition or repair of the premises should be included under this heading. It also covers wider environmental issues, e.g. smoking.

19. Hotel / Support / Security Services

This heading includes any complaint issue referring to ancillary or support services, e.g. portering, facilities, catering. It also refers to security issues, e.g. stolen vehicles parked on Trust property.

20. Infection Control

This heading refers to compliance with infection control standards, e.g. hand hygiene; aseptic procedures; inappropriate use of personal protective equipment; incorrect disposal of waste or soiled linen; equipment / furniture not decontaminated. It covers issues around all infections but especially resistant micro-organism infections, e.g. MRSA, VRE. However, complaint issues about lack of information or not being informed would not be included in this heading, but would be logged under '*Communication / Information' (5).*

21. Mortuary & Post-Mortem

This category refers to complaint issues in relation to the mortuary and/or post-mortem.

22. Policy / Commercial Decisions

This category refers to complaint issues related to policy and/or commercial decisions.

23. Privacy / Dignity

This heading includes complaint issues specifically relating to the privacy or personal dignity of patients/clients.

24. Professional Assessment of Need

This heading refers to the assessment of need in either clinical or non-clinical contexts, however, should be distinguished from '*Clinical Diagnosis'* (4).

25. Property / Expenses / Finance

This heading refers to issues of the personal property, expenses or finance of patients/clients, e.g. due money for fostering; issues around direct payments; concerns about Trust charging / invoicing for

clients in Nursing/Residential Home (either Private or Trust Home); broken hearing aid; lost spectacles / dentures.

Property damaged by staff arising in the course of care / treatment would fall into this category; however, property stolen from a patient's locker (as not being entrusted to or in the custodianship of staff and not known to be attributable to staff) would come under the heading of '*Hotel/Support/Security Services' (19).* Complaint issues about stolen vehicles (visitor or patient) and property lost or stolen from visitors should similarly be logged as a '*Hotel/Support/Security Services' (19).*

26. Records / Record Keeping

This refers to cases where records (such as medical notes, case files, X-rays) are unavailable, e.g. records have been mislaid or misfiled. Complaint issues about access rights to deceased patients' health records (governed by Access to Health Records (1993) NI Order) should be included under this heading. Complaint issues about any aspect of content of records or right of access should only be included under this heading, if they are not more appropriately dealt with under other procedures, such as Data Protection Act or Freedom of Information Act appeals processes.

27. Staff Attitude / Behaviour

This category refers to complaint issues related to staff attitude and/or staff behaviour.

28. Transport, Late or Non-arrival / Journey Time

This heading refers to complaint issues about the late arrival or non-arrival of transport or about the length of journey.

29. Transport, Suitability of Vehicle / Equipment

This heading refers to the appropriateness of the vehicle assigned and will include issues such as comfort, ease of access for the client group served. Complaint issues about the appropriateness of equipment would also be logged under this heading.

30. Quality of Treatment & Care

This refers to the quality or standard of treatment and care provided. It also covers complaint issues relating to patient / client safety. However, it is to be distinguished from *'Quantity' of Treatment & Care, (31)* which refers to the quantity or amount of treatment and care.

31. Quantity of Treatment & Care

This refers to the amount of treatment and care provided or available, e.g. someone receiving good quality home help but feel they are receiving inadequate number of hours.

32. Waiting Lists, Delay/Cancellation Community Based Appointments

This heading refers to the time spent waiting for either assessment or for the delivery of services following assessment, e.g. waiting list for an OT assessment, waiting list for a care package. 'Unmet need' should also be logged under this heading. This heading should be distinguished from '*Waiting Times, Community Services' (36).*

33. Waiting Lists, Delay/Cancellation Outpatient Appointments

This heading refers to delay or cancellation in securing an outpatient appointment, i.e. outpatient waiting lists. It is to be distinguished from '*Waiting Lists, Delay/Cancellation Community Based Appointments'* (32) and '*Waiting Times, Outpatient Departments'* (*37*).

34. Waiting Lists, Delay/Cancellation Planned Admission to Hospital

This refers to delay or cancellation of a planned admission to hospital, e.g. waiting list for surgery. Delayed admissions from A&E should not be included in this category but under '*Delayed Admission from A&E' (15).*

35. Waiting Times, A&E Departments

Complaint issues regarding waiting time for initial assessment or waiting time to be treated should all be logged under this heading. Complaint issues about delayed admission from A&E are not included here but should be listed under '*Delayed Admission from A&E' (15).*

36. Waiting Times, Community Services

This heading refers to waiting time during delivery of community services. It would include such issues as erratic timing, failure of professional staff to turn up at the specified time for an appointment. It should be distinguished from '*Waiting Lists, Delay/Cancellation Community Based Appointments' (32).*

37. Waiting Times, Outpatient Departments

This heading refers to the time waiting at an outpatient appointment, other than at A&E. It should be distinguished from **'***Waiting Lists, Delay/Cancellation Outpatient Appointments (33)'.*

38. Other

This is a residual heading for any complaint issues, which do not fall into any categories listed above.

APPENDIX 4: SUBJECT GROUPED BY GENERAL CATEGORY

Admissions/Discharges

Delayed Admission from A&E

Discharge/Transfer Arrangements

Waiting Lists, Delay/Cancellation Planned Admission to Hospital

Aids/Adaptations/Appliance

Aids/Adaptations/Appliances

Appointments/Waiting Times

Waiting Lists, Delay/Cancellation Community Based Appointments

Waiting Lists, Delay/Cancellation Outpatient Appointments

Waiting Times, A&E Departments

Waiting Times, Community Services

Waiting Times, Outpatient Departments

Children Order

Children Order Complaint Issues

Contracted Services

Contracted Regulated Children's Services

Contracted Regulated Domiciliary Agency

Contracted Regulated Residential Nursing

Contracted Independent Hospital Services

Other Contracted Services

Diagnosis/Operation/Treatment

Clinical Diagnosis

Consent to Treatment/Care

Delay/Cancellation for Inpatients

Treatment & Care, Quality

Treatment & Care, Quantity

Information & Communication

Communication/Information to Patients

Complaints Handling

Confidentiality

Records/Records Keeping

Mortuary

Mortuary & Post-Mortem

Patient Experience

Discrimination

Privacy/Dignity

Property/Expenses/Finance

Staff Attitude/Behaviour

Policy/Commercial Decisions

Policy/Commercial Decisions

Premises

Access to Premises

Environmental

Hotel/Support/Security Services

Infection Control

Prison Health Care

Prison Healthcare Related Complaint Issues

Professional Assessment of Need

Professional Assessment of Need

Transport

Transport, Late or Non-arrival/Journey Time

Transport, Suitability of Vehicle/Equipment

Other

Other

APPENDIX 5: HSC BOARD COMPLAINTS

The information presented within this release relating to FPS complaints derives from the HSC Board CHB statistical return. The CHB is collected on a quarterly basis by the HSC Board, in respect of the services for which they have responsibility.

Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services.

Under HSC Complaints Procedure all FPS practices are required to forward to the HSC Board anonymised copies of each letter of complaint received along with the subsequent response, within 3 working days of this being issued.

The first stage of the HSC Complaints Procedure is known as 'local resolution'. The purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint. In the case of FPS practices, local resolution involves a practitioner seeking to resolve the complaint through discussion and negotiation.

Where a complainant does not wish to approach the FPS practice directly, HSC Board Complaints staff, with the agreement of both the practice and complainant, may act as an intermediary or 'honest broker' with the aim of assisting in the local resolution of the complaint.

The HSC Board has a responsibility to record and monitor the outcome of all complaints lodged with them. It will provide support and advice to FPS in relation to the resolution of complaints and it will also appoint independent experts, lay persons or conciliation services, where appropriate.

APPENDIX 6: COMPLIMENTS GUIDANCE / DEFINITIONS

Introduction

1. The purpose of this form is to record the number of compliments received by Trusts during the quarter, the subject areas to which they referred and how the compliment was received.

2. The form should be returned quarterly by Trusts in respect of services for which they have responsibility. Deadline for receipt by Hospital Information Branch is not later than one month and 10 working days after the end of the quarter to which the return refers. For example, figures for the quarter April – June will be provided not later than 10 working days into August.

Compliments

3. For the purposes of this return a compliment may be understood as 'an expression of praise, commendation or admiration'.

4. Only compliments received from/on behalf of patients/clients or other 'existing or former users of a Trust's services and facilities' should be included. Compliments from staff should not be included on this form.

5. A singe communication may include more than one compliment. In such cases each distinct compliment should be recorded separately on the return.

6. Compliments received by a Trust which properly refer to the services of another Trust or party should be recorded on the return of that relevant Trust/party and not on the return of the Trust of first receipt.

7. Where separate communications (whether from a single party or from several parties in respect of a single patient) refer to one subject only, they should be treated as one compliment for the purposes of this form.

8. In other words, if two relatives submit a compliment about the same subject/episode in respect of the same patient, this should be treated as one compliment only.

9. However, if two relatives submit compliments about separate subjects/episodes in the care of the same patient, these should be treated as separate compliments.

Subjects

10. This part deals with the subject of the compliment. The subject of the compliment is to be assigned on the basis of the subject that best describes the nature of the patient / client's praise.

Definitions of Subjects:

i. Quality of Treatment & Care

This refers to the quality or standard of treatment and care provided. It also covers compliments relating to patient/client safety.

ii. Staff Attitude & Behaviour

This category refers to compliments related to staff attitude and/or staff behaviour.

iii. Information & Communication

This heading includes all issues of communication and information provided to patients / clients / families / carers regarding any aspect of their contact with staff. However, this should be distinguished from compliments about the attitude of staff when communicating with patients / clients, which should be logged under *'Staff Attitude & Behaviour'*.

iv. Environment

Compliments referring to the general condition or repair of the premises should be included under this heading.

v. Other

This is a residual heading for any compliments which do not fall into any of the categories listed above.

11. Where the subject is recorded as *'Other'* a brief description of the compliment should be provided in part 2 of the return.

Method of Compliment

12. Only written compliments received by (i) Card, (ii) Email, (iii) Feedback Form, (iv) Letter or (v) Social Media (Facebook & Twitter only) should be included in this return.

13. Only Facebook posts / Tweets linked to the official organisational Facebook/Twitter accounts should be included.

APPENDIX 7: ABOUT HOSPITAL INFORMATION BRANCH

Hospital Information Branch is responsible for the collection, quality assurance, analysis and publication of timely and accurate information derived from a wide range of statistical information returns supplied by the Health & Social Care (HSC) Trusts and the HSC Board. Statistical information is collected routinely from a variety of electronic patient level administrative systems and pre-defined EXCEL survey return templates.

The Branch aims to present information in a meaningful way and provide advice on its uses to customers in the HSC Committee, Professional Advisory Groups, policy branches within the DoH, other Health organisations, academia, private sector organisations, charity/voluntary organisations as well as the general public. The statistical information collected is used to contribute to major exercises such as reporting on the performance of the HSC system, other comparative performance exercises, target setting and monitoring, development of service frameworks as well as policy formulation and evaluation. In addition, the information is used in response to a significantly high volume of Parliamentary / Assembly questions and ad-hoc queries each year.

Information is disseminated through a number of key statistical publications, including: Inpatient Activity, Outpatient Activity, Emergency Care, Mental Health & Learning Disability and Waiting Time Statistics (Inpatient, Outpatient, Diagnostics, Cancer and Emergency Care). A detailed list of these publications is available from:

https://www.health-ni.gov.uk/topics/doh-statistics-and-research

APPENDIX 8: ADDITIONAL INFORMATION

Further information on HSC Trust Complaint Issues and Compliments in Northern Ireland are available from:

Carol Murphy

Hospital Information Branch

Information & Analysis Directorate

Department of Health

Stormont Estate

Belfast, BT4 3SQ

Email: [redacted]

INFORMATION ANALYSIS DIRECTORATE

Complaints and Compliments Received by HSC Trusts

in Northern Ireland (2019/20)

Published 30th September 2020
(delayed due to COVID-19 outbreak, see appendix 7)

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

NISRA
Northern Ireland Statistics and Research Agency
Gníomhaireacht Thuaisceart Éireann um Staitistící agus Taighde

Reader Information

Purpose:	This publication monitors and reports the number of HSC Trust complaint issues received, by the programme of care, category, subject and specialty of the complaint issue, as well as demographic information and the time taken to provide a substantive response to complaints received. It also includes information on compliments received by HSC Trusts regarding the services they provide.
Authors	Carol Murphy, Jamie Houston, Kieran Taggart, Siobhan Morgan
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Issued by	Hospital Information Branch Information & Analysis Directorate Department of Health Stormont Estate Belfast, BT4 3SQ
Statistician	Carol Murphy statistics@health-ni.gov.uk
Statistical Quality	Information detailed in this release has been provided by HSC Trusts / Board and has been validated and quality assured by Hospital Information Branch (HIB) prior to release.
Target Audience	DoH, Chief Executives of HSC Board and Trusts in Northern Ireland, health care professionals, academics, Health & Social Care stakeholders, media and general public.
Further Copies	statistics@health-ni.gov.uk
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Price	Free
Copyright	This publication is Crown copyright and may be reproduced free of charge in any format or medium. Any material used must be acknowledged, and the title of the publication specified.

CONTENTS

KEY POINTS

Latest Year (2019/20)

- A total of 4,370 complaints, relating to 6,105 complaint issues, were received by HSC Trusts in 2019/20 (Tables 1 & 9); equating to 84 complaints per week or approximately 12 complaints per day.
- Almost three fifths (3,576, 58.6%) of complaint issues received during 2019/20 related to the 'Acute' POC (Table 2, Figure 3).
- During 2019/20, the greatest number (1,855, 30.4%) of complaint issues concerned the patient's 'Diagnosis/Operation/Treatment' (Table 5).
- The highest percentage of complaint issues received in 2019/20 related to the 'Accident & Emergency' (746, 12.2%) specialty (Table 7).
- Of the 4,370 complaints received in 2019/20, the median age of the patient / client was 46.7 years (Figure 8).
- On average HSC Trusts took 29.4 working days to provide a substantive response to complaints received in 2019/20 (Table 9, Figure 13).
- During 2019/20, 27,817 compliments (via card, email, feedback form, letter, social media or telephone) were received by HSC Trusts in Northern Ireland.
- Of the 27,817 compliments received, 16,909 (60.8%) related to 'Quality of Treatment & Care', 7,306 (26.3%) to 'Staff Attitude & Behaviour', 2,203 (7.9%) to 'Information & Communication', 1,064 (3.8%) to 'Environment', and 335 (1.2%) to 'Other' subjects (Table 15, Figure 20).

Last Five Years (2015/16 to 2019/20)

- Since 2015/16, the number of complaint issues received by HSC Trusts has shown minor change from 6,181 to 6,105 in 2019/20 (Table 1, Figure 2).
- Over the last five years, four of the six HSC Trusts reported a decrease in complaint issues received; whilst the South Eastern and Belfast HSC Trusts reported increases (231, 19.9% and 99, 4.9%, respectively) (Table 1, Figure 2).
- Between 2015/16 and 2019/20, the largest increase in the number of complaint issues (95, 34.9%) was observed in the 'Maternal & Child Health' POC (272 to 367) (Table 3).
- Complaints handled in 2019/20 against Family Practitioner Services decreased by a third (107, 33.8%) compared to the previous year (317 in 2018/19); the number of complaints being at its lowest in five years (Table 10, Figure 14).

SECTION 1

COMPLAINT ISSUES RECEIVED BY HSC TRUSTS

What is the Difference between a Complaint and a Complaint Issue?

A ***complaint*** is defined as an 'expression of dissatisfaction' received from or on behalf of patients, clients or other users of HSC Trust and/or Family Practitioner Services or facilities.

A single communication regarding a complaint, however, may refer to more than one issue. In such cases each individual ***complaint issue*** is recorded separately for the Programme of Care, Subject and Specialty to which it relates.

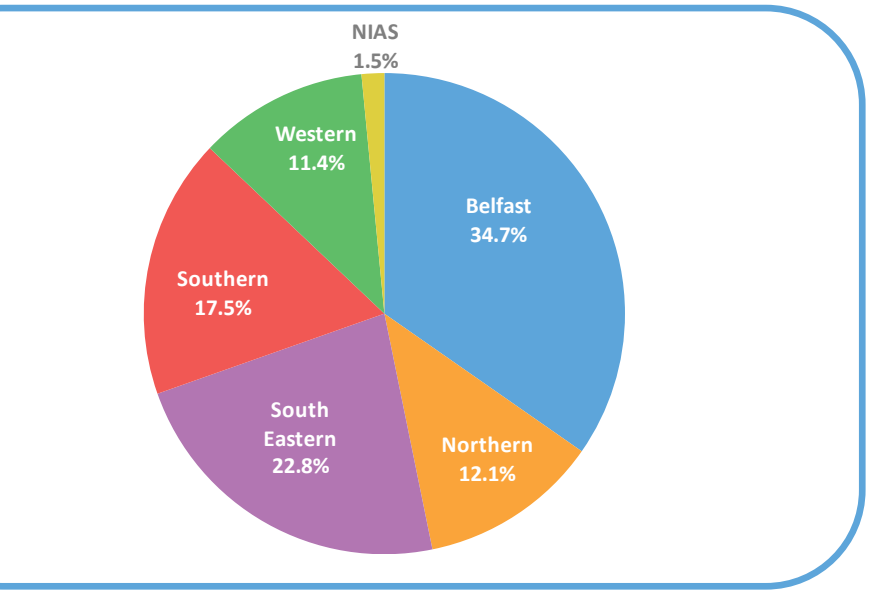
Over a third of complaint issues were received by the Belfast HSC Trust

Complaint Issues Received by HSC Trusts

During 2019/20, HSC Trusts received 4,370 complaints relating to 6,105 complaint issues (Tables 1 & 9).

Of the 6,105 complaint issues, over a third (2,118, 34.7%) were received by the Belfast HSC Trust, 1,392 (22.8%) by the South Eastern HSC Trust, 1,067 (17.5%) by the Southern HSC Trust, 739 (12.1%) by the Northern HSC Trust, 696 (11.4%) by the Western HSC Trust and 93 (1.5%) by the Northern Ireland Ambulance Service (NIAS) (Tables 1 & 2, Figure 1).

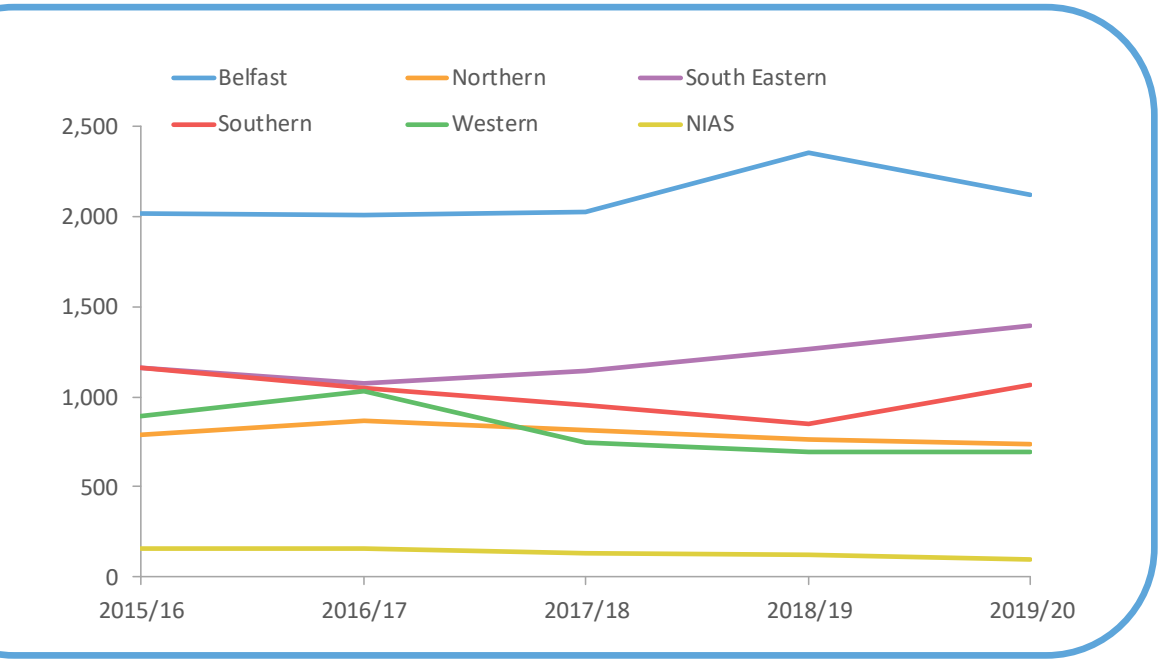
Figure 1: Complaint Issues Received by HSC Trusts (2019/20)



During the last five years, the highest number of complaint issues received by HSC Trusts was in 2016/17 (6,189) and the lowest in 2017/18 (5,814) (Table 1, Figure 2).

Since 2015/16, the number of complaint issues received increased in just two of the six HSC Trusts, with the South Eastern HSC Trust reporting the largest increase (231, 19.9%) from 1,161 in 2015/16 to 1,392 in 2019/20 (Table 1, Figure 2).

Figure 2: Complaint Issues Received by HSC Trusts (2015/16 - 2019/20)



Complaint Issues Received by Programme of Care (POC)[1]

Each complaint issue received is recorded against the POC of the patient / client to whom the complaint relates. If a complaint is made by a user of HSC Trust facilities who is not a patient / client, the complaint issue will be recorded against the POC of that service.

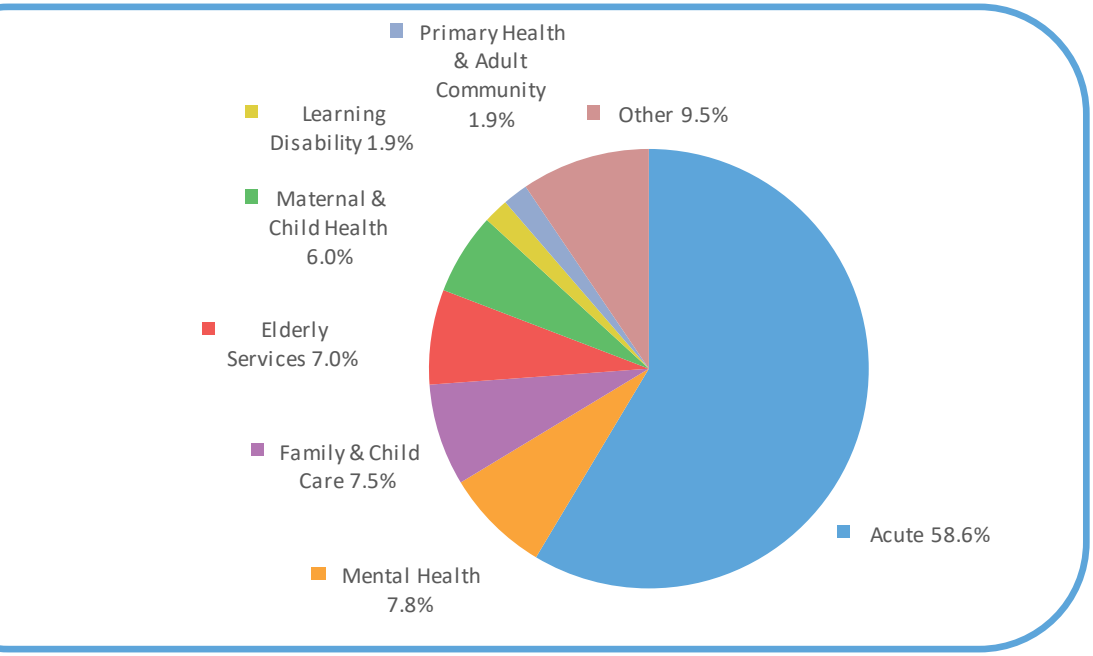
59% of complaint issues received during 2019/20 related to the Acute POC

Of the 6,105 complaint issues received by HSC Trusts in 2019/20, almost three fifths (3,576, 58.6%) related to the Acute POC (Table 2)

Four POCs accounted for over 80% (4,934, 80.8%) of all complaint issues received during 2019/20; Acute POC (3,576, 58.6%), Mental Health POC (474, 7.8%) Family & Child Care POC (458, 7.5%), and Elderly Services POC (426, 7.0%) (Table 2 & Figure 3).

Since 2015/16, the number of complaint issues received by HSC Trusts relating to the Maternal & Child Health POC increased by 34.9% (95), from 272 to 367 (Table 3).

Figure 3: Complaint Issues by POC (2019/20)[2]



[1] Refer to Appendix 2: Definitions for full list of Programmes of Care (POCs)
[2] 'The 'Other' category includes all complaint issues not included within the seven named POCs above.

Complaint Issues Received by POC and HSC Trust

There is variation across HSC Trusts in the distribution of complaint issues across POCs. During 2019/20:

- Belfast HSC Trust reported the highest number of complaint issues relating to the Acute POC (1,560, 43.6%), Mental Health POC (130, 27.4%), and the Elderly Services POC (108, 25.4%) (Table 2).

- South Eastern HSC Trust reported the highest number of complaint issues relating to the Maternal & Child Health POC (120, 32.7%) and the Primary Health & Adult Community POC (52, 46.0%). The South Eastern HSC Trust, the sole provider of Prison Healthcare in Northern Ireland, reported 40 complaint issues in relation to this POC (Table 2).

- Southern HSC Trust reported the highest number of complaint issues relating to the Sensory Impairment & Physical Disability POC (17, 42.5%) and the Learning Disability POC (38, 33.6%) (Table 2).

- The Western HSC Trust reported the highest number of complaint issues relating to the Primary Health & Adult Community POC (23, 95.8%) (Table 2).

74%
of complaint issues received in the Belfast HSC Trust related to the Acute POC

Complaint Issues Received by Category

The category of each complaint issue is based on the subject[3] which best describes the nature of the patient's / client's concern. To enable the category of the complaint issue to be presented, the subject area of each complaint issue has been grouped into one of 15 main categories[4].

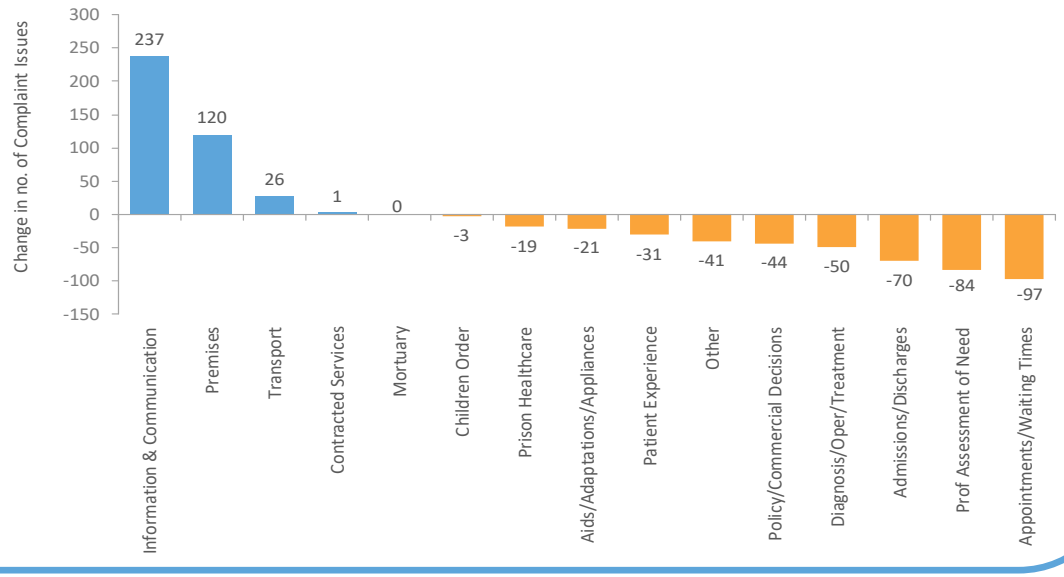
During 2019/20, HSC Trusts reported that the highest number of complaint issues related to 'Diagnosis/Operation/Treatment' (1,855, 30.4%), 'Information & Communication' (1,176, 19.3%), 'Patient Experience' (1,077, 17.6%) and 'Appointments/Waiting Times' (688, 11.3%) (Table 5).

66% increase in Premises related complaint issues received

Between 2015/16 and 2019/20, four categories reported increases in the number of complaint issues received, the 'Premises' category increased by 65.9% from 182 to 302, 'Transport' by 28.6% from 91 to 117, 'Information & Communication' by 25.2% from 939 to 1,176 and 'Contracted Services' by 1.7% from 59 to 60 (Figure 4, Table 5).

The 'Appointments/Waiting Times' and 'Professional Assessment of Need' categories reported the largest decrease in the number of complaint issues received, 97 (12.4%) and 84 (30.0%), respectively (Figure 4, Table 5).

Figure 4: Change in the Number of Complaint Issues Received, by Category of Complaint (2015/16 - 2019/20)



[3] A complete list of complaint issue subjects is detailed in Appendix 3, whilst an analysis of complaint issues by subject can be found in Table 4.
[4] A list of complaint issue subjects grouped by general category is detailed in Appendix 4.

Complaint Issues Received by Category and HSC Trust

During 2019/20:

- In the Belfast HSC Trust, a third (692, 32.7%) of complaint issues related to the 'Diagnosis/Operation/Treatment' category. The next largest categories were 'Information & Communication' (426, 20.1%), 'Appointments & Waiting Times' (315, 14.9%) and 'Patient Experience' (297, 14.0%) (Figure 5, Table 6).

- In the Northern HSC Trust, the largest category of complaint issues related to 'Diagnosis/Operation/Treatment' (254, 34.4%). The second largest category was 'Patient Experience' (150, 20.3%) (Figure 5, Table 6).

- The 'Diagnosis/Operation/Treatment' category accounted for the largest number (418, 30.0%) of complaint issues received in the South Eastern HSC Trust followed by 'Information & Communication' (308, 22.1%) and Patient Experience (271, 19.5%) (Figure 5, Table 6).

- In the Southern HSC Trust, the largest number (271, 25.4%) of complaint issues related to the 'Information & Communication' category. The next largest categories were 'Diagnosis/Operation/Treatment' (246, 23.1%) and 'Patient Experience' (216, 20.2%) (Figure 5, Table 6).

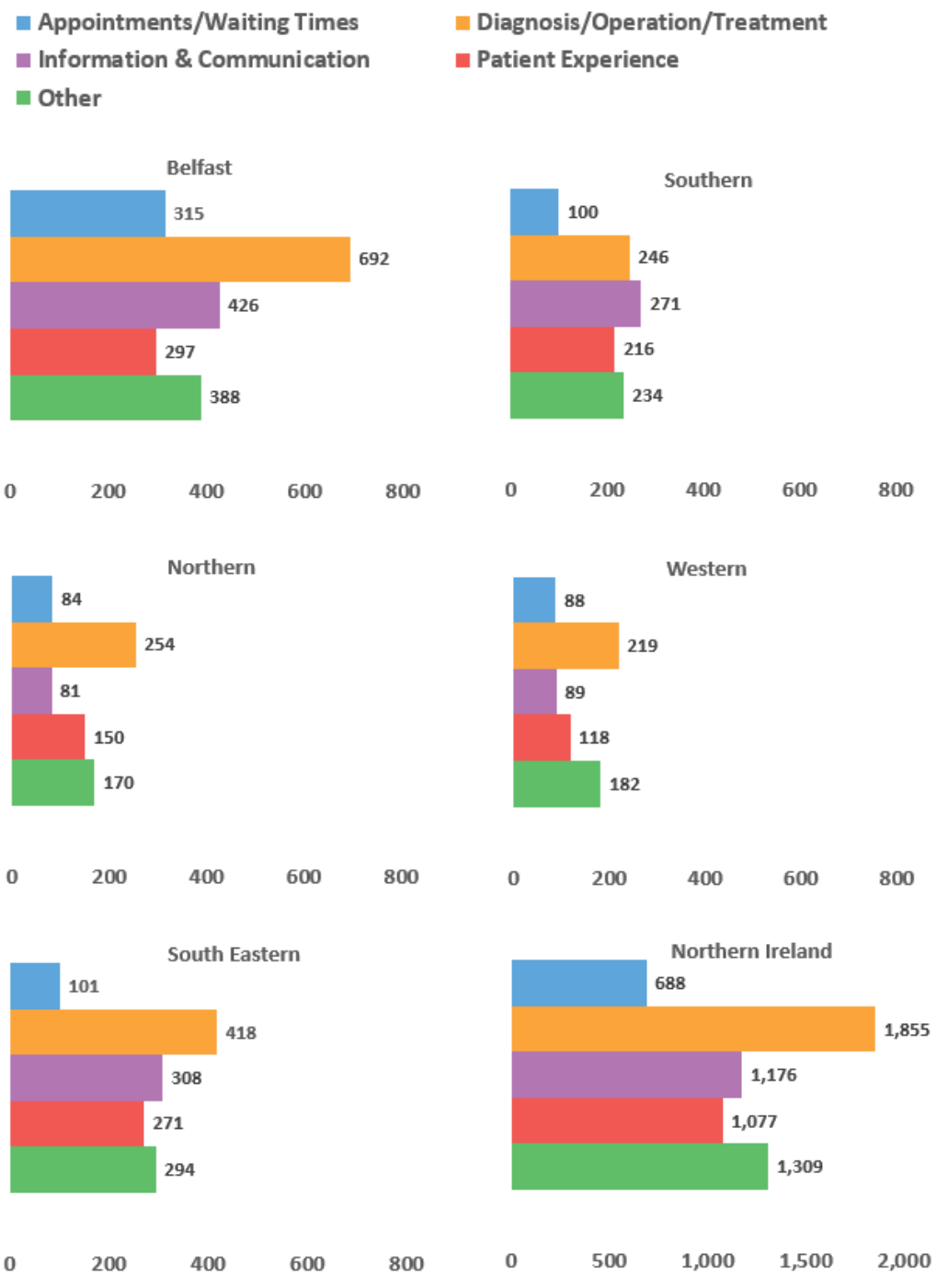
- Almost a third (219, 31.5%) of complaint issues received by the Western HSC Trust related to 'Diagnosis/Operation/Treatment'. The next largest category was 'Patient Experience' (118, 17.0%) (Figure 5, Table 6).

- The majority of complaint issues received by NIAS related to 'Transport' (40, 43.0%) followed by 'Diagnosis/Operation/Treatment' (26, 28.0%) and 'Patient Experience' (25, 26.9%) (Table 6).

Figure 5 below presents a summary of the four largest categories, accounting for 78.6% (4,796) of complaint issues received during 2019/20 for each HSC Trust. In the charts below complaint issues not in the four largest categories are referred to as 'Other'.

3 in 10
complaint issues related to Diagnosis/Operation/ Treatment

Figure 5: Main Category of Complaint Issues Received by HSC Trusts (2019/20)[5]



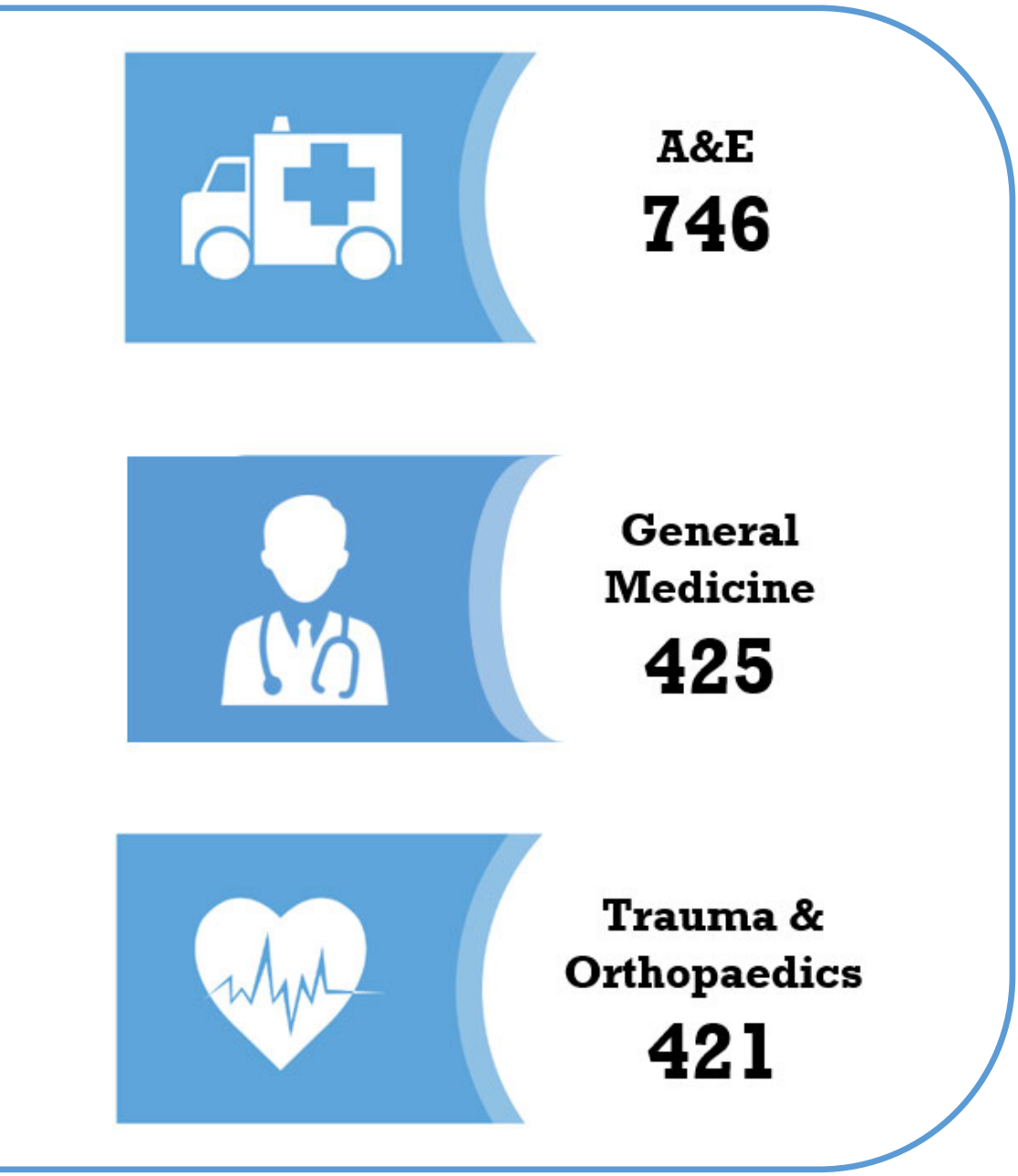
[5] Information for Northern Ireland includes complaint issues received by all HSC Trusts including the NIAS.

Complaint Issues Received by Specialty

During 2019/20, HSC Trusts reported that the highest number of complaint issues received related to the 'Accident & Emergency' (746, 12.2%), 'General Medicine' (425, 7.0%) and 'Trauma & Orthopaedics' (421, 6.9%) specialties (Table 7).

These three specialties accounted for just over a quarter (1,592, 26.1%) of all complaint issues received during this time (Table 7).

Figure 6: Top 3 Complaint Issues Received by Specialty



SECTION 2

COMPLAINTS RECEIVED BY HSC TRUSTS

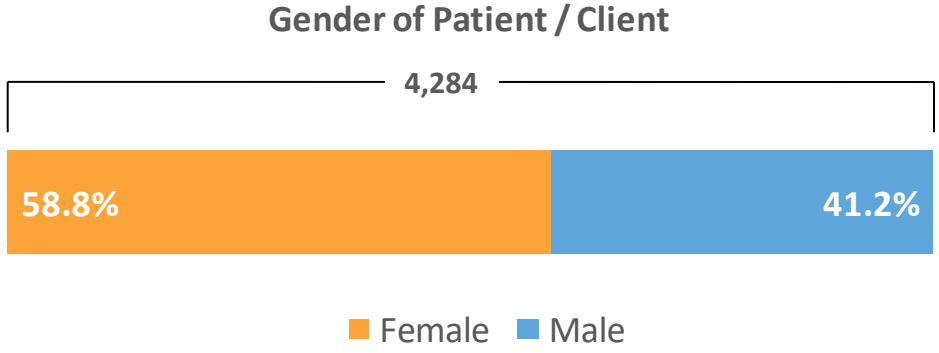
During 2019/20, HSC Trusts received 4,370 complaints relating to 6,105 complaint issues. Section 2 presents a summary of information relating to these 4,370 complaints. Further information on the difference between a complaint and a complaint issue is detailed on page 5.

Age and Gender of Patient / Client

During 2019/20, the gender of the patient / client was recorded in 4,284 (98.0%) of complaints received by HSC Trusts (Figure 7).

Of those complaints where the gender of the patient / client was recorded, 2,519 (58.8%) were females and 1,765 (41.2%) males (Figure 7).

Figure 7: Gender of Patient / Client (2019/20)



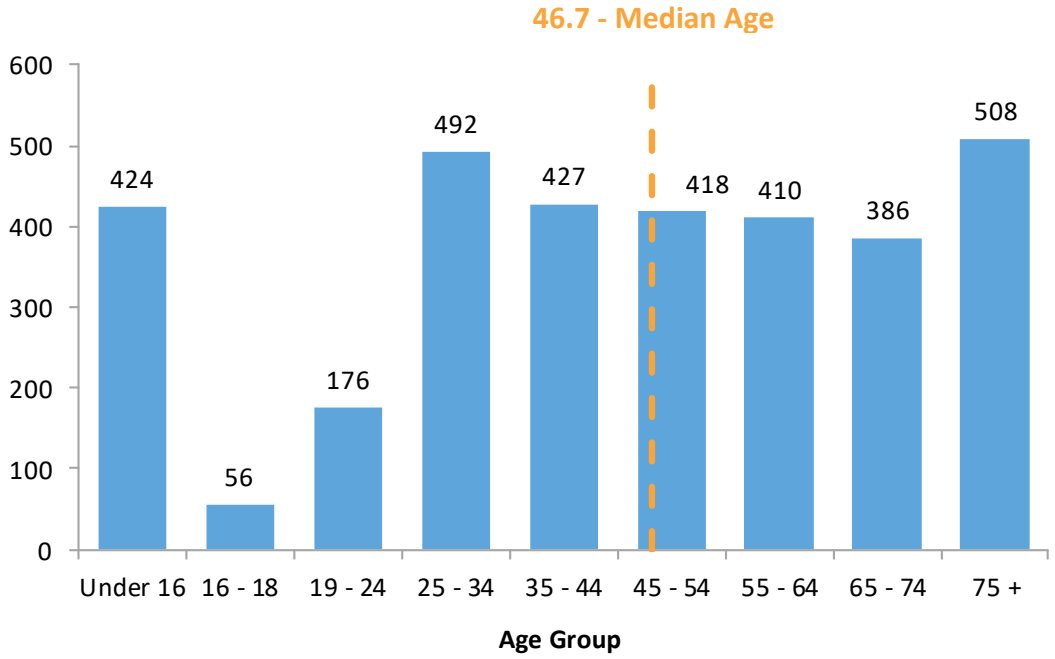
During 2019/20, both the age and gender of the patient / client was recorded in 3,297 (75.4%) of the complaints received by HSC Trusts.

47 years
the median age of patient / client complaints received in 2019/20

For those complaints where the age and gender of the patient / client was recorded, 508 (15.4%) related to patients / clients aged 75 & over and 424 (12.9%) to those aged under 16 (Figure 8, Table 8).

Of the complaints received by HSC Trusts during 2019/20, the median age of the patient / client was 46.7 years (Figure 8).

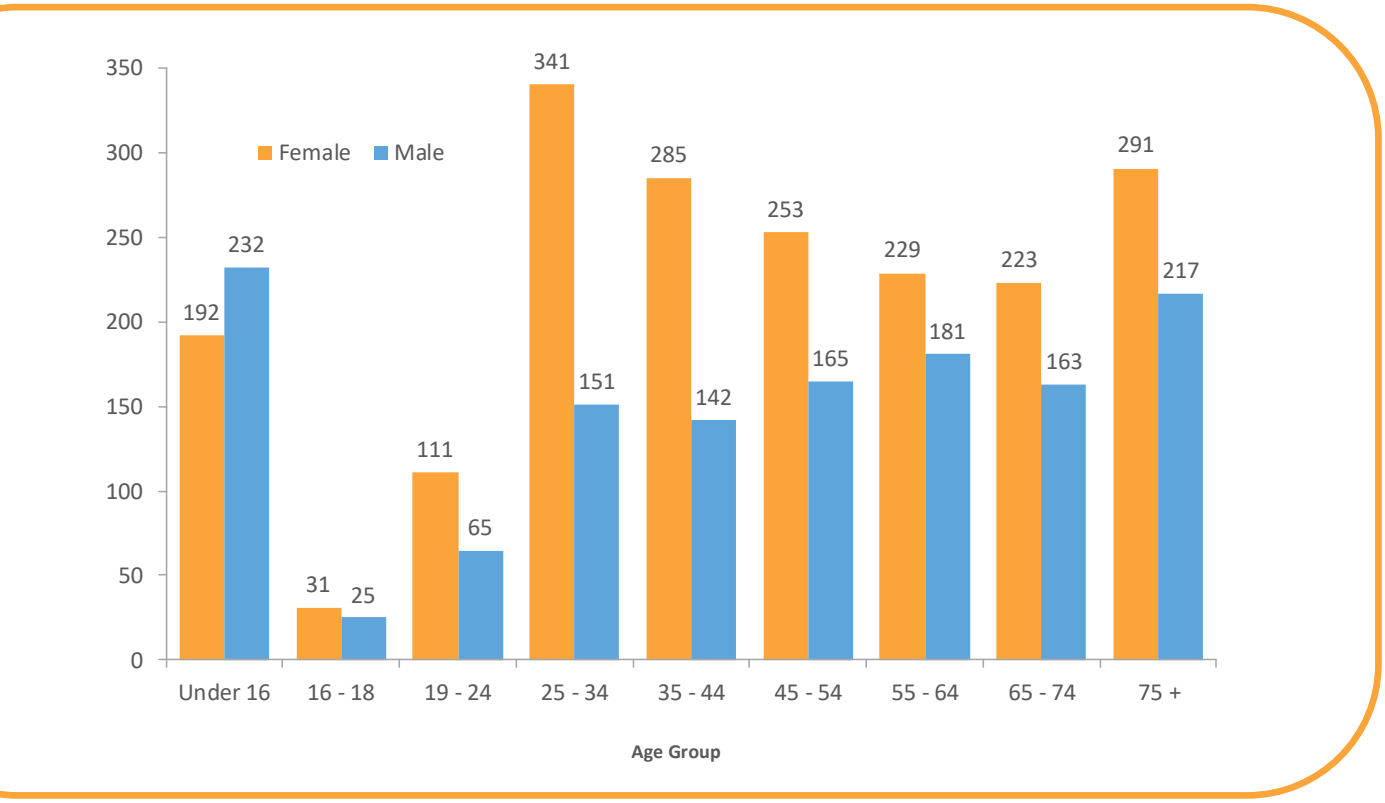
Figure 8: Complaints Received by Age Group of Patient / Client (2019/20)



Of the 3,297 complaints where the age and gender of the patient / client was recorded, 1,956 (59.3%) were females and 1,341 (40.7%) were males (Table 8, Figure 9).

There were over twice as many complaints received relating to females than males in the 25-34 and 35-44 age groups. The only age group where males outnumbered females was the under 16s (Table 8, Figure 9).

Figure 9: Complaints Received by Age Group and Gender of Patient / Client (2019/20)



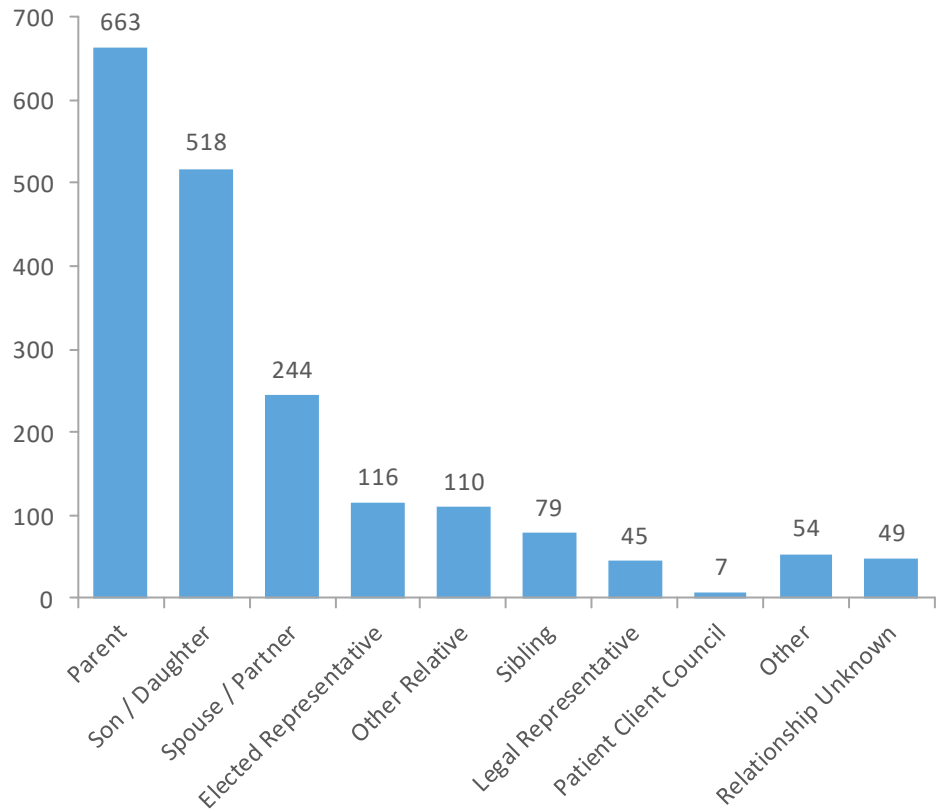
Relationship of Complainant to Patient / Client

Over half (2,472, 56.6%) of all complaints received in 2019/20 were from the patient / client, with 1,885 (43.1%) complaints from persons acting on behalf of the patient / client and 13 (0.3%) complaints where no particular patient / client was identified or it was unknown whether the complainant was the patient / client themselves or acting on behalf of a patient / client.

57%
of complaints were received from the patients / clients themselves in 2019/20

Of the 1,885 complaints received from persons acting on behalf of the patient / client, over a third (663, 35.2%) were from the parents of the patient / client, 518 (27.5%) from the son / daughter, 244 (12.9%) from a spouse / partner and 116 (6.2%) from an elected representative (Figure 10).

Figure 10: Complaints Received by Relationship of Complainant (2019/20)[6]



[6] Includes only those complaints made by persons acting on behalf of the patient / client i.e. the complainant was not the patient / client

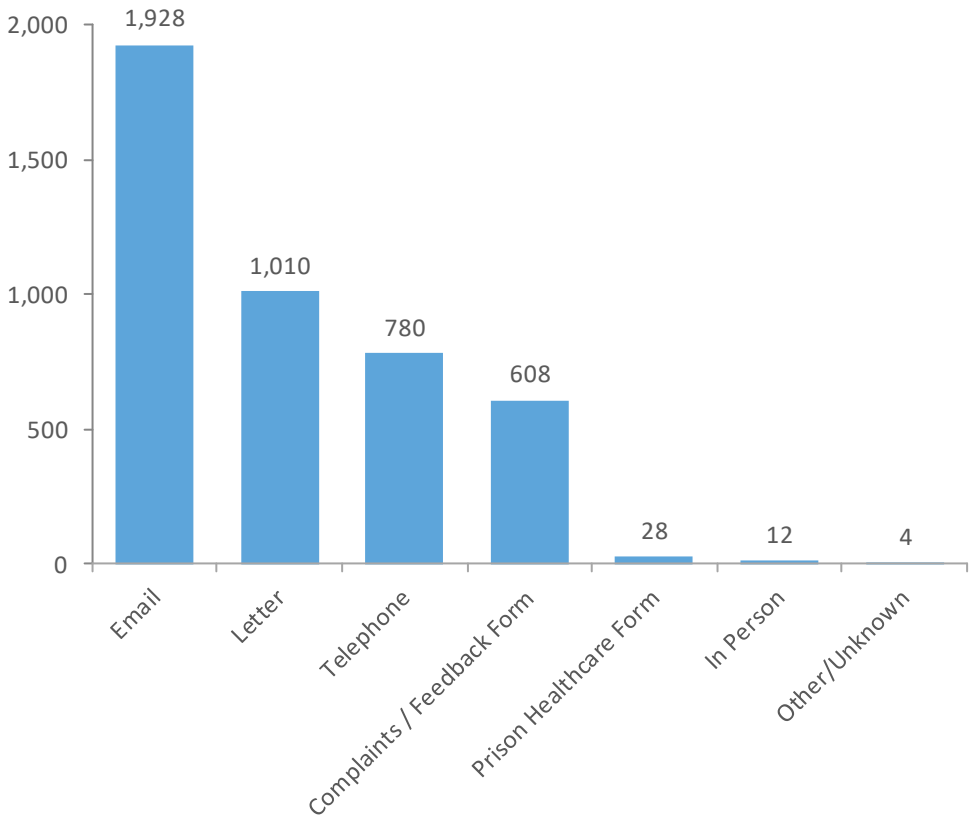
Method of Complaint

Of the 4,370 complaints received during 2019/20, more than two fifths (1,928, 44.1%) were sent by email, 1,010 (223.1%) by letter and 780 (17.8%) by telephone. These three methods accounted for over four fifths (85.1%, 3,718) of all complaints received during the year (Figure 11).

44%

of complaints received were sent by email in 2019/20

Figure 11: Complaints Received by Method of Complaint (2019/20)



SECTION 3

TIME TAKEN TO PROVIDE A SUBSTANTIVE RESPONSE TO COMPLAINTS RECEIVED

A substantive response is defined as a communication of the outcome of the complaint to the complainant following an investigation. It should be noted that a single substantive response will be provided to a complaint which may include a number of complaint issues.

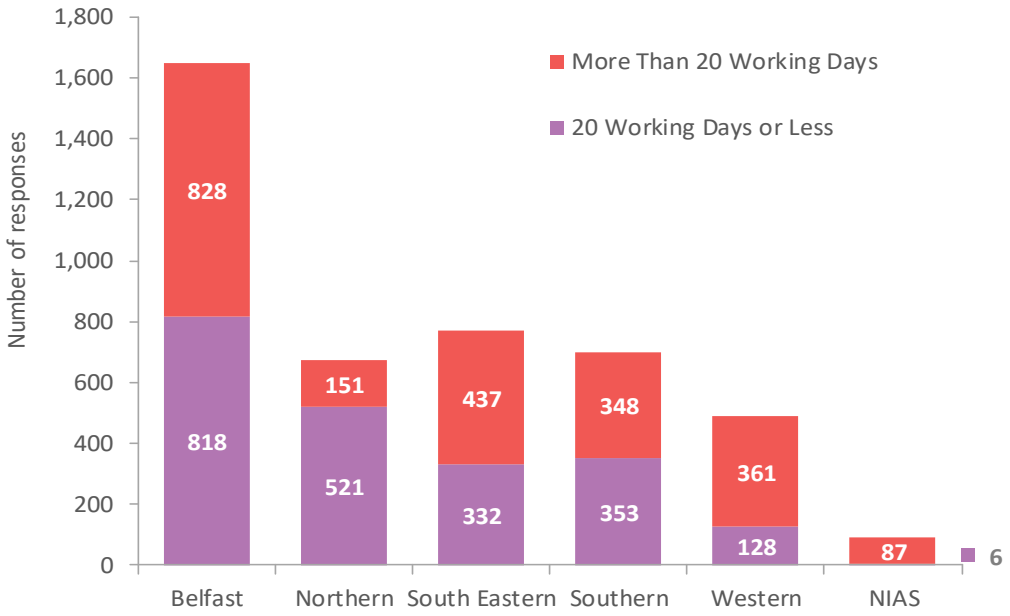
The HSC Complaints Policy requires HSC Trusts to provide a substantive response to the complainant within 20 working days of receipt of a complaint. Where this is not possible, a holding response explaining the reason for the delay is sent to the complainant. **All holding responses are issued in 20 working days or less.**

During 2019/20, just under half (2,158, 49.4%) of substantive responses were provided by HSC Trusts within 20 working days of having received the complaint (Table 9, Figure 12).

The Northern HSC Trust provided the highest proportion of substantive responses within 20 working days (521, 77.5%) during 2019/20, whilst the NIAS provided the lowest (6, 6.5%) (Table 9, Figure 12).

49%
of complaints received a substantive response within 20 working days

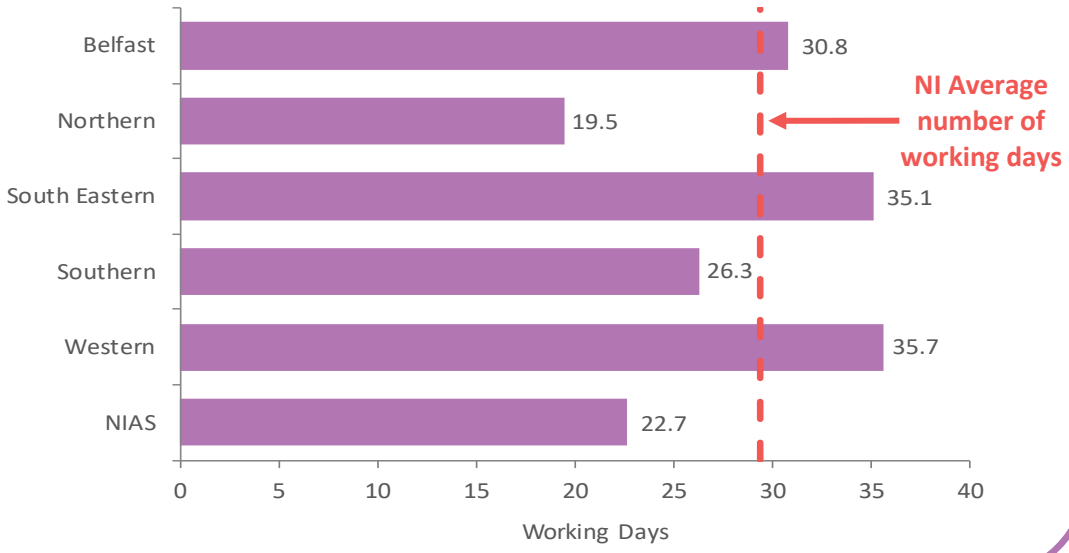
Figure 12: Time Taken to Provide a Substantive Response to Complaints Received, by HSC Trusts (2019/20)



Average Number of Working Days to Substantive Response

On average HSC Trusts took 29.4 working days to provide a substantive response to a complaint received in 2019/20 (Table 9, Figure 13)

Figure 13: Average Number of Working Days to Provide a Substantive Response to Complaints Received, by HSC Trusts (2019/20)[7]



On average substantive responses were provided within 29 working days

[7] Where it is not possible to provide a substantive response within 20 working days, a holding response explaining the reason for the delay is sent to the complainant. All holding responses are issued in 20 working days or less.

SECTION 4

FAMILY PRACTITIONER SERVICE (FPS) COMPLAINTS

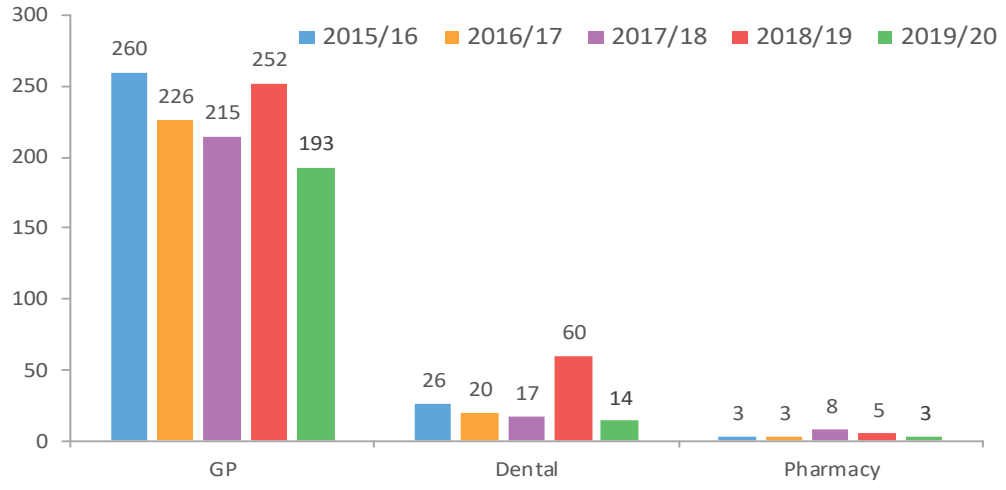
Information in this section refers to complaints received by the HSCB[8] regarding FPS practices in Northern Ireland.

There are over 1,500 FPS practices across Northern Ireland encompassing general practitioners, dental practitioners, pharmacists and optometrists. Under HSC Complaints Procedure all FPS practices are required to forward to the HSC Board anonymised copies of each letter of complaint received along with the subsequent response, within 3 working days of this being issued.

During the five year period from 2015/16 to 2019/20 the number of complaints made against FPS practices in Northern Ireland has fallen by more than a quarter (27.3%) from 289 to 210 (Table 10, Figure 14). The figures for 2019/20 show a decrease of 33.8% (107) on the previous year.

34% decrease in FPS complaints in the last year

Figure 14: FPS Complaints Handled by Practice Type (2015/16 - 2019/20)[9]



[8] Refer to Appendix 5 for further details.
[9] There have been no ophthalmic complaints handled over the last 5 years.

Local resolution

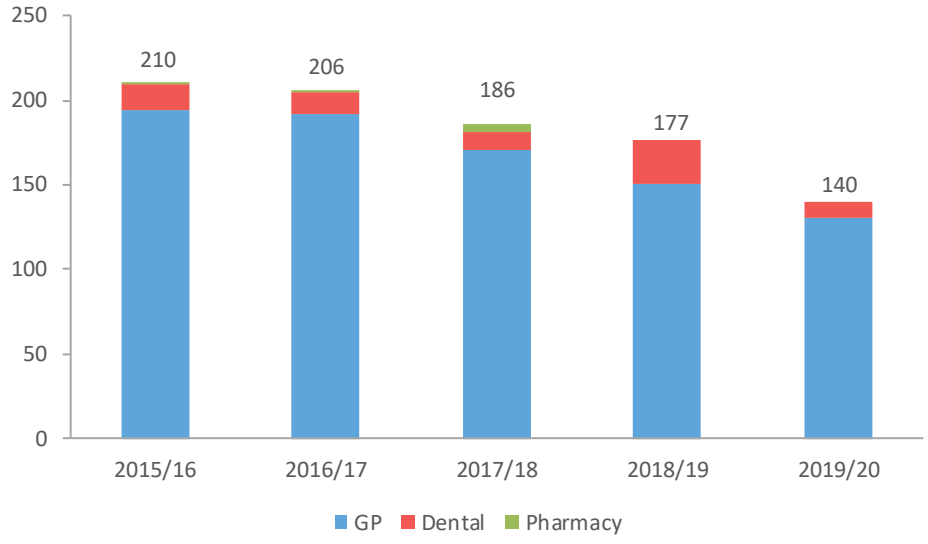
The first stage of the HSC Complaints Procedure is known as 'local resolution'. The purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint. In the case of FPS practices, local resolution involves a practitioner seeking to resolve the complaint through discussion and negotiation.

94%
of complaints handled under Local Resolution related to GPs in 2019/20

Of the 210 complaints received by the HSCB regarding FPS practices in 2019/20, 140 (66.7%) were handled under Local Resolution and the HSCB acted as an Honest Broker in 70 (33.3%) (Tables 11 & 14, Figures 15 & 17). In 2019/20, 93.6% of complaints handled under local resolution were related to GPs (Table 11, Figure 15).

Between 2015/16 and 2019/20, the number of complaints handled under local resolution decreased year on year, from 210 in 2015/16 to 140 in 2019/20 (Table 11, Figure 15).

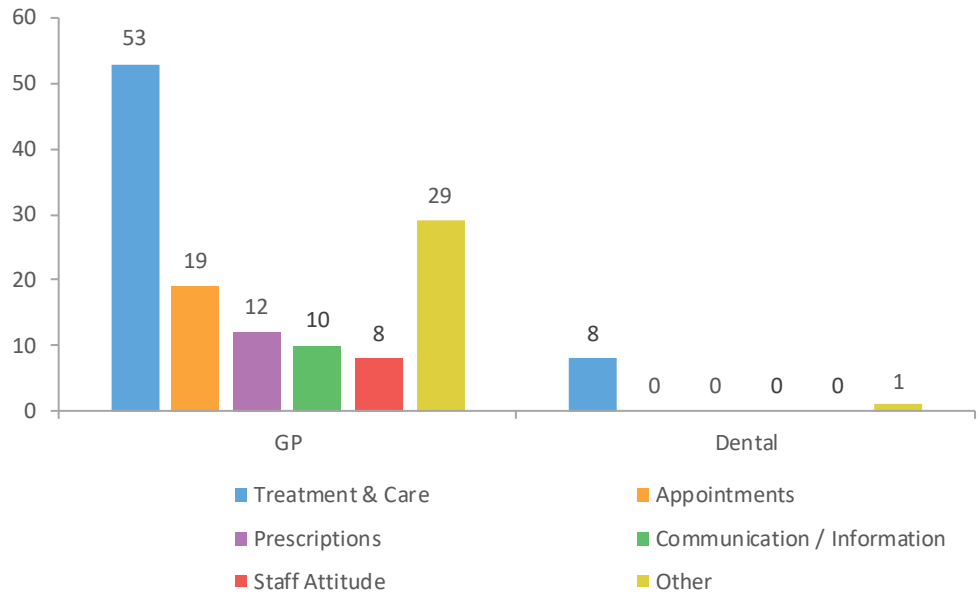
Figure 15: FPS Complaints Handled Under Local Resolution, by Year and Practice Type (2015/16 - 2019/20)[10]



[10] There have been no ophthalmic complaints handled over the last 5 years.

During 2019/20, 'Treatment & Care' accounted for 43.6% (61) of all complaints handled under local resolution, 42 (40.8%) less than in the previous year (Table 12, Figure 16).

Figure 16: FPS Complaints Handled Under Local Resolution, by Subject and Practice Type (2019/20)[11]



Honest Broker

Where a complainant does not wish to approach the FPS practice directly, HSC Board Complaints staff, with the agreement of both the practice and complainant, may act as an intermediary or 'honest broker' with the aim of assisting in the local resolution of the complaint.

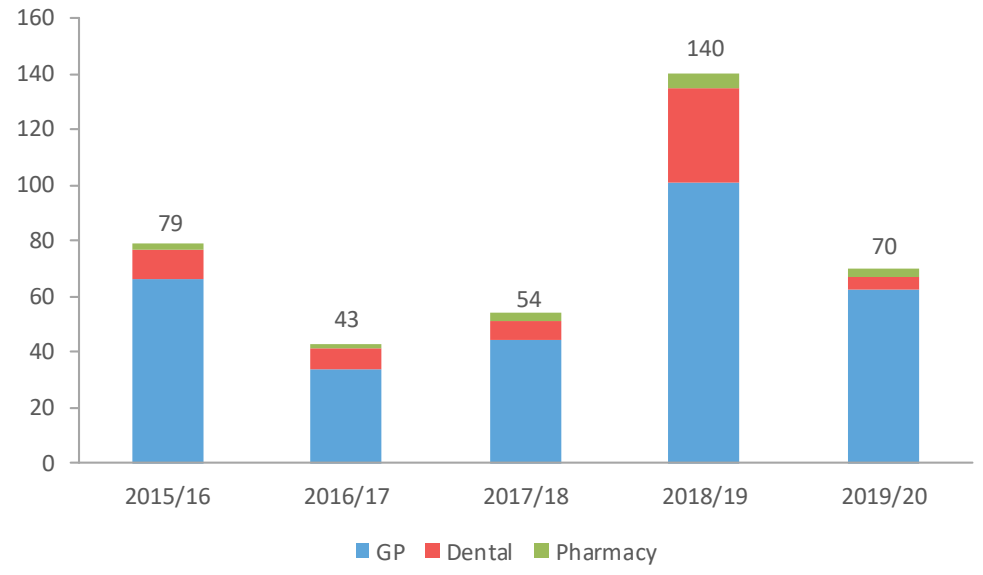
The number of complaints where the HSC Board acted as an honest broker halved, from 140 in 2018/19 to 70 in 2019/20 (Table 13, Figure 17).

89%

of complaints, where the HSCB acted as an Honest Broker, related to GPs in 2019/20

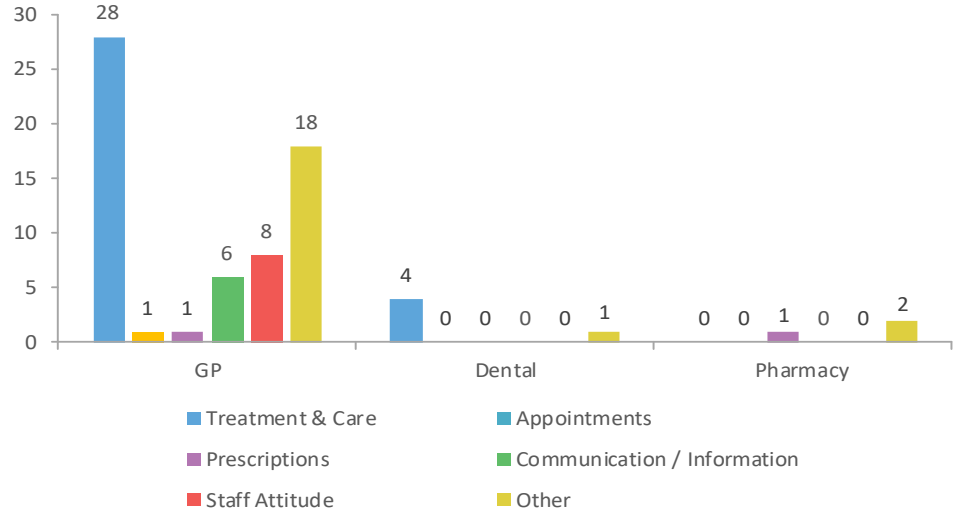
[11] There were no ophthalmic or pharmacy complaints handled under local resolution in 2019/20.

Figure 17: FPS Complaints where the HSC Board Acted as an Honest Broker, by Year and Practice Type (2015/16 - 2019/20)[12]



'Treatment & Care' accounted for more than two fifths (45.7%, 32), of all complaints in which the HSC Board acted as an honest broker during 2019/20 (Table 14, Figure 18).

Figure 18: FPS Complaints where the HSC Board Acted as an Honest Broker, by Subject and Practice Type (2019/20)[12]



[12] There were no ophthalmic complaints handled over the last 5 years.

SECTION 5

COMPLIMENTS RECEIVED BY HSC TRUSTS

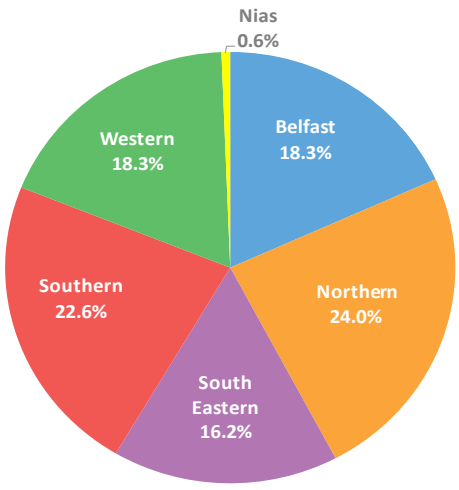
A statistical information return to collate information on compliments received by HSC Trusts was introduced in December 2017[13], with data first being published in the 2018/19 report.

For the purposes of this statistical collection, a compliment may be understood as 'an expression of praise, commendation or admiration'. In addition, only compliments received by: Card, Email, Feedback Form, Letter, Social Media (Facebook & Twitter only) or Telephone should be included.

Compliments Received by HSC Trusts

During 2019/20, HSC Trusts received 27,817 compliments. Almost a quarter (6,668, 24.0%) were received by the Northern HSC Trust, 6,281 (22.6%) by the Southern HSC Trust, 5,093 (18.3%) by the Western HSC Trust, 5,084 (18.3%) by the Belfast HSC Trust, 4,517 (16.2%) by the South Eastern HSC Trust and 174 (0.6%) by NIAS (Table 15, Figure 19).

Figure 19: Compliments Received by HSC Trusts (2019/20) [12]



28,000
compliments received by HSC Trusts in 2019/20

[13] Additional information on the compliments information collection is detailed in Appendix 1 & 6.

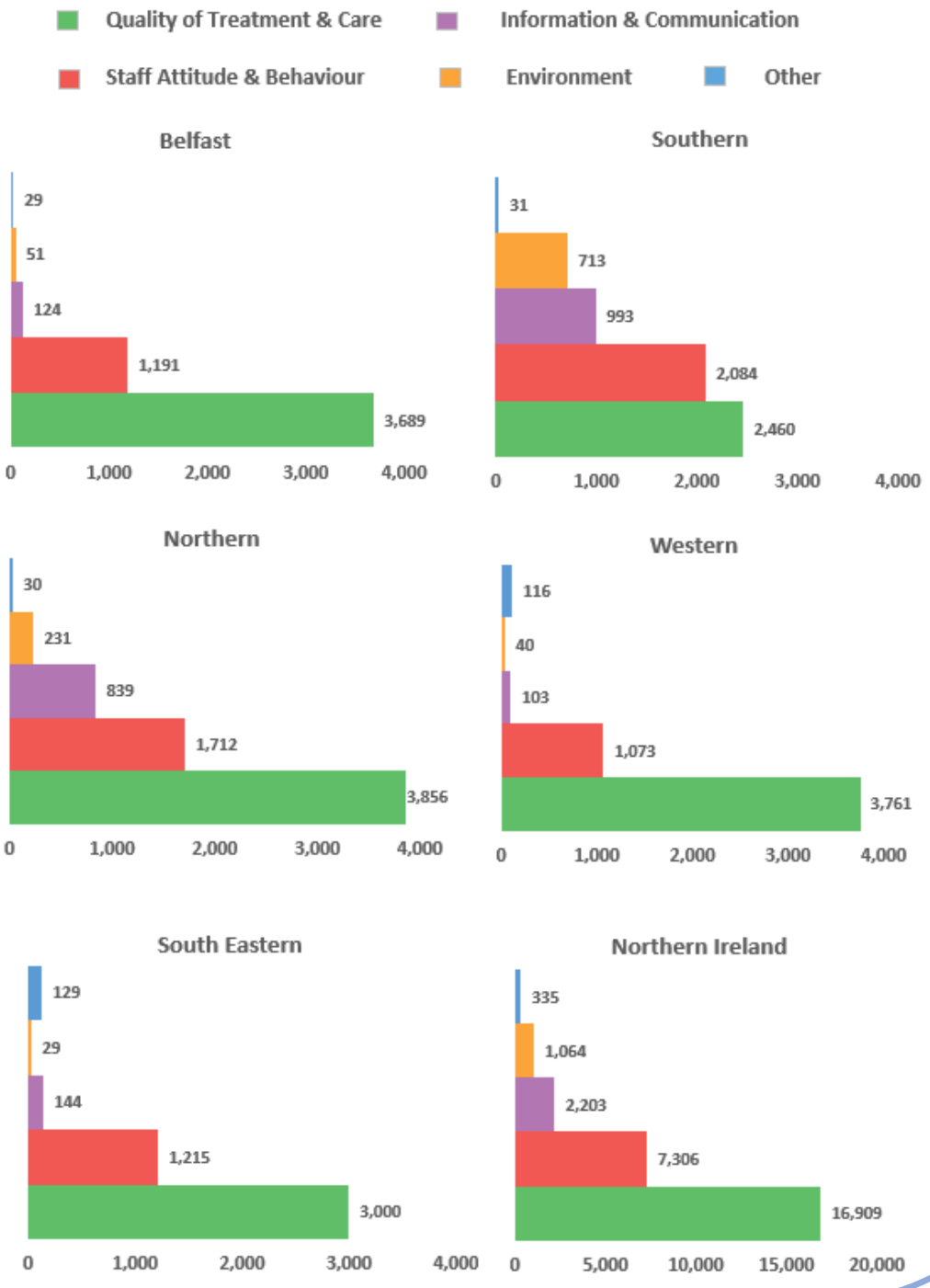
MMcG-285

Subject of Compliment Received

61% of compliments related to Quality of Treatment & Care

Of the 27,817 compliments received by HSC Trusts, 16,909 (60.8%) related to 'Quality of Treatment & Care', 7,306 (26.3%) to 'Staff Attitude & Behaviour', 2,203 (7.9%) to 'Information & Communication', 1,064 (3.8%) to 'Environment', and 335 (1.2%) to 'Other' subjects (Table 15, Figure 20).

Figure 20: Compliments received by HSC Trusts, by Subject and HSC Trust (2019/20)[14]

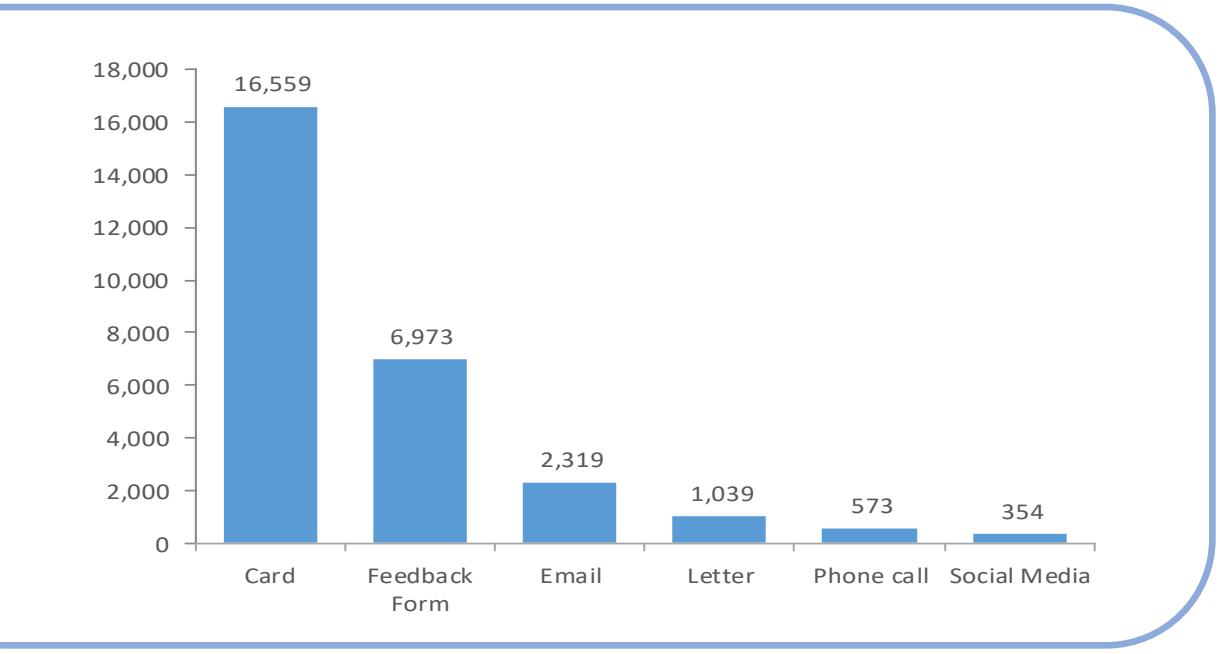


[14] Information for Northern Ireland includes compliments received by all HSC Trusts including the NIAS.

Method of Compliment

Almost two fifths (16,559, 59.5%) of compliments received during 2019/20 were made by card, 6,973 (25.1%) by feedback form, 2,319 (8.3%) by email, 1,039 (3.7%) by letter, 573 (2.1%) by social media[15] and 354 (2.1%) by phone call (Figure 21).

Figure 21: Compliments received by HSC Trusts by Method (2019/20)[14]



[15] Only Facebook posts / Tweets linked to the official organisational Facebook / Twitter accounts are included as social media compliments.

SECTION 6

ADDITIONAL TABLES

Table 1: Complaint Issues Received by HSC Trusts (2015/16 - 2019/20)

HSC Trust	2015/16	2016/17	2017/18	2018/19	2019/20
Belfast	2,019	2,007	2,026	2,356	2,118
Northern	786	869	814	760	739
South Eastern	1,161	1,076	1,140	1,269	1,392
Southern	1,163	1,046	955	850	1,067
Western	892	1,030	746	690	696
NIAS	160	161	133	124	93
Northern Ireland	**6,181**	**6,189**	**5,814**	**6,049**	**6,105**

Table 2: Complaint Issues Received by HSC Trusts, by POC (2019/20)[16]

Programme of Care	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Total
Acute	1,560	343	710	550	413	0	**3,576**
Maternal & Child Health	91	49	120	59	48	0	**367**
Family & Child Care	100	79	99	179	1	0	**458**
Elderly Services	108	86	102	86	44	0	**426**
Mental Health	130	97	92	96	59	0	**474**
Learning Disability	19	20	21	38	15	0	**113**
Sens Impairment & Physical Disability	6	4	7	17	6	0	**40**
Health Promotion & Disease Prevention	0	1	0	0	23	0	**24**
Primary Health & Adult Community	0	17	52	40	4	0	**113**
Prison Healthcare			40				**40**
None (No POC assigned)	104	43	149	2	83	93	**474**
Total	**2,118**	**739**	**1,392**	**1,067**	**696**	**93**	**6,105**

[16] The South Eastern HSC Trust is the sole provider of Prison Healthcare in Northern Ireland.

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Table 3: Complaint Issues Received by HSC Trusts, by POC (2015/16 - 2019/20)

Programme of Care	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Acute	4,189	3,666	3,703	3,371	3,626	3,576
Maternal & Child Health	399	272	354	361	281	367
Family & Child Care	495	496	459	466	429	458
Elderly Services	457	439	378	370	322	426
Mental Health	366	440	431	390	412	474
Learning Disability	160	166	134	119	93	113
Sens Impairment & Physical Disability	114	77	61	73	58	40
Health Promotion & Disease Prevention	0	1	5	2	4	24
Primary Health & Adult Community	214	194	167	190	287	113
Prison Healthcare	109	62	46	51	39	40
None (No POC assigned)	512	368	451	421	498	474
Total	**7,015**	**6,181**	**6,189**	**5,814**	**6,049**	**6,105**

Table 4: Subject of Complaint Issues by HSC Trust (2019/20)

Subject	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Total
Access to Premises	33	0	106	4	0	0	**143**
Aids/Adaptations/Appliances	31	1	17	9	5	0	**63**
Children Order Complaints	0	0	0	0	1	0	**1**
Clinical Diagnosis	78	29	72	35	26	1	**241**
Communication/Information	394	66	265	230	49	1	**1,005**
Complaints Handling	2	0	7	1	24	0	**34**
Confidentiality	17	8	13	19	10	0	**67**
Consent to Treatment/Care	4	1	0	0	2	0	**7**
Contracted Regulated Domiciliary Services	0	8	2	1	0	0	**11**
Contracted Regulated Residential Nursing	2	11	5	1	1	0	**20**
Contracted Independent Hospital Services	0	0	0	0	1	0	**1**
Other Contratced Services	3	6	3	4	12	0	**28**
Delay/Cancellation for Inpatients	4	1	11	1	6	0	**23**
Delayed Admission from A&E	0	0	8	1	10	0	**19**
Discharge/Transfer Arrangements	42	10	15	23	12	0	**102**
Discrimination	5	2	9	0	0	0	**16**
Environmental	24	8	33	19	5	0	**89**
Hotel/Support/Security Services (Excludes Contracted Services)	13	32	2	9	1	0	**57**
Infection Control	2	0	5	4	2	0	**13**
Mortuary & Post-Mortem	1	0	0	0	0	0	**1**
Policy/Commercial Decisions	9	35	13	25	1	0	**83**
Privacy/Dignity	5	5	34	15	8	1	**68**
Professional Assessment of Need	17	30	8	102	39	0	**196**
Property/Expenses/Finances	29	14	11	12	1	0	**67**
Records/Record Keeping	13	7	29	21	6	0	**76**
Staff Attitude/Behaviour	258	129	223	189	109	24	**932**
Transport, Late or Non-arrival/Journey Time	1	1	2	2	47	40	**93**
Transport, Suitability of Vehicle/Equipment	0	1	1	1	21	0	**24**
Quality of Treatment & Care	448	211	346	191	148	23	**1,367**
Quantity of Treatment & Care	158	12	16	19	37	2	**244**
Waiting List, Delay/Cancellation Community Based Appointments	19	22	18	4	2	0	**65**
Waiting List, Delay/Cancellation Outpatient Appointments	243	45	54	26	61	0	**429**
Waiting List, Delay/Cancellation Planned Admission to Hospital	190	15	18	20	8	0	**251**
Waiting Times, A&E Departments	15	9	17	19	9	0	**69**
Waiting Times, Community Services	5	1	4	22	8	0	**40**
Waiting Times, Outpatient Departments	33	7	8	29	8	0	**85**
Other	20	12	17	9	16	1	**75**
Total Number of Complaint Issues	**2,118**	**739**	**1,392**	**1,067**	**696**	**93**	**6,105**

Table 5: Category of Complaint Issue (2015/16 - 2019/20)

Category of Complaint Issue	2015/16		2016/17		2017/18		2018/19		2019/20	
	No.	%	No.	%	No.	%	No.	%	No.	%
Admissions/Discharges	442	*7.2%*	429	*6.9%*	374	*6.4%*	348	*5.8%*	372	*6.1%*
Aids/Adaptations/Appliances	83	*1.3%*	72	*1.2%*	62	*1.1%*	51	*0.8%*	62	*1.0%*
Appointments/Waiting Times	785	*12.7%*	896	*14.5%*	737	*12.7%*	711	*11.8%*	688	*11.3%*
Children Order	4	*0.1%*	8	*0.1%*	5	*0.1%*	2	*0.0%*	1	*0.0%*
Contracted Services	59	*1.0%*	69	*1.1%*	64	*1.1%*	63	*1.0%*	60	*1.0%*
Diagnosis/Oper/Treatment	1,905	*30.8%*	1,775	*28.7%*	1,733	*29.8%*	1,920	*31.7%*	1,855	*30.4%*
Information & Communication	939	*15.2%*	1,007	*16.3%*	1,035	*17.8%*	1,075	*17.8%*	1,176	*19.3%*
Mortuary	1	*0.0%*	1	*0.0%*	0	*0.0%*	2	*0.0%*	1	*0.0%*
Patient Experience	1,108	*17.9%*	1,080	*17.5%*	1,030	*17.7%*	1,068	*17.7%*	1,077	*17.6%*
Policy/Commercial Decisions	127	*2.1%*	125	*2.0%*	111	*1.9%*	99	*1.6%*	83	*1.4%*
Premises	182	*2.9%*	214	*3.5%*	238	*4.1%*	317	*5.2%*	302	*4.9%*
Prison Healthcare	59	*1.0%*	46	*0.7%*	51	*0.9%*	39	*0.6%*	40	*0.7%*
Prof Assessment of Need	280	*4.5%*	275	*4.4%*	237	*4.1%*	191	*3.2%*	196	*3.2%*
Transport	91	*1.5%*	78	*1.3%*	61	*1.0%*	59	*1.0%*	117	*1.9%*
Other	116	*1.9%*	114	*1.8%*	76	*1.3%*	104	*1.7%*	75	*1.2%*
Total	**6,181**	*100.0%*	**6,189**	*100.0%*	**5,814**	*100.0%*	**6,049**	*100.0%*	**6,105**	*100.0%*

Table 6: Category of Complaint Issue by HSC Trust (2019/20)[17]

Category of Complaint Issue	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Northern Ireland
Admissions/Discharges	232	25	41	44	30	0	**372**
Aids/Adaptations/Appliances	31	1	16	9	5	0	**62**
Appointments/Waiting Times	315	84	101	100	88	0	**688**
Children Order	0	0	0	0	1	0	**1**
Contracted Services	5	25	10	6	14	0	**60**
Diagnosis/Operation/Treatment	692	254	418	246	219	26	**1,855**
Information & Communication	426	81	308	271	89	1	**1,176**
Mortuary	1	0	0	0	0	0	**1**
Patient Experience	297	150	271	216	118	25	**1,077**
Policy/Commercial Decisions	9	35	13	25	1	0	**83**
Premises	72	40	146	36	8	0	**302**
Prison Healthcare			40				**40**
Professional Assessment of Need	17	30	8	102	39	0	**196**
Transport	1	2	3	3	68	40	**117**
Other	20	12	17	9	16	1	**75**
Total	**2,118**	**739**	**1,392**	**1,067**	**696**	**93**	**6,105**

[17] The South Eastern HSC Trust is the sole provider of Prison Healthcare in Northern Ireland.

Table 7: Specialty of Complaint Issues by HSC Trust (2019/20)

Specialty	Belfast	Northern	South Eastern	Southern	Western	NIAS	Total
Accident & Emergency	155	94	210	118	116	53	**746**
Allied Health Professions	62	34	56	25	16	0	**193**
Anaesthetics & Pain Management	10	4	20	5	8	0	**47**
Cardiology	35	9	16	17	14	0	**91**
Child & Adolescent Psychiatry	25	2	0	11	4	0	**42**
Children & Young Peoples Services	73	78	118	86	54	0	**409**
Community Nursing/Midwives	0	16	7	1	8	0	**32**
Community Paediatrics	28	5	1	15	0	0	**49**
Dentistry	27	5	0	4	0	0	**36**
Dermatology	11	0	11	5	1	0	**28**
Domicillary Services	14	10	1	21	7	0	**53**
ENT	56	4	18	26	40	0	**144**
General Medicine	93	47	122	112	51	0	**425**
General Surgery	57	40	45	79	66	0	**287**
Geriatric Medicine	53	17	9	0	11	0	**90**
Gynaecology	139	16	33	30	17	0	**235**
Joint Consultant Clinics	0	31	0	0	0	0	**31**
Learning Disability	17	18	12	38	14	0	**99**
Mental Health Acute	104	41	32	30	24	0	**231**
Mental Health Community	5	39	53	58	29	0	**184**
Neurology	95	0	10	5	7	0	**117**
NIAS - Emergency Ambulance Control	0	0	0	0	0	22	**22**
Obstetrics	88	18	106	70	24	0	**306**
Old Age Psychiatry	0	15	7	0	4	0	**26**
Oncology	29	5	6	2	11	0	**53**
Ophthalmology	112	0	3	5	20	0	**140**
Other	278	147	384	163	66	18	**1,056**
Paediatrics	113	6	12	24	10	0	**165**
Physical Disability/ Sensory Support	6	0	9	18	2	0	**35**
Radiology	44	23	30	27	7	0	**131**
Rehabilitation	0	7	2	3	10	0	**22**
Residential Care	4	4	22	24	10	0	**64**
Trauma & Orthopaedics	320	4	31	39	27	0	**421**
Urology	40	0	3	6	18	0	**67**
Vascular	25	0	3	0	0	0	**28**
Total	**2,118**	**739**	**1,392**	**1,067**	**696**	**93**	**6,105**

Table 8: Complaints by Age Group and Gender of Patient / Client (2019/20)[18]

Age Group	Female	Male	Total
Under 16	192	232	**424**
16 - 18	31	25	**56**
19 - 24	111	65	**176**
25 - 34	341	151	**492**
35 - 44	285	142	**427**
45 - 54	253	165	**418**
55 - 64	229	181	**410**
65 - 74	223	163	**386**
75 +	291	217	**508**
Total	**1,956**	**1,341**	**3,297**

Table 9: Time Taken to Provide a Substantive Response to Complaints Received, by HSC Trust (2019/20)

HSC Trust	20 Working Days or Less		More Than 20 Working Days		Total No.	Mean No. of Working Days
	No.	%	No.	%		
Belfast	818	*49.7%*	828	*50.3%*	**1,646**	30.8
Northern	521	*77.5%*	151	*22.5%*	**672**	19.5
South Eastern	332	*43.2%*	437	*56.8%*	**769**	35.1
Southern	353	*50.4%*	348	*49.6%*	**701**	26.3
Western	128	*26.2%*	361	*73.8%*	**489**	35.7
NIAS	6	*6.5%*	87	*93.5%*	**93**	22.7
Northern Ireland	**2,158**	*49.4%*	**2,212**	*50.6%*	**4,370**	**29.4**

[18] Includes only those complaints where both age and gender of the patient / client was recorded.

Table 10: FPS Complaints Handled (2015/16 - 2019/20)

FPS Complaints	2015/16	2016/17	2017/18	2018/19	2019/20
GP	260	226	215	252	193
Dental	26	20	17	60	14
Pharmacy	3	3	8	5	3
Ophthalmic	0	0	0	0	0
Total	**289**	**249**	**240**	**317**	**210**

Table 11: FPS Complaints Handled Under Local Resolution (2015/16 - 2019/20)

Local Resolution	2015/16	2016/17	2017/18	2018/19	2019/20
GP	194	192	171	151	131
Dental	15	13	10	26	9
Pharmacy	1	1	5	0	0
Ophthalmic	0	0	0	0	0
Total	**210**	**206**	**186**	**177**	**140**

Table 12: FPS Complaints Handled Under Local Resolution, by Subject (2019/20)[19]

Local Resolution	GP	Dental	Total
Treatment & Care	53	8	**61**
Appointments	19	0	**19**
Prescriptions	12	0	**12**
Communication / Information	10	0	**10**
Staff Attitude	8	0	**8**
Other	29	1	**30**
Total	**131**	**9**	**140**

[19] There were no ophthalmic nor pharmacy complaints handled under local resolution in 2019/20.

Table 13: FPS Complaints where the HSC Board Acted as an Honest Broker (2015/16 - 2019/20)

Honest Broker	2015/16	2016/17	2017/18	2018/19	2019/20
GP	66	34	44	101	62
Dental	11	7	7	34	5
Pharmacy	2	2	3	5	3
Ophthalmic	0	0	0	0	0
Total	**79**	**43**	**54**	**140**	**70**

Table 14: FPS Complaints where the HSC Board Acted as an Honest Broker, by Subject (2019/20)[20]

Honest Broker	GP	Dental	Pharmacy	Total
Treatment & Care	28	4	0	**32**
Appointments	1	0	0	**1**
Prescriptions	1	0	1	**2**
Communication / Information	6	0	0	**6**
Staff Attitude	8	0	0	**8**
Other	18	1	2	**21**
Total	**62**	**5**	**3**	**70**

Table 15: Subject of Compliments by HSC Trust (2019/20)

Subject of Compliment	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Northern Ireland
Quality of Treatment and Care	3,689	3,856	3,000	2,460	3,761	143	**16,909**
Staff Attitude & Behaviour	1,191	1,712	1,215	2,084	1,073	31	**7,306**
Information & Communication	124	839	144	993	103	0	**2,203**
Environment	51	231	29	713	40	0	**1,064**
Other	29	30	129	31	116	0	**335**
Total	**5,084**	**6,668**	**4,517**	**6,281**	**5,093**	**174**	**27,817**

[20] There were no ophthalmic complaints handled in 2019/20.

APPENDIX 1: TECHNICAL NOTES

This statistical release presents information on complaint issues received by HSC Trusts in Northern Ireland. It details the number of HSC Trust complaint issues received, by the programme of care, category, subject, specialty of the complaint and the time taken to provide a substantive response.

Information is also included on the number of complaints received by the HSC Board regarding Family Practitioner Services in Northern Ireland.

Data Collection

The information presented in this statistical release derives from the Departmental CH8 Revised statistical return provided by the six HSC Trusts, (including the NIAS) in Northern Ireland. The CH8 return was originally introduced in 1998 and updated in 2007 to take account of the structural changes within the HSC system following the Review of Public Administration (RPA). In 2014, the CH8 return was redesigned to allow the collection of patient level data on all complaints received by HSC Trusts. The patient level collection was titled CH8 Revised to distinguish it from the original CH8 aggregate return. This return is submitted on a quarterly basis by HSC Trusts, in respect of the services for which they have responsibility.

Information presented on FPS complaints forwarded to the HSC Board derives from CHB statistical return. The CHB is collected on a quarterly basis by the HSC Board, in respect of the services for which they have responsibility.

Data presented on compliments is collected from the six HSC Trusts on a quarterly basis using the compliments information return (CP1). The compliments information return was developed in consultation with HSC Trusts to ensure regional consistency, and enable comparisons across HSC Trusts.

Data providers are supplied with technical guidance documents outlining the methodologies that should be used in the collection, reporting and validation of each of these data returns. These documents can be accessed at the following link:

https://www.health-ni.gov.uk/publications/trust-complaints-form-ch8

https://www.health-ni.gov.uk/publications/trust-compliments-form-cp1

Rounding

Percentages have been rounded to one decimal place and as a consequence some totals may not sum to 100.

Data Quality

All information presented in this bulletin has been provided by HSC Trusts / Board and has been validated and quality assured by Hospital Information Branch (HIB) prior to release.

For the CH8 Revised information collection, HSC Trusts are given a set period of time to submit the information. At the end of the financial year HIB carry out a detailed series of validations to verify that the information is consistent both within and across returns. Trend analyses are used to monitor annual variations and emerging trends. Queries arising from validation checks are presented to HSC Trusts for clarification and if required returns may be amended and/or re-submitted. This report incorporates all returns and amendments received up to 8th September 2020.

The compliments information collection was introduced in December 2017 and took some time to embed, with data first being published in the 2018/19 report. In 2018/19, information had to be estimated for two of the six Trusts as they were only able to provide a partial return for the year because their monitoring systems had not been fully implemented. For 2019/20, full year's data was available for all Trusts. However for 2019/20, it should be noted that Belfast HSC Trust's telephone system to capture compliments was only effective from 1 October 2019, Western HSC Trust did not have a system in place to record compliments received by phone call and NIAS did not monitor compliments via social media.

Main Uses of Data

The main uses of these data are to monitor and report the number of HSC Trust compliments, HSC Trust and FPS complaints received during the year, to help assess performance, for corporate monitoring, to inform and monitor related policy, and to respond to assembly questions and ad-hoc queries from the public.

Contextual Information for Using Complaint and Compliment Statistics

Readers should be aware that contextual information about Northern Ireland and the health services provided is available to read while using statistics from this publication.

This includes information on the current and future population, structures within the Health and Social Care system, the vision for future health services as well as targets and indicators. This information is available at the following link:

https://www.health-ni.gov.uk/publications/contextual-information-using-hospital-statistics

Contact Information

As we want to engage with users of our statistics, we invite you to feedback your comments on the publication to:

Hospital Information Branch

Email: statistics@health-ni.gov.uk

APPENDIX 2: DEFINITIONS

Programme of care

Programmes of care are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. There are nine programmes of care as follows:

POC1 Acute
POC2 Maternity and Child Health
POC3 Family and Child Care
POC4 Elderly Services
POC5 Mental Health
POC6 Learning Disability
POC7 Sensory Impairment and Physical Disability
POC8 Health Promotion and Disease Prevention
POC9 Primary Health and Adult Community

Complaint Issues

For the purposes of the CH8 return, a complaint may be understood as 'an expression of dissatisfaction requiring a response'. This return includes information on all formal complaints only, informal complaints or communications criticising a service or the quality of care but not adjudged to require a response, are not included on this form.

A single communication regarding a complaint may refer to more than one issue. In such cases each individual complaint issue is recorded separately for Programme of Care (POC) and Subject.

Only complaints received from/on behalf of patients/clients or other 'existing or former users of a Trust's services and facilities' are included. Complaints from staff are not included.

Where separate communications in respect of a single patient / client refer to one episode, they are treated as a single complaint issue for the purposes of this publication. In other words, if two relatives complain about the same subject/episode in respect of the same patient, this will be treated as one complaint issue only. However, if two relatives complain about separate subjects/episodes but in the care of the same patient, these will be treated as separate complaint issues.

Where separate unconnected communications refer to the same episode/issue, they will be treated as separate complaint issues. In other words, if separate individuals complain about a matter they have all experienced, this would be treated as separate complaint issues, e.g. if ten clients complain individually about conditions in a day centre, these will be treated as ten separate complaint issues.

The logic of the complaints procedure is that it should afford a speedy resolution of cases of individual dissatisfaction of service. This differs from the case of petitions where the concern is primarily the collective representation of views, e.g. if a single complaint is received from a group of users, it will be treated as a single complaint issue.

Where a complainant is dissatisfied with the Trust's response to his/her complaint and enters into further communications about the same matter/s, this is not a new complaint, rather it will be the same complaint reopened. Such a complaint would only be recorded once in the CH8 Revised, i.e. in the quarter it was initially received. However, if this complainant were to then complain about a separate/different matter, this would be a new complaint.

APPENDIX 3: SUBJECT OF COMPLAINT ISSUES

1. Access to Premises

This heading includes all issues concerning ease of movement inside and outside the buildings, e.g. signage, car parking, etc. Problems of wheelchair access / disabled parking etc. should also be included under this heading, if not covered under '*Discrimination' (17).*

2. Aids / Adaptations / Appliances

This heading refers to the suitability / availability of any aids / adaptations, once they have been recommended. Complaint issues about waiting for assessment should be included under '*Waiting Lists, Delay/Cancellation Community Based Appointments'* (*32*).

3. Children Order Complaints

This heading refers to all formal complaint issues received under the Children Order Representations and Complaint Issues Procedure, irrespective of their subject or content.

4. Clinical Diagnosis

This heading covers clinical diagnosis only and is to be distinguished from '*Professional Assessment of Need'* (*24*).

5. Communication / Information

This heading includes all issues of communication and information provided to patients / clients / families / carers regarding any aspect of their contact with staff. However, this should be distinguished from complaint issues about the attitude of staff when communicating with patients / clients, which would be logged under '*Staff Attitude / Behaviour'* (*27*).

6. Complaint Handling

This refers to handling of a complaint issue at any point up to and including the conclusion of local resolution stage, e.g. a complainant complains that he/she did not receive a response within the timescale. However, a complaint issue would not be included under this heading if it obviously falls under another heading, e.g. if the complaint issue is about attitude of staff handling the complaint issue, it would be logged under '*Staff Attitude / Behaviour'* (*27*).

7. Confidentiality

This heading includes any issues of confidentiality regarding patients / clients, e.g. (i) complaint by a patient regarding a breach of confidentiality or (ii) complaint by the parents of a young adolescent who are denied information by staff on the grounds of that adolescent's right to confidentiality.

8. Consent to Treatment / care

This refers to complaint issues made regarding consent to treatment/care.

9. Contracted Regulated Children's Services

10. Contracted Regulated Domiciliary Agency

11. Contracted Regulated Residential Nursing

These three headings refer to complaints about services that are provided by Trusts via contractual / commissioned arrangements. Establishments may be children's homes, nursing or residential homes, while Agencies may be a domiciliary care agency, fostering agency or nursing agency. For a full list of Regulated Establishments and Agencies please refer to 'Quality & Improvement Regulation NI Order 2003, Article 8'.

In the first instance, the service provider is expected to deal with complaints, however, where the complainant, Trust or RQIA wishes, the matter may be investigated by the Trust under the HSC Complaint Procedure.

Examples: (i) the Trust (as the commissioner) is asked by either RQIA or a relative, to investigate a complaint about the care or treatment provided to a resident in a Residential Home; (ii) a patient / client asks the Trust (as the commissioner) to investigate a complaint about the attitude of a member of staff of a Voluntary Agency with whom the Trust has contracted a home care service (e.g. personal care).

12. Contracted Independent Hospital Services

This heading refers to complaints about services that are provided by Trusts via contractual / commissioned arrangements with independent hospitals.

13. Contracted Services – Other

This heading refers to complaint issues about services that are provided by Trusts via contractual / commissioned arrangements that are not captured in '*Contracted Regulated Children's Services/Domiciliary Agency/Residential Nursing' (9, 10 & 11).* In the first instance, the service provider is expected to deal with complaint issues, however, where the complainant or Trust wishes, the matter may be investigated by the Trust under the HSC Complaint Procedure.

Example: Attitude of a member of staff of facilities services operating under contract on Trust premises, (e.g. car clamping company or catering).

14. Delay/Cancellation for Inpatients

This heading includes all aspects of delay or cancellation of operation or procedure once the patient is in hospital, e.g. Radiology investigation cancelled, or theatre cancelled due to lack of ICU beds, theatre overrun, no anaesthetist, etc. This should be distinguished from the cancellation or delay of admission for the procedure captured under *'Waiting List, Delay/Cancellation Planned Admission to Hospital' (34*).

15. Delayed Admission from A&E

This refers to patients waiting in Accident & Emergency, following decision to 'admit', before being allocated a bed in a ward. This should be distinguished from '*Waiting Times, A&E Departments'* (*35*) and '*Waiting List, Delay/Cancellation Planned Admission to Hospital' (34).*

16. Discharge / Transfer Arrangements

This heading refers to the adequacy of arrangements and includes early discharges or delayed discharges. It does not include failure to communicate discharge arrangements, which would be included under '*Communication / Information' (5).*

17. Discrimination

This heading refers to complaint issues regarding disadvantageous treatment. It includes discrimination under the 9 Equality categories (i.e. age, gender, marital status, political opinions, religious belief, racial group, sexual orientation, persons with or without a disability, persons with or without dependents) and under the Human Rights Act (e.g. Article 1, Right to Life; Article 3, Right to Freedom from Torture, Inhuman or Degrading Treatment; Article 8, Right to Respect for Private or Family Life). Complaint issues about patient choice should also be included under this heading.

18. Environmental

Complaint issues referring to the general condition or repair of the premises should be included under this heading. It also covers wider environmental issues, e.g. smoking.

19. Hotel / Support / Security Services

This heading includes any complaint issue referring to ancillary or support services, e.g. portering, facilities, catering. It also refers to security issues, e.g. stolen vehicles parked on Trust property.

20. Infection Control

This heading refers to compliance with infection control standards, e.g. hand hygiene; aseptic procedures; inappropriate use of personal protective equipment; incorrect disposal of waste or soiled linen; equipment / furniture not decontaminated. It covers issues around all infections but especially resistant micro-organism infections, e.g. MRSA, VRE. However, complaint issues about lack of information or not being informed would not be included in this heading, but would be logged under '*Communication / Information' (5).*

21. Mortuary & Post-Mortem

This category refers to complaint issues in relation to the mortuary and/or post-mortem.

22. Policy / Commercial Decisions

This category refers to complaint issues related to policy and/or commercial decisions.

23. Privacy / Dignity

This heading includes complaint issues specifically relating to the privacy or personal dignity of patients/clients.

24. Professional Assessment of Need

This heading refers to the assessment of need in either clinical or non-clinical contexts, however, should be distinguished from '*Clinical Diagnosis'* (4).

25. Property / Expenses / Finance

This heading refers to issues of the personal property, expenses or finance of patients/clients, e.g. due money for fostering; issues around direct payments; concerns about Trust charging / invoicing for

clients in Nursing/Residential Home (either Private or Trust Home); broken hearing aid; lost spectacles / dentures.

Property damaged by staff arising in the course of care / treatment would fall into this category; however, property stolen from a patient's locker (as not being entrusted to or in the custodianship of staff and not known to be attributable to staff) would come under the heading of '*Hotel/Support/Security Services' (19).* Complaint issues about stolen vehicles (visitor or patient) and property lost or stolen from visitors should similarly be logged as a '*Hotel/Support/Security Services' (19).*

26. Records / Record Keeping

This refers to cases where records (such as medical notes, case files, X-rays) are unavailable, e.g. records have been mislaid or misfiled. Complaint issues about access rights to deceased patients' health records (governed by Access to Health Records (1993) NI Order) should be included under this heading. Complaint issues about any aspect of content of records or right of access should only be included under this heading, if they are not more appropriately dealt with under other procedures, such as Data Protection Act or Freedom of Information Act appeals processes.

27. Staff Attitude / Behaviour

This category refers to complaint issues related to staff attitude and/or staff behaviour.

28. Transport, Late or Non-arrival / Journey Time

This heading refers to complaint issues about the late arrival or non-arrival of transport or about the length of journey.

29. Transport, Suitability of Vehicle / Equipment

This heading refers to the appropriateness of the vehicle assigned and will include issues such as comfort, ease of access for the client group served. Complaint issues about the appropriateness of equipment would also be logged under this heading.

30. Quality of Treatment & Care

This refers to the quality or standard of treatment and care provided. It also covers complaint issues relating to patient / client safety. However, it is to be distinguished from *'Quantity' of Treatment & Care, (31)* which refers to the quantity or amount of treatment and care.

31. Quantity of Treatment & Care

This refers to the amount of treatment and care provided or available, e.g. someone receiving good quality home help but feel they are receiving inadequate number of hours.

32. Waiting Lists, Delay/Cancellation Community Based Appointments

This heading refers to the time spent waiting for either assessment or for the delivery of services following assessment, e.g. waiting list for an OT assessment, waiting list for a care package. 'Unmet need' should also be logged under this heading. This heading should be distinguished from '*Waiting Times, Community Services' (36).*

33. Waiting Lists, Delay/Cancellation Outpatient Appointments

This heading refers to delay or cancellation in securing an outpatient appointment, i.e. outpatient waiting lists. It is to be distinguished from '*Waiting Lists, Delay/Cancellation Community Based Appointments'* (32) and '*Waiting Times, Outpatient Departments'* (*37*).

34. Waiting Lists, Delay/Cancellation Planned Admission to Hospital

This refers to delay or cancellation of a planned admission to hospital, e.g. waiting list for surgery. Delayed admissions from A&E should not be included in this category but under '*Delayed Admission from A&E' (15).*

35. Waiting Times, A&E Departments

Complaint issues regarding waiting time for initial assessment or waiting time to be treated should all be logged under this heading. Complaint issues about delayed admission from A&E are not included here but should be listed under '*Delayed Admission from A&E' (15).*

36. Waiting Times, Community Services

This heading refers to waiting time during delivery of community services. It would include such issues as erratic timing, failure of professional staff to turn up at the specified time for an appointment. It should be distinguished from '*Waiting Lists, Delay/Cancellation Community Based Appointments' (32).*

37. Waiting Times, Outpatient Departments

This heading refers to the time waiting at an outpatient appointment, other than at A&E. It should be distinguished from **'***Waiting Lists, Delay/Cancellation Outpatient Appointments (33)'.*

38. Other

This is a residual heading for any complaint issues, which do not fall into any categories listed above.

APPENDIX 4: SUBJECT GROUPED BY GENERAL CATEGORY

Admissions/Discharges

Delayed Admission from A&E

Discharge/Transfer Arrangements

Waiting Lists, Delay/Cancellation Planned Admission to Hospital

Aids/Adaptations/Appliance

Aids/Adaptations/Appliances

Appointments/Waiting Times

Waiting Lists, Delay/Cancellation Community Based Appointments

Waiting Lists, Delay/Cancellation Outpatient Appointments

Waiting Times, A&E Departments

Waiting Times, Community Services

Waiting Times, Outpatient Departments

Children Order

Children Order Complaint Issues

Contracted Services

Contracted Regulated Children's Services

Contracted Regulated Domiciliary Agency

Contracted Regulated Residential Nursing

Contracted Independent Hospital Services

Other Contracted Services

Diagnosis/Operation/Treatment

Clinical Diagnosis

Consent to Treatment/Care

Delay/Cancellation for Inpatients

Treatment & Care, Quality

Treatment & Care, Quantity

Information & Communication

Communication/Information to Patients

Complaints Handling

Confidentiality

Records/Records Keeping

Mortuary

Mortuary & Post-Mortem

Patient Experience

Discrimination

Privacy/Dignity

Property/Expenses/Finance

Staff Attitude/Behaviour

Policy/Commercial Decisions

Policy/Commercial Decisions

Premises

Access to Premises

Environmental

Hotel/Support/Security Services

Infection Control

Prison Health Care

Prison Healthcare Related Complaint Issues

Professional Assessment of Need

Professional Assessment of Need

Transport

Transport, Late or Non-arrival/Journey Time

Transport, Suitability of Vehicle/Equipment

Other

Other

APPENDIX 5: HSC BOARD COMPLAINTS

The information presented within this release relating to FPS complaints derives from the HSC Board CHB statistical return. The CHB is collected on a quarterly basis by the HSC Board, in respect of the services for which they have responsibility.

Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services.

Under HSC Complaints Procedure all FPS practices are required to forward to the HSC Board anonymised copies of each letter of complaint received along with the subsequent response, within 3 working days of this being issued.

The first stage of the HSC Complaints Procedure is known as 'local resolution'. The purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint. In the case of FPS practices, local resolution involves a practitioner seeking to resolve the complaint through discussion and negotiation.

Where a complainant does not wish to approach the FPS practice directly, HSC Board Complaints staff, with the agreement of both the practice and complainant, may act as an intermediary or 'honest broker' with the aim of assisting in the local resolution of the complaint.

The HSC Board has a responsibility to record and monitor the outcome of all complaints lodged with them. It will provide support and advice to FPS in relation to the resolution of complaints and it will also appoint independent experts, lay persons or conciliation services, where appropriate.

APPENDIX 6: COMPLIMENTS GUIDANCE / DEFINITIONS

Introduction

1. The purpose of the CP1 return is to record the number of compliments received by Trusts during the quarter, the subject areas to which they referred and how the compliment was received.

2. The form should be returned quarterly by Trusts in respect of services for which they have responsibility. Deadline for receipt by Hospital Information Branch is no later than the last working day of the month after the end of the quarter to which the information refers.

Compliments

3. For the purposes of this return a compliment may be understood as 'an expression of praise, commendation or admiration'.

4. Only compliments received from/on behalf of patients/clients or other 'existing or former users of a Trust's services and facilities' should be included. Compliments from staff should not be included on this form.

5. A singe communication may include more than one compliment. In such cases each distinct compliment should be recorded separately on the return.

6. Only compliments pertaining to the services of the Trust returning the form to Hospital Information Branch (DoH) should be recorded on the CP1 return. Compliments received by a Trust, which properly refer to the services of another Trust, should be recorded on the return of the relevant Trust to which the compliment/s pertains.

7. Where separate communications (whether from a single party or from several parties in respect of a single patient) refer to one subject only, they should be treated as one compliment for the purposes of this form. In other words, if two relatives submit a compliment about the same subject/episode in respect of the same patient, this should be treated as one compliment only. However, if two relatives submit compliments about separate subjects/episodes in the care of the same patient, these should be treated as separate compliments.

Subjects

8. This part deals with the subject of the compliment. The subject of the compliment is to be assigned on the basis of the subject that best describes the nature of the patient / client's praise.

Definitions of Subjects:

i. Quality of Treatment & Care

This refers to the quality or standard of treatment and care provided. It also covers compliments relating to patient/client safety.

ii. Staff Attitude & Behaviour

This category refers to compliments related to staff attitude and/or staff behaviour.

iii. Information & Communication

This heading includes all issues of communication and information provided to patients / clients / families / carers regarding any aspect of their contact with staff. However, this should be distinguished from compliments about the attitude of staff when communicating with patients / clients, which should be logged under *'Staff Attitude & Behaviour'*.

iv. Environment

Compliments referring to the general condition or repair of the premises should be included under this heading.

v. Other

This is a residual heading for any compliments which do not fall into any of the categories listed above.

9. Where the subject is recorded as *'Other'* a brief description of the compliment should be provided in part 2 of the return.

Method of Compliment

10. The CP1 return should include (A) written compliments received by (i) Card, (ii) Email, (iii) Feedback Form, (iv) Letter or (v) Social Media (Facebook & Twitter only), or (B) compliments received by telephone, whereby the primary purpose of the phone call is to express a compliment. Only Facebook posts / Tweets linked to the official organisational Facebook/Twitter accounts should be included.

APPENDIX 7: ABOUT HOSPITAL INFORMATION BRANCH

Hospital Information Branch is responsible for the collection, quality assurance, analysis and publication of timely and accurate information derived from a wide range of statistical information returns supplied by the Health & Social Care (HSC) Trusts and the HSC Board. Statistical information is collected routinely from a variety of electronic patient level administrative systems and pre-defined EXCEL survey return templates.

The Branch aims to present information in a meaningful way and provide advice on its uses to customers in the HSC Committee, Professional Advisory Groups, policy branches within the DoH, other Health organisations, academia, private sector organisations, charity/voluntary organisations as well as the general public. The statistical information collected is used to contribute to major exercises such as reporting on the performance of the HSC system, other comparative performance exercises, target setting and monitoring, development of service frameworks as well as policy formulation and evaluation. In addition, the information is used in response to a significantly high volume of Parliamentary / Assembly questions and ad-hoc queries each year.

Information is disseminated through a number of key statistical publications, including: Inpatient Activity, Outpatient Activity, Emergency Care, Mental Health & Learning Disability and Waiting Time Statistics (Inpatient, Outpatient, Diagnostics, Cancer and Emergency Care). A detailed list of these publications is available from:

https://www.health-ni.gov.uk/topics/doh-statistics-and-research

The 'Complaints and Compliments Received by HSC Trusts in Northern Ireland (2019/20)' publication was originally due to be published on 8th July but was delayed due to pressures associated with the COVID-19 outbreak.

APPENDIX 8: ADDITIONAL INFORMATION

Further information on HSC Trust Complaint Issues and Compliments in Northern Ireland are available from:

Hospital Information Branch

Information & Analysis Directorate

Department of Health

Stormont Estate

Belfast, BT4 3SQ

Email: statistics@health-ni.gov.uk

INFORMATION ANALYSIS DIRECTORATE

Complaints and Compliments Received by HSC Trusts

in Northern Ireland (2020/21)

Published 28th September 2021

(Delayed due to COVID-19 outbreak, see appendix 7)

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

NISRA
Northern Ireland Statistics and Research Agency
Gníomhaireacht Thuaisceart Éireann um Staitistící agus Taighde

Reader Information

Purpose	This publication monitors and reports the number of HSC Trust complaint issues received, by the programme of care, category, subject and specialty of the complaint issue, as well as demographic information and the time taken to provide a substantive response to complaints received. It also includes information on compliments received by HSC Trusts regarding the services they provide.
Authors	Mark Cassidy, Michael O'Donnell, Kieran Taggart, Siobhan Morgan
Publication Date	28th September 2020
Reporting Period	1st April 2020 – 31st March 2021
Issued by	Hospital Information Branch Information & Analysis Directorate Department of Health Stormont Estate Belfast, BT4 3SQ
Statisticians	Mark Cassidy
Statistical Quality	Information detailed in this release has been provided by HSC Trusts / Board and has been validated and quality assured by Hospital Information Branch (HIB) prior to release.
Target Audience	DoH, Chief Executives of HSC Board and Trusts in Northern Ireland, health care professionals, academics, Health & Social Care stakeholders, media and general public.
Further Copies	statistics@health-ni.gov.uk
Website	https://www.health-ni.gov.uk/articles/complaints-statistics
Copyright	

CONTENTS

KEY POINTS

Latest Year (2020/21)

- A total of 3,292 complaints, relating to 5,005 complaint issues, were received by HSC Trusts in 2020/21 (Tables 1 & 9); equating to 63 complaints per week or approximately 9 complaints per day.
- Over half (2,695, 53.8%) of complaint issues received during 2020/21 related to the 'Acute' POC (Table 2, Figure 3).
- During 2020/21, the highest number (1,631, 32.6%) of complaint issues related to a patient's 'Diagnosis/Operation/Treatment' (Table 5).
- The highest percentage of complaint issues received in 2020/21 related to the 'General Medicine' specialty (635, 12.7%) (Table 7).
- Of the 3,292 complaints received in 2020/21, the median age of the patient / client was 46.5 years (Figure 8).
- On average HSC Trusts took 31.4 working days to provide a substantive response to complaints received in 2020/21 (Table 9, Figure 13).
- During 2020/21, 14,683 compliments (via card, email, feedback form, care opinion, letter, social media or telephone) were received by HSC Trusts in Northern Ireland.
- Of the 14,683 compliments received by HSC Trusts, 8,675 (59.1%) related to 'Quality of Treatment & Care', 3,913 (26.6%) to 'Staff Attitude & Behaviour', 1,149 (7.8%) to 'Information & Communication', 578 (3.9%) to 'Environment', and 368 (2.5%) to 'Other' subjects (Table 15, Figure 20).

Last Five Years (2016/17 to 2020/21)

- Since 2016/17, the number of complaint issues received by HSC Trusts decreased from 6,189 to 5,005 in 2020/21 (Table 1, Figure 2).
- Over the last five years, five of the six HSC Trusts reported a decrease in the number of complaint issues received; with the largest decrease (47.1%) reported by the Western Trust (Table 1, Figure 2).
- Between 2016/17 and 2020/21, the largest increase in the number of complaint issues (65, 14.2%) was reported in the 'Family and Child Care' POC (459 to 524) (Table 3).
- Complaints issues relating to Family Practitioner Services decreased by almost a third (75, 30.1%) in 2020/21 compared to the 2016/17 year (Table 10, Figure 14).

SECTION 1: COMPLAINT ISSUES RECEIVED BY HSC TRUSTS

What is the Difference between a Complaint and a Complaint Issue?

A *complaint* is defined as an 'expression of dissatisfaction' received from or on behalf of patients, clients or other users of HSC Trust and/or Family Practitioner Services or facilities.

A single communication regarding a complaint, however, may refer to more than one issue. In such cases each individual *complaint issue* is recorded separately for the Programme of Care, Subject and Specialty to which it relates.

One third

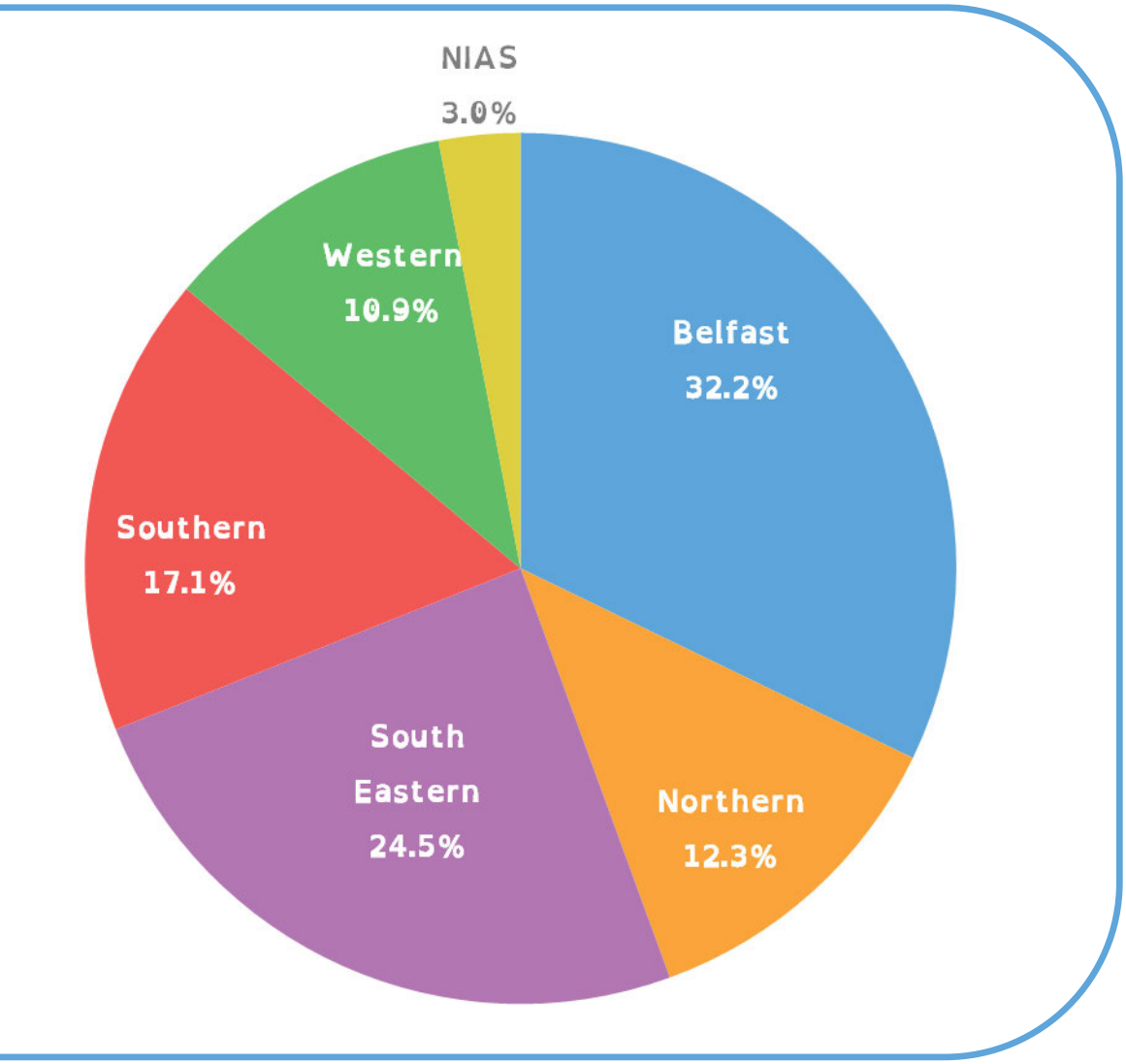
of complaint issues were received by the Belfast HSC Trust

Complaint Issues Received by HSC Trusts

During 2020/21, HSC Trusts received 3,292 complaints relating to 5,005 complaint issues (Tables 1 & 9).

Of the 5,005 complaint issues, almost a third (1,610, 32.2%) were received by the Belfast HSC Trust, 1,228 (24.5%) by the South Eastern HSC Trust, 857 (17.1%) by the Southern HSC Trust, 614 (12.3%) by the Northern HSC Trust, 545 (10.9%) by the Western HSC Trust and 151 (3.0%) by the Northern Ireland Ambulance Service (NIAS) (Tables 1 & 2, Figure 1).

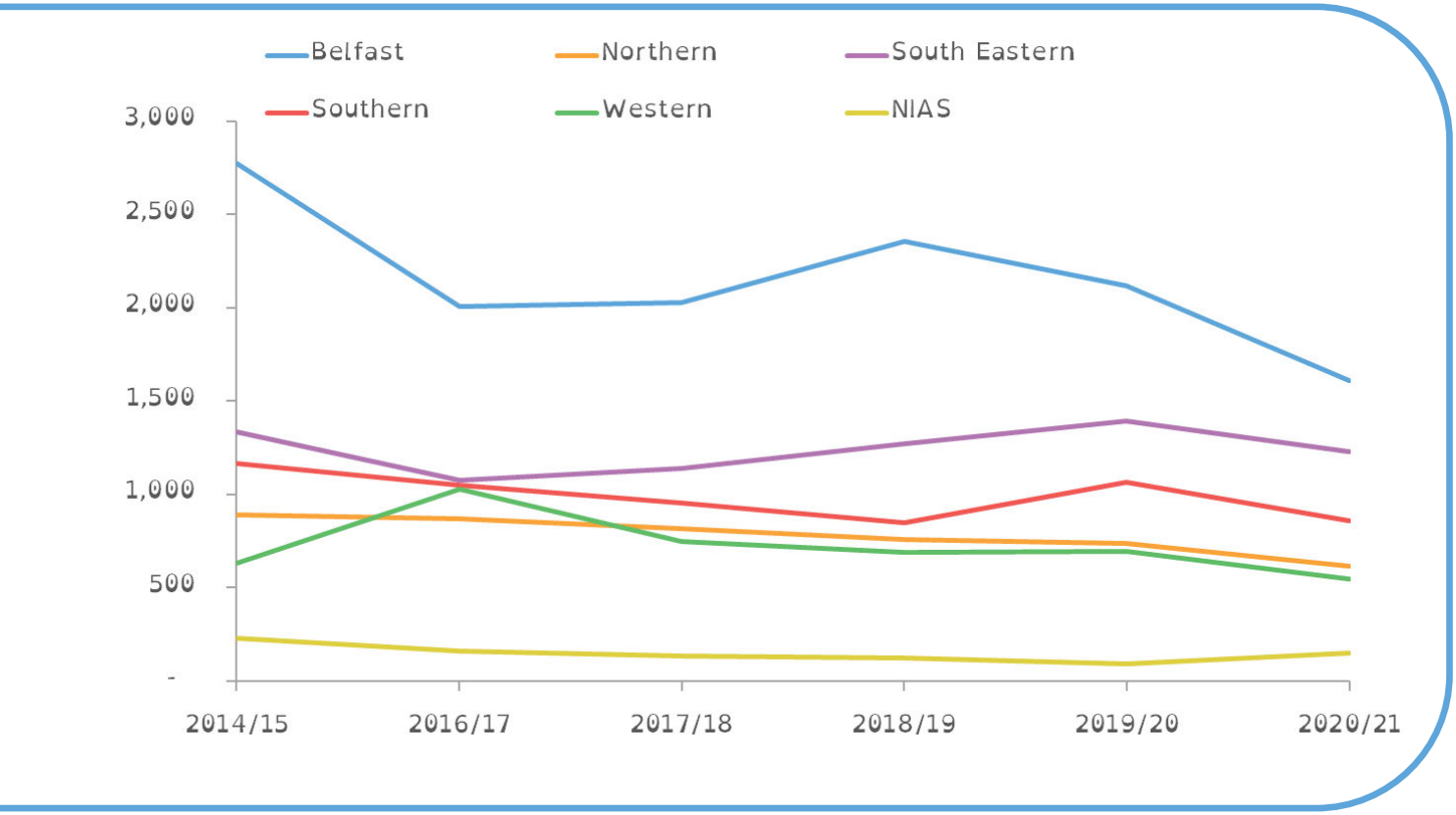
Figure 1: Complaint Issues Received by HSC Trusts (2020/21)



During the last five years, the highest number of complaint issues received by HSC Trusts was in 2016/17 (6,189) and the lowest was in 2020/21 (5,005) (Table 1, Figure 2).

Since 2016/17, the number of complaint issues received decreased in five of the six HSC Trusts, with the Western HSC Trust reporting the largest decrease (485, 47.1%) from 1,030 in 2016/17 to 545 in 2020/21 (Table 1, Figure 2).

Figure 2: Complaint Issues Received by HSC Trusts (2016/17 – 2020/21)



Complaint Issues Received by Programme of Care (POC)[1]

Each complaint issue received is recorded against the POC of the patient / client to whom the complaint relates. If a complaint is made by a user of HSC Trust facilities who is not a patient / client, the complaint issue will be recorded against the POC of that service.

54%

of complaint issues received in 2020/21 related to the Acute POC

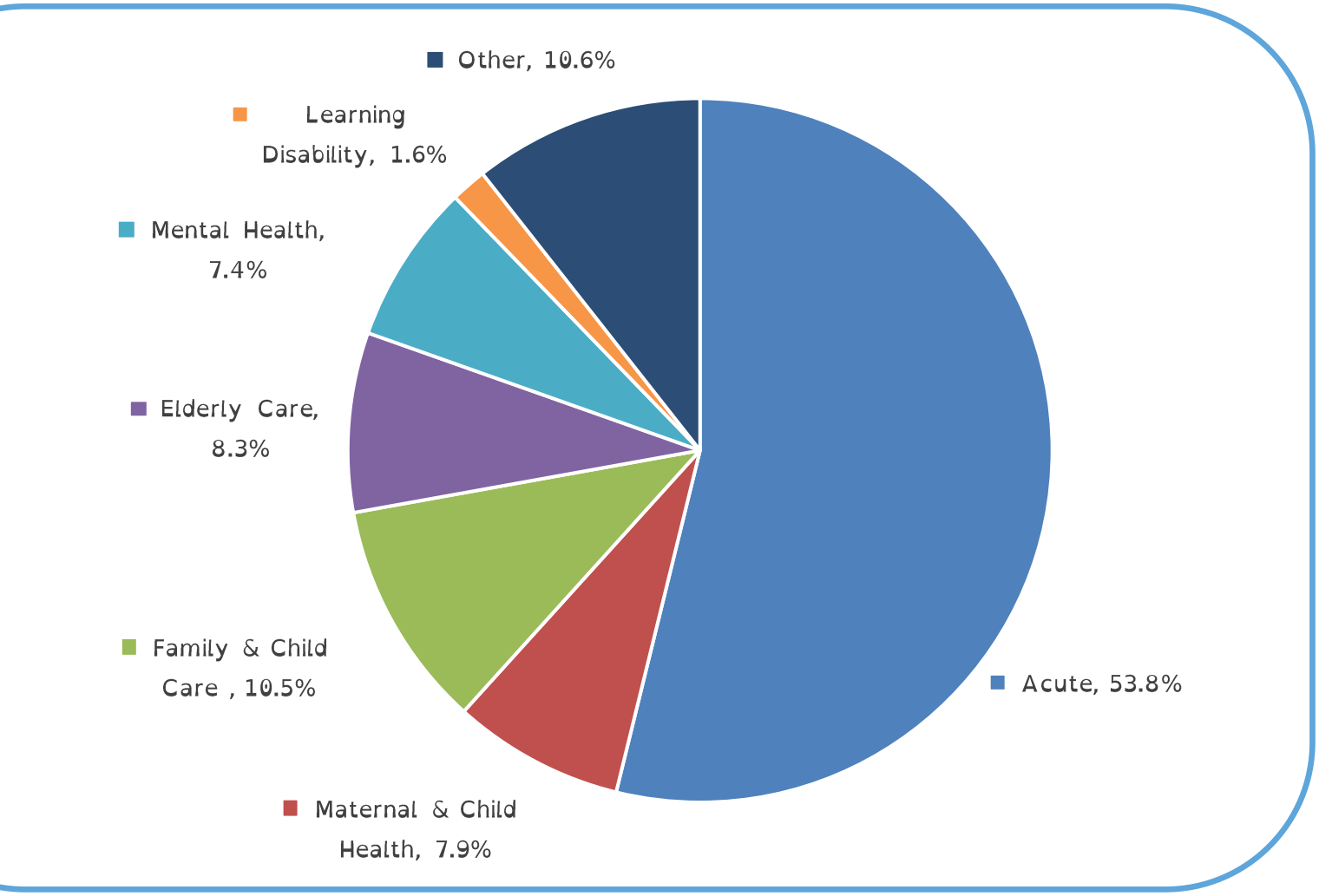
Of the 5,005 complaint issues received by HSC Trusts in 2020/21, more than half (2,695, 53.8%) related to the Acute POC (Table 2)

Four POCs accounted for over 80% (4,026, 80.4%) of all complaint issues received during 2020/21; Acute POC (2,695, 53.8%), Family & Child Care POC (524, 10.5%), Elderly Care POC (413, 8.3%) and Maternal & Child Health POC (394, 7.9%) (Table 2 & Figure 3).

Since 2016/17, the number of complaint issues received by HSC Trusts relating to the Family & Child Care POC increased by 14.2% (65), from 459 to 524 (Table 3).

[1] Refer to Appendix 2: Definitions for full list of Programmes of Care (POCs)

Figure 3: Complaint Issues by POC (2020/21)[2]



[2] 'The 'Other' category includes all complaint issues not included within the seven named POCs above.

Complaint Issues Received by POC and HSC Trust

There is variation across HSC Trusts in the distribution of complaint issues across POCs. During 2020/21:

- Belfast HSC Trust reported the highest number of complaint issues relating to the Acute POC (997, 37.0%), Mental Health POC (132, 35.9%), and the Elderly Care POC (125, 30.3%). Of all complaints received across Northern Ireland, the Belfast HSC Trust Acute POC accounted for nearly a fifth (997, 19.9%).

- South Eastern HSC Trust reported the highest number of complaint issues relating to the Learning Disability POC (32, 39.0%), Sensory Impairment & Physical Disability POC (17, 60.7%), Primary Health & Adult Community POC (24, 47.1). The South Eastern HSC Trust, the sole provider of Prison Healthcare in Northern Ireland, reported 62 complaint issues in relation to this POC (Table 2).

- Southern HSC Trust reported the highest number of complaint issues relating to the Family & Child Care POC (220, 42.0%) (Table 2).

- The Western HSC Trust reported the highest number of complaint issues relating to the Health Promotion & Disease Prevention POC (11, 91.7%) (Table 2).

20% of all complaint issues received related to the Belfast HSC Trust Acute POC

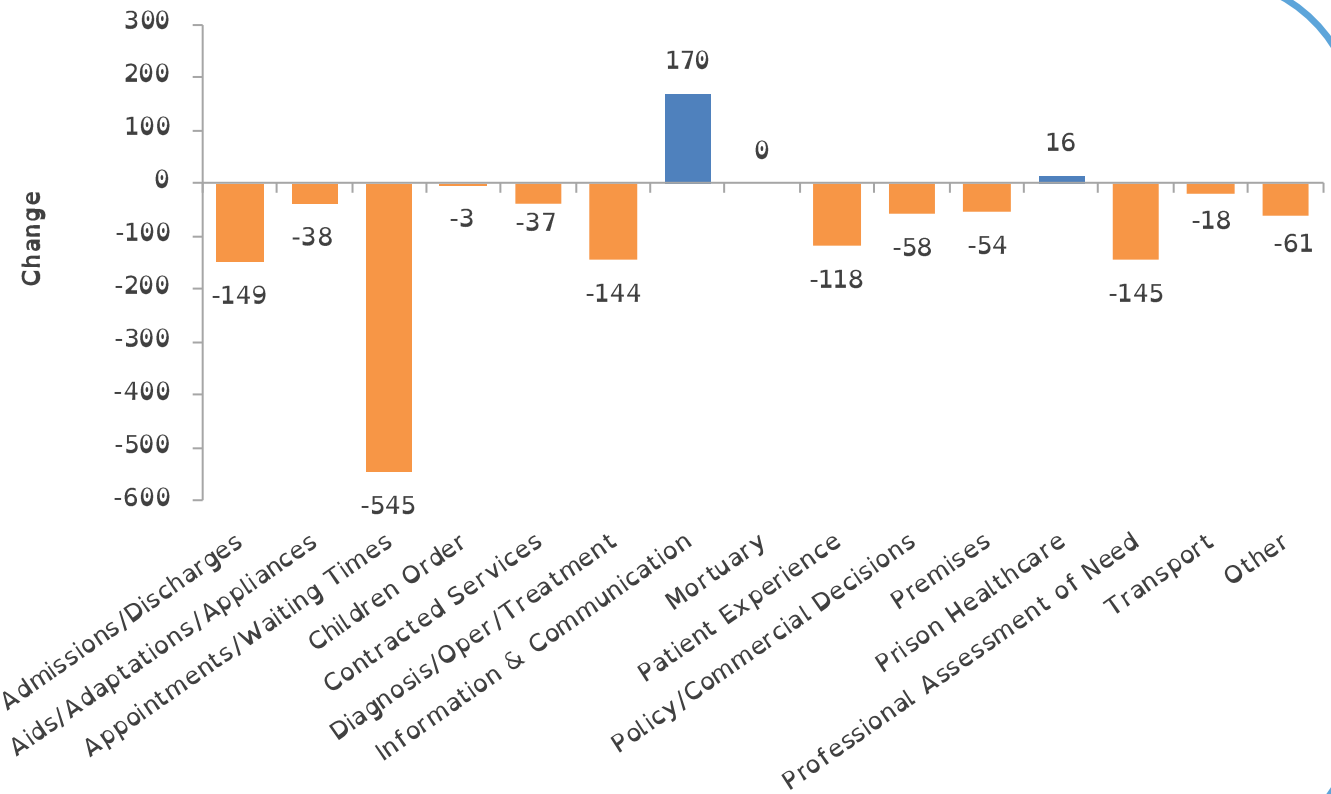
Complaint Issues Received by Category

The category of each complaint issue is based on the subject[3] which best describes the nature of the patient's / client's concern. To enable the category of the complaint issue to be presented, the subject area of each complaint issue has been grouped into one of 15 main categories[4].

During 2020/21, HSC Trusts reported that the highest number of complaint issues related to Diagnosis, Operation and Treatment (1,631, 32.6%), Information & Communication (1,177, 23.5%) and Patient Experience (962, 19.2%) (Table 5).

35% increase in Prison Healthcare related complaint issues received

Figure 4: Change in the Number of Complaint Issues Received, by Category of Complaint (2016/17 - 2020/21)



[3] A complete list of complaint issue subjects is detailed in Appendix 3, whilst an analysis of complaint issues by subject can be found in Table 4.

[4] A list of complaint issue subjects grouped by general category is detailed in Appendix 4.

Between 2016/17 and 2020/21, two categories reported increases in the number of complaint issues received, the 'Information and Communication' category increased by 16.9% from 1,007 to 1,177 and 'Prison Healthcare' increased by 34.8% from 46 to 62 (Figure 4, Table 5).

The 'Appointments/Waiting Times' and 'Admissions/Discharges' categories had the largest decrease in the number of complaint issues received; 545 (60.8%) and 149 (34.7%), respectively (Figure 4, Table 5).

61% decrease
in complaint issues related to Appointments Waiting Times

Complaint Issues Received by Category and HSC Trust

During 2020/21:

In the Belfast HSC Trust, almost three tenths (461, 28.6%) of complaint issues related to the 'Diagnosis/Operation/Treatment' category. The next largest categories were 'Information & Communication' (411, 25.5%) and 'Patient Experience' (264, 16.4%) (Figure 5, Table 6).

In the Northern HSC Trust, the largest category of complaint issues related to 'Diagnosis/Operation/Treatment' (263, 42.8%). The second largest category was 'Patient Experience' (118, 19.2%) (Figure 5, Table 6).

The 'Diagnosis/Operation/Treatment' category accounted for the largest number (406, 33.1%) of complaint issues received in the South Eastern HSC Trust followed by 'Information & Communication' (350, 28.5%) and Patient Experience (237, 19.3%) (Figure 5, Table 6).

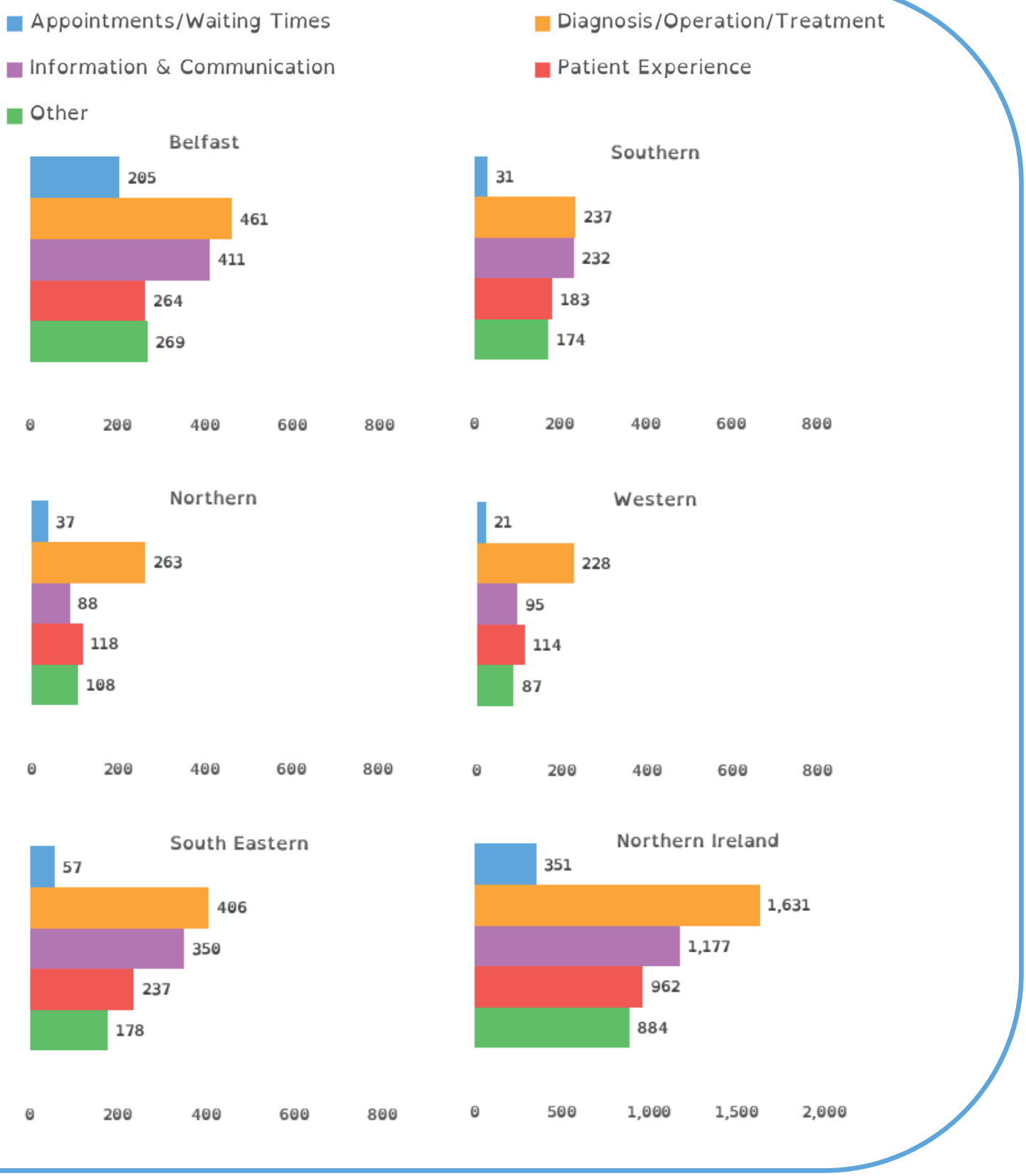
In the Southern HSC Trust, the largest number (237, 27.7%) of complaint issues related to the 'Diagnosis/Operation/Treatment' category. The next largest categories were 'Information & Communication' (232, 27.1%) and 'Patient Experience' (183, 21.4%) (Figure 5, Table 6).

The majority (228, 41.8%) of complaint issues received by the Western HSC Trust related to 'Diagnosis/Operation/Treatment'. The next largest category was 'Patient Experience' (114, 20.9%) (Figure 5, Table 6).

Complaint issues received by NIAS mainly related to 'Transport' (56, 37.1%) followed by 'Patient Experience' (46, 30.5%) and 'Diagnosis/Operation/Treatment' (36, 23.8%) (Table 6).

Figure 5 overleaf presents a summary of the four largest categories, accounting for 82.3% (4,121) of complaint issues received during 2020/21 for each HSC Trust. In Figure 5 complaint issues not in the four largest categories are referred to as 'Other'.

Figure 5: Main Category of Complaint Issues Received by HSC Trusts (2020/21)[5]



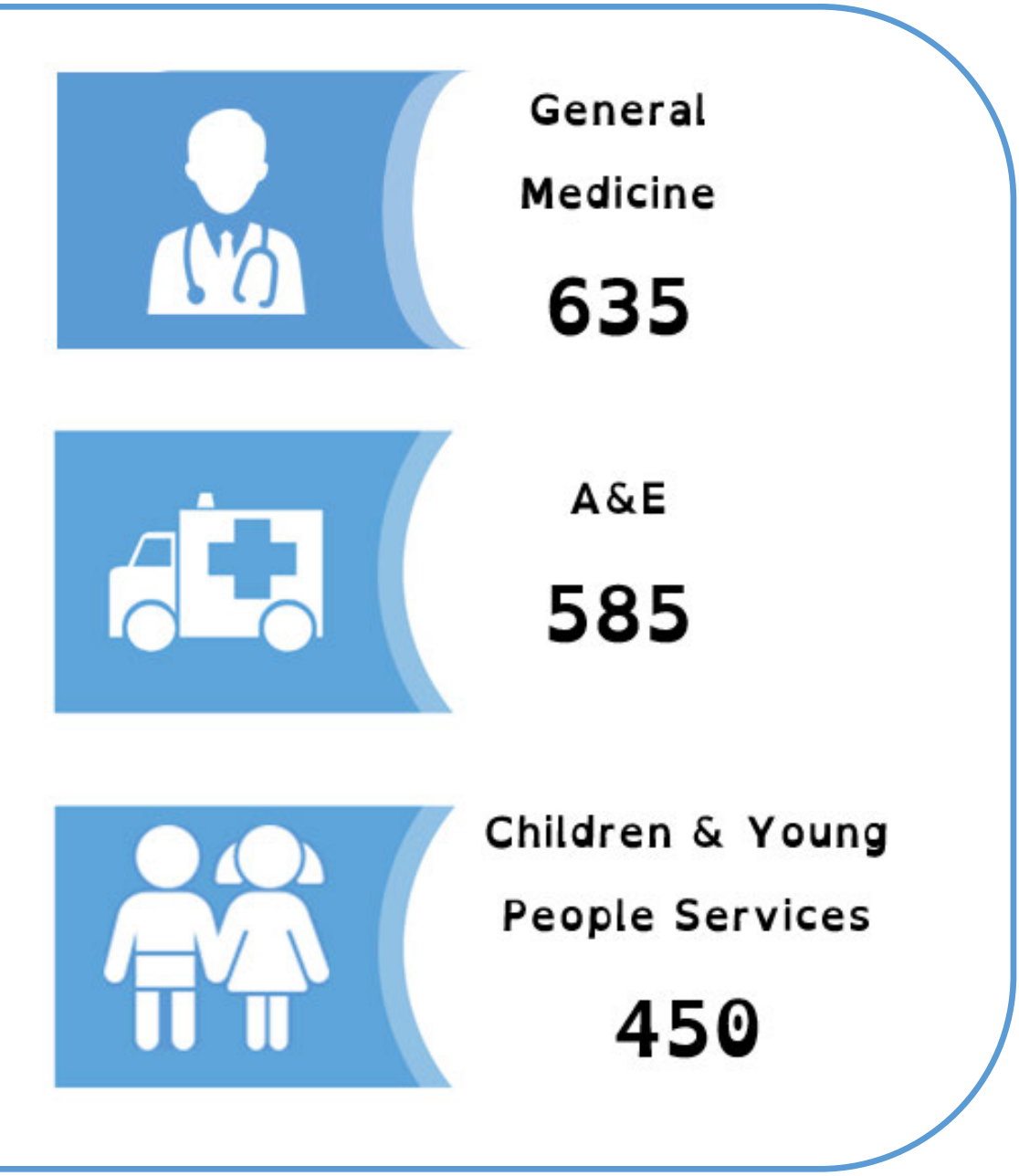
[5] Information for Northern Ireland includes complaint issues received by all HSC Trusts including the NIAS.

Complaint Issues Received by Specialty

During 2020/21, HSC Trusts reported that the highest number of complaint issues received related to the 'General Medicine' (635, 12.7%), 'Accident & Emergency' (585, 11.7%) and 'Children & Young People's Services' (450, 9.0%) (Table 7).

These three specialties accounted for a third (1,670, 33.4%) of all complaint issues received during this time (Table 7).

Figure 6: Top 3 Complaint Issues Received by Specialty



SECTION 2: COMPLAINTS RECEIVED BY HSC TRUSTS

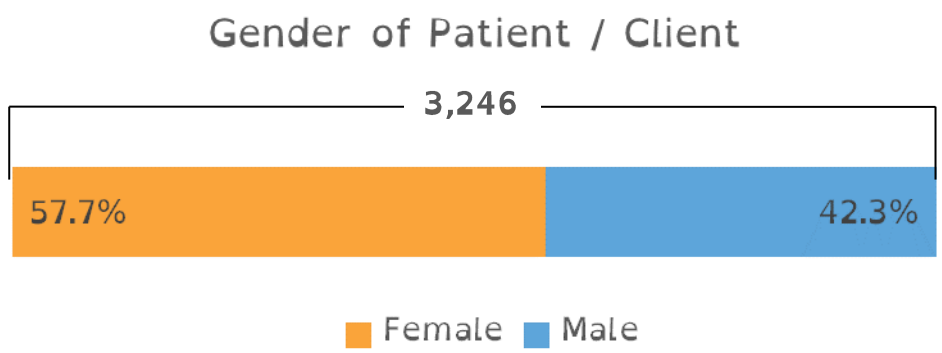
During 2020/21, HSC Trusts received 3,292 complaints, relating to 5,005 complaint issues. Section 2 presents a summary of information relating to these 3,292 complaints. Further information on the difference between a complaint and a complaint issue is detailed on page 6.

Age and Gender of Patient / Client

During 2020/21, a patient/client's gender was recorded in 3,246 (98.6%) of complaints received by HSC Trusts (Figure 7).

Of those complaints where the gender of the patient / client was recorded, 1,873 (57.7%) were females and 1,373 (42.3%) were males (Figure 7).

Figure 7: Gender of Patient / Client (2020/21)



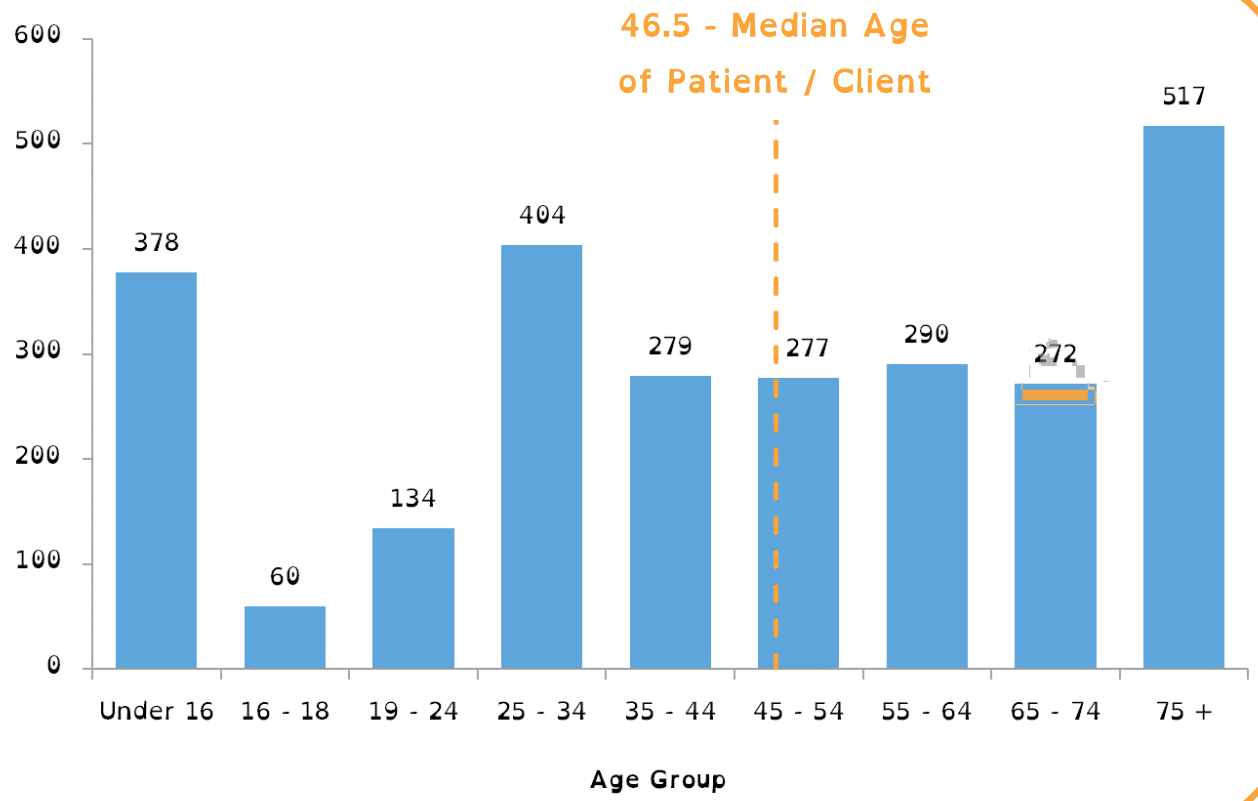
During 2020/21, both the age and gender of the patient / client was recorded in 2,611 (79.3%) of the complaints received by HSC Trusts.

For those complaints where the age and gender of the patient / client was recorded, 517 (19.8%) related to patients / clients aged 75 & over and 378 (14.5%) to those aged under 16 (Figure 8, Table 8).

Of the complaints received by HSC Trusts during 2020/21, the median age of the patient / client was 46.5 years (Figure 8).

47 years
the median age of patient / client complaints received in 2020/21

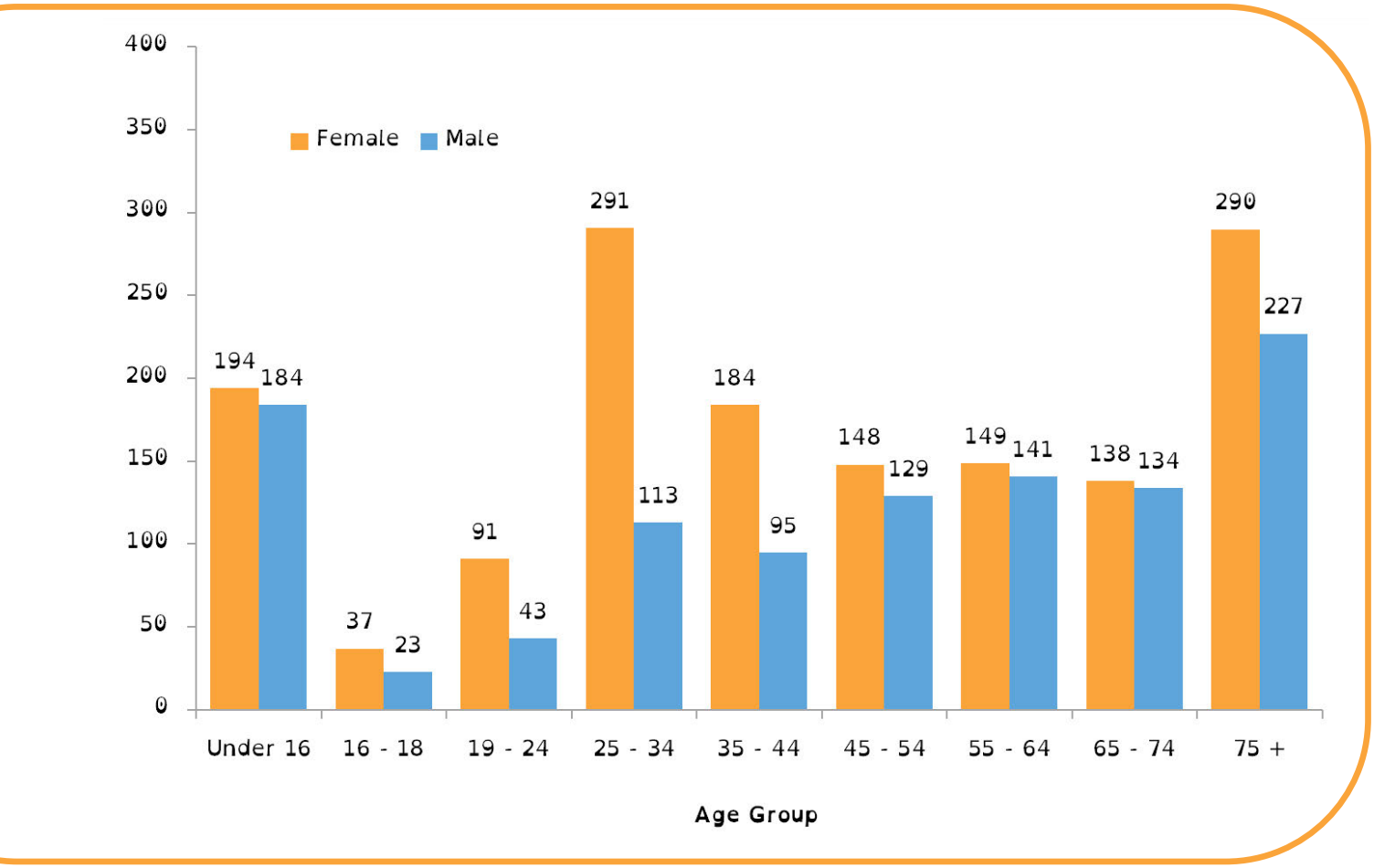
Figure 8: Complaints Received by Age Group of Patient / Client (2020/21)



Of the 2,611 complaints where the age and gender of the patient/client was recorded, 1,522 (58.3%) were females and 1,089 (41.7%) were males (Table 8, Figure 9).

There were over twice as many complaints received relating to females than males in the 25-34 age group, with females outnumbering males in each age group (Table 8, Figure 9).

Figure 9: Complaints Received by Age Group and Gender of Patient / Client (2020/21)



Relationship of Complainant to Patient / Client

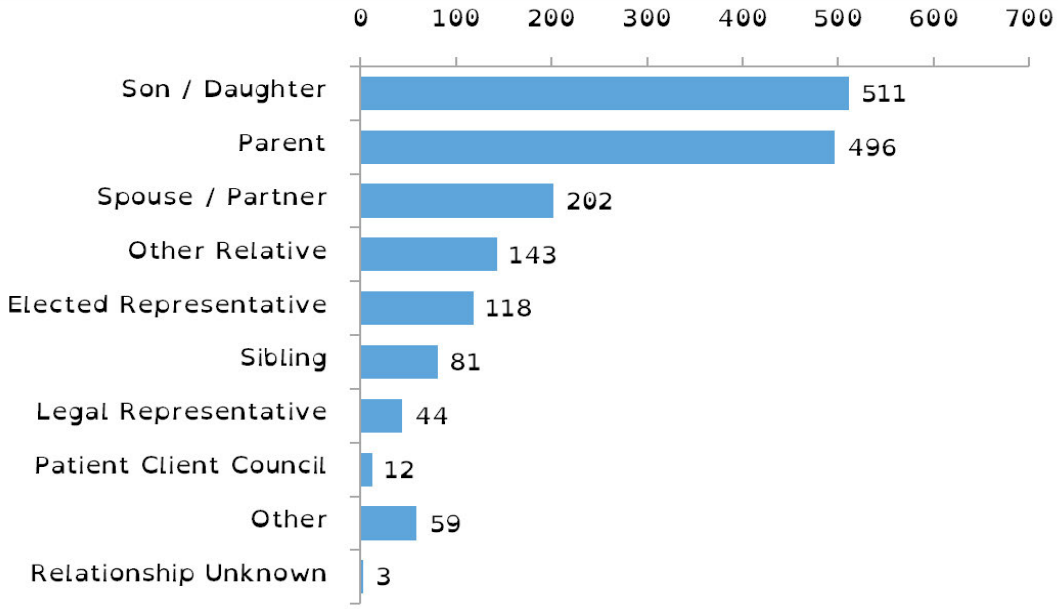
Less than half (1,623, 49.3%) of all complaints received in 2020/21 were identified as being from the patient / client, with 1,669 (50.7%) complaints from persons acting on behalf of the patient / client.

51%

of complaints were received from those acting on behalf of patients / clients in 2020/21

Of the 1,669 complaints received from persons acting on behalf of the patient / client, three tenths (511, 30.6%) were from the son / daughter of the patient / client, 496 (29.7%) from the parent, 202 (12.1%) from a spouse / partner and 143 (8.6%) from another relative (Figure 10) (Tables 16a and 16b).

Figure 10: Complaints Received by Relationship of Complainant (2020/21)[6]



[6] Includes only those complaints made by persons acting on behalf of the patient / client i.e. the complainant was not the patient / client

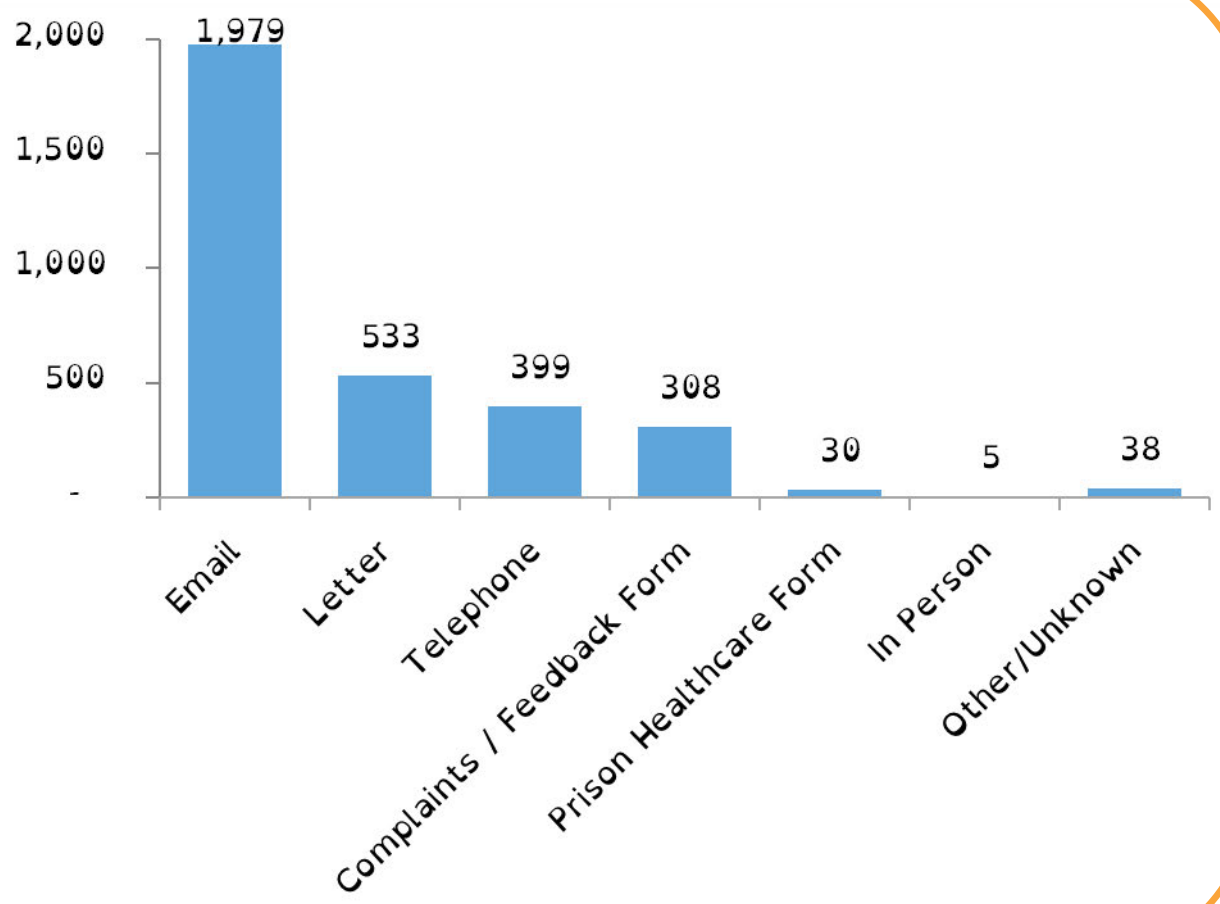
Method of Complaint

Of the 3,292 complaints received during 2020/21, more than three fifths (1,979, 60.1%) were sent by email, 533 (16.2%) by letter and 399 (12.1%) by telephone. These three methods accounted for over four fifths (88.4%, 2,911) of all complaints received during the year (Figure 11).

60%

of complaints received were sent by email in 2020/21

Figure 11: Complaints Received by Method of Complaint (2020/21)



SECTION 3: TIME TAKEN TO PROVIDE A SUBSTANTIVE RESPONSE TO COMPLAINTS RECEIVED

A substantive response is defined as a communication of the outcome of the complaint to the complainant following an investigation. It should be noted that a single substantive response will be provided to a complaint which may include a number of complaint issues.

49%

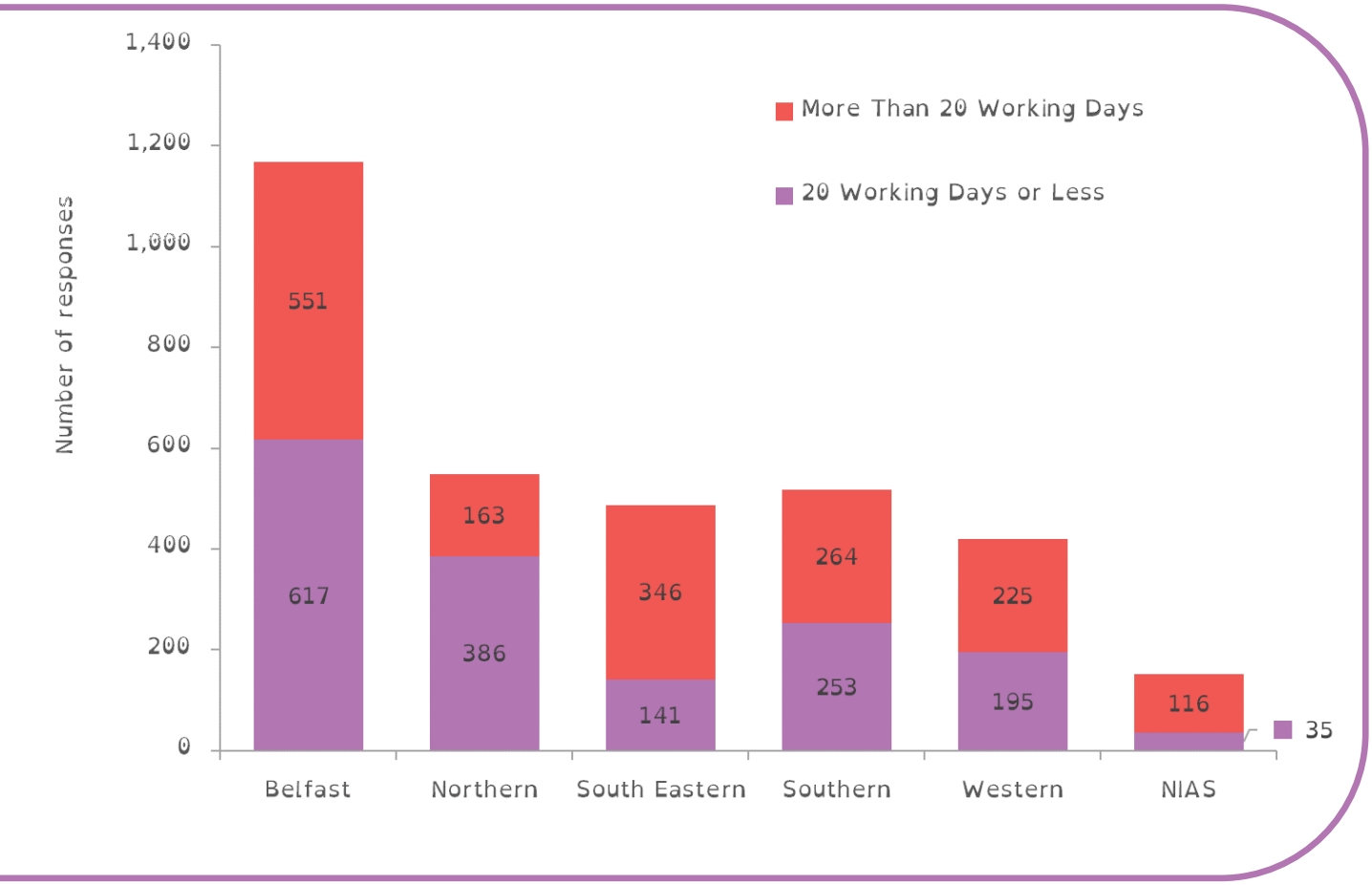
of complaints received a substantive response within 20 working days

The HSC Complaints Policy requires HSC Trusts to provide a substantive response to the complainant within 20 working days of receipt of a complaint. Where this is not possible, a holding response explaining the reason for the delay is sent to the complainant. **All holding responses are issued in 20 working days or less.**

During 2020/21, just under half (1,627, 49.4%) of substantive responses were provided by HSC Trusts within 20 working days of having received the complaint (Table 9, Figure 12).

The Northern HSC Trust provided the highest proportion of substantive responses within 20 working days (386, 70.3%) during 2020/21, whilst the NIAS provided the lowest (35, 23.2%) (Table 9, Figure 12).

Figure 12: Time Taken to Provide a Substantive Response to Complaints Received, by HSC Trusts (2020/21)



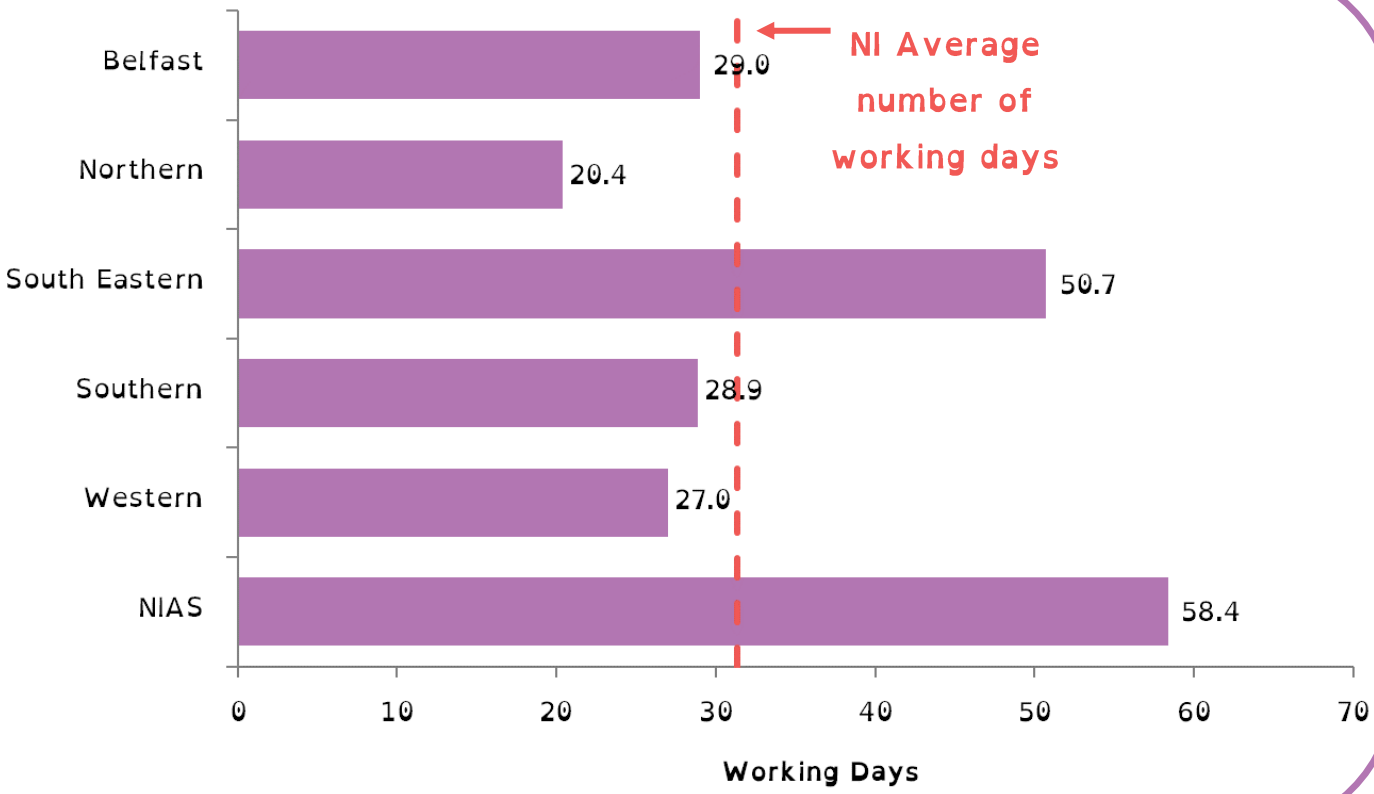
Average Number of Working Days to Substantive Response

On average HSC Trusts took 31.4 working days to provide a substantive response to a complaint received in 2020/21 (Table 9, Figure 13)

On average substantive responses were provided within

31 working days

Figure 13: Average Number of Working Days to Provide a Substantive Response to Complaints Received, by HSC Trusts (2020/21)[7]



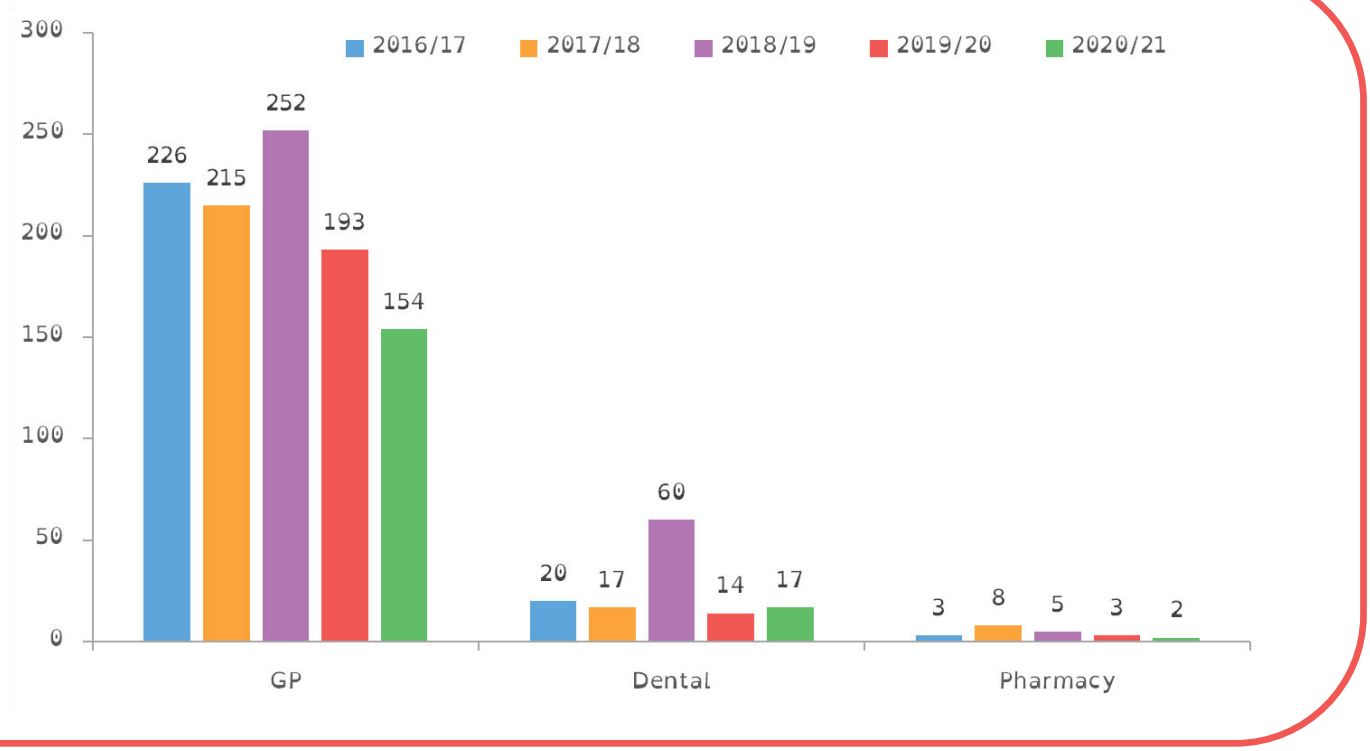
[7] Where it is not possible to provide a substantive response within 20 working days, a holding response explaining the reason for the delay is sent to the complainant. All holding responses are issued in 20 working days or less.

SECTION 4: FAMILY PRACTITIONER SERVICE (FPS) COMPLAINTS

Information in this section refers to complaints received by the HSCB[8] regarding FPS practices in Northern Ireland.

There are over 1,500 FPS practices across Northern Ireland encompassing general practitioners, dental practitioners, pharmacists and optometrists. Under HSC Complaints Procedure all FPS practices are required to forward to the HSC Board anonymised copies of each letter of complaint received along with the subsequent response, within 3 working days of this being issued.

Figure 14: FPS Complaints Handled by Practice Type (2016/17 – 2020/21)[9]



[8] Refer to Appendix 5 for further details.

[9] There have been no ophthalmic complaints handled over the last 5 years.

Between 2016/17 and 2020/21, the number of complaints made against FPS practices in Northern Ireland decreased by 30.5%, from 249 to 173 (Table 10, Figure 14), with the number of complaints made in 2020/21 being 17.6% (37) less than the previous year (2019/20).

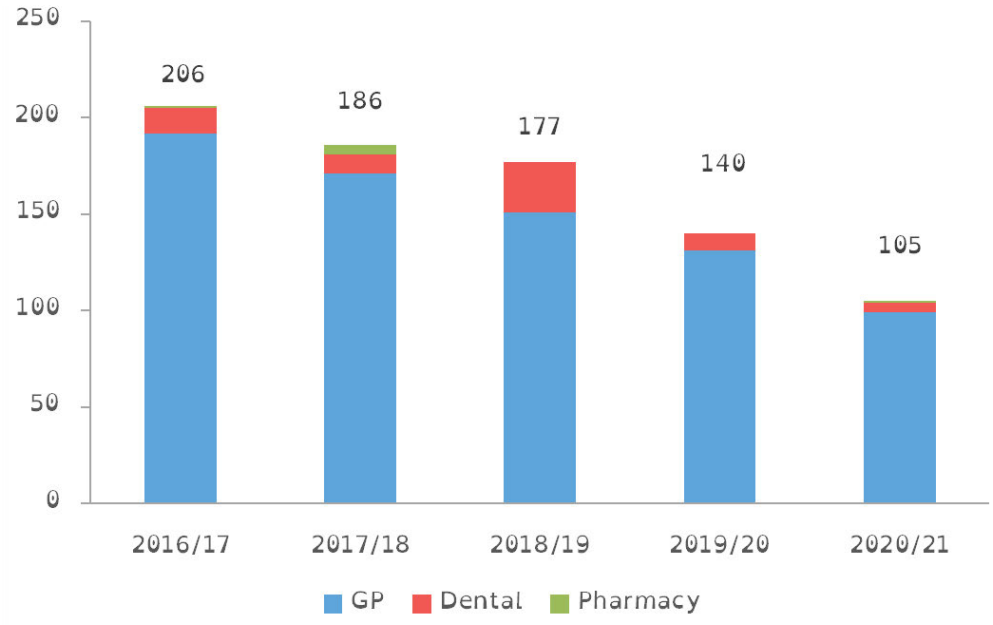
17%

decrease in FPS complaints in the last year

Local resolution

The first stage of the HSC Complaints Procedure is known as 'local resolution'. The purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint. In the case of FPS practices, local resolution involves a practitioner seeking to resolve the complaint through discussion and negotiation.

Figure 15: FPS Complaints Handled Under Local Resolution, by Year and Practice Type (2016/17 - 2020/21)[10]



[10] There have been no ophthalmic complaints handled over the last 5 years.

Of the 173 complaints received by the HSCB regarding FPS practices in 2020/21, 105 (60.7%) were handled under Local Resolution and the HSCB acting as an Honest Broker in 68 (39.3%) (Tables 11 & 14, Figures 15 & 17).

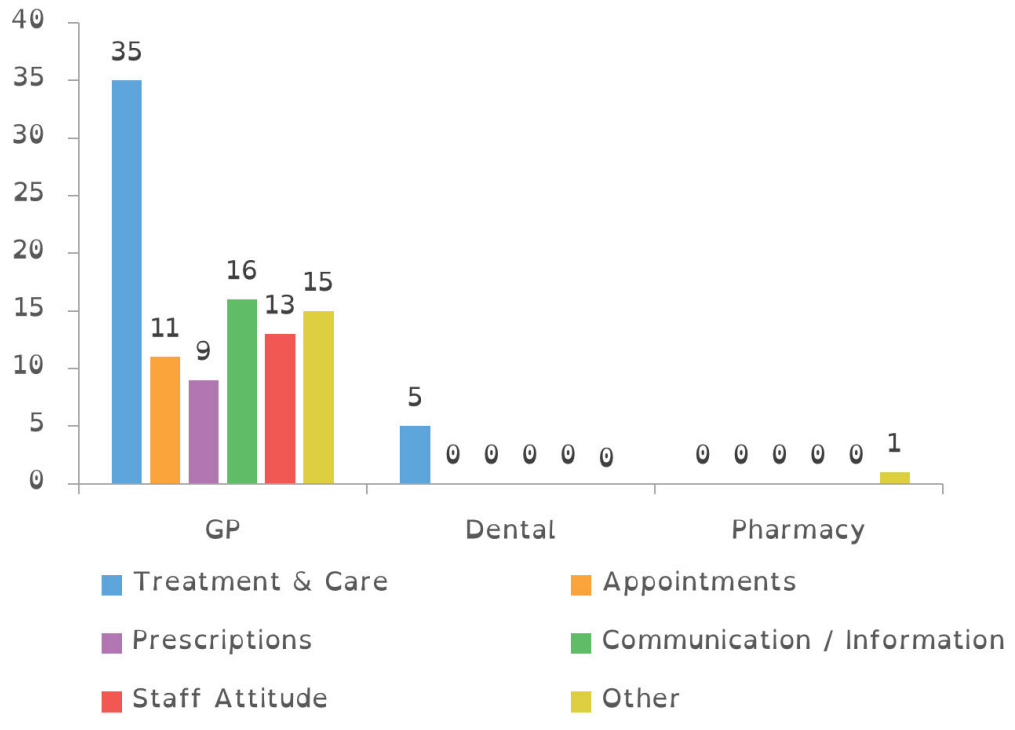
94%

of complaints handled under Local Resolution related to GPs in 2020/21

In 2020/21, 94.3% of complaints handled under local resolution related to GPs (Table 11, Figure 15).

During 2020/21, 'Treatment & Care' accounted for 38.1% (40) of all complaints handled under local resolution, 21 less than in the previous year (Table 12, Figure 16).

Figure 16: FPS Complaints Handled Under Local Resolution, by Subject and Practice Type (2020/21)[11]



[11] There were no ophthalmic or pharmacy complaints handled under local resolution in 2019/20.

Honest Broker

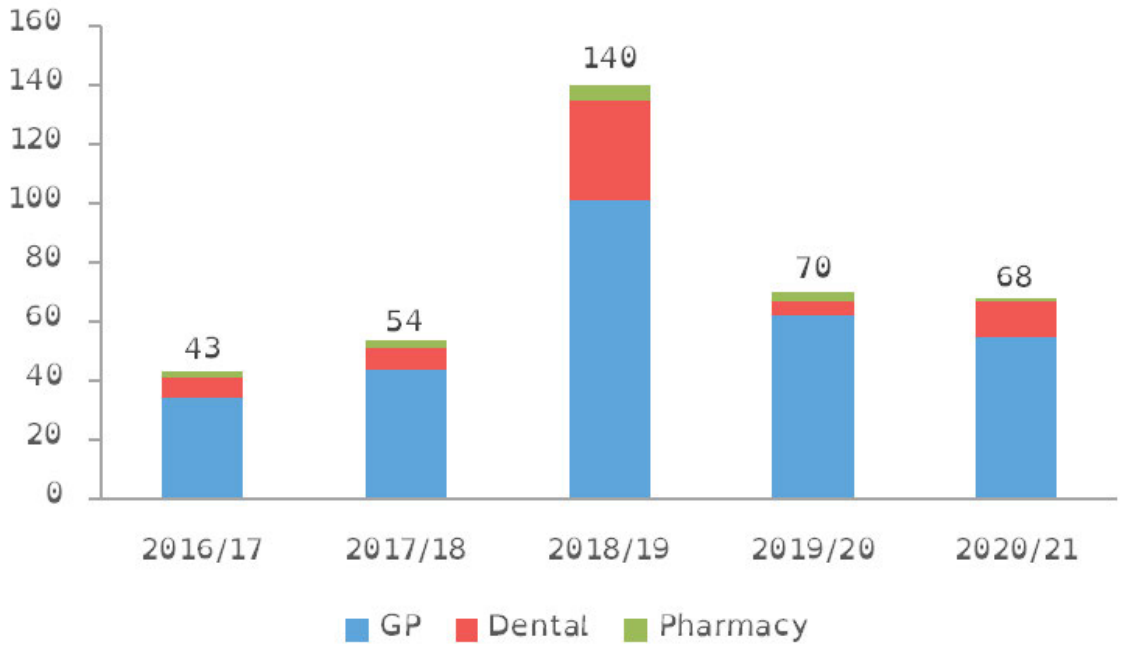
Where a complainant does not wish to approach the FPS practice directly, HSC Board Complaints staff, with the agreement of both the practice and complainant, may act as an intermediary or 'honest broker' with the aim of assisting in the local resolution of the complaint.

81%

of complaints, where the HSCB acted as an Honest Broker, related to GPs in 2020/21

The number of complaints where the HSC Board acted as an honest broker remained similar, with 70 in 2019/20 and 68 in 2020/21 (Table 13, Figure 17).

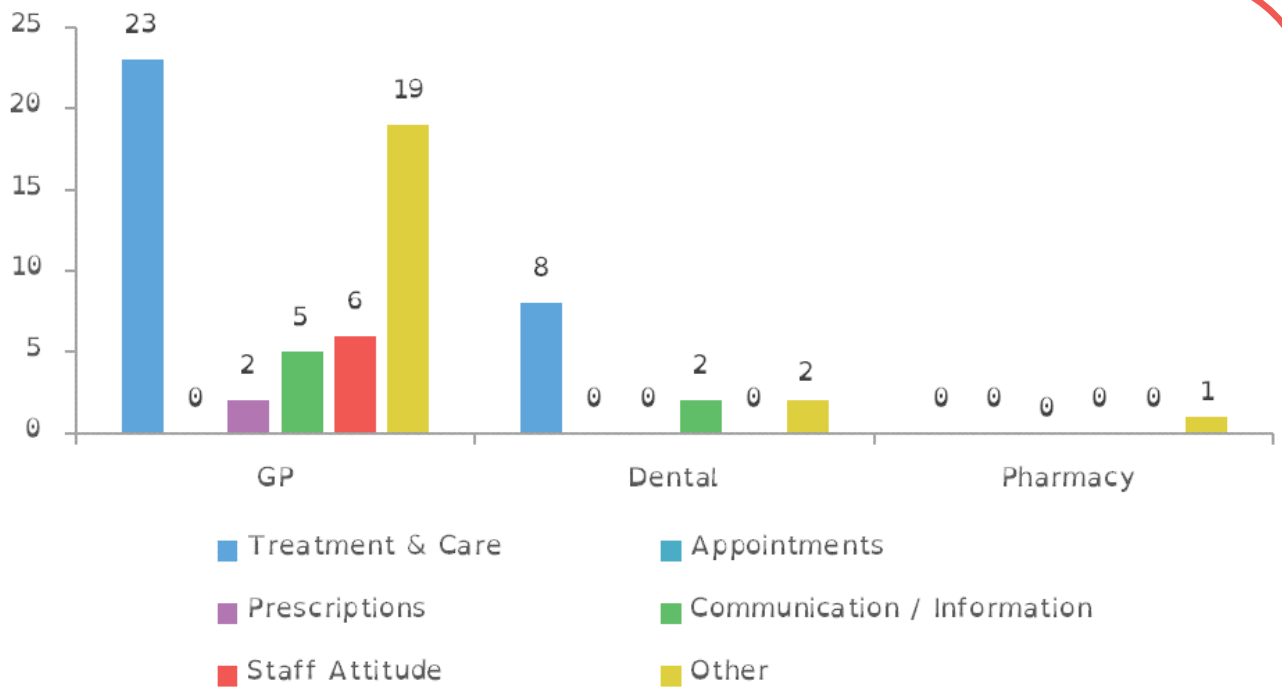
Figure 17: FPS Complaints where the HSC Board Acted as an Honest Broker, by Year and Practice Type (2015/16 – 2020/21)[12]



[12] There were no ophthalmic complaints handled over the last 5 years.

'Treatment & Care' accounted for more than two fifths (31, 45.6%), of all complaints in which the HSC Board acted as an honest broker during 2020/21 (Table 14, Figure 18).

Figure 18: FPS Complaints where the HSC Board Acted as an Honest Broker, by Subject and Practice Type (2020/21)[12]



SECTION 5: COMPLIMENTS RECEIVED BY HSC TRUSTS

A statistical information return to collate information on compliments received by HSC Trusts was introduced in December 2017[13], with data first being published in the 2018/19 report.

For the purposes of this statistical collection, a compliment may be understood as 'an expression of praise, commendation or admiration'. In addition, only compliments received by: Card, Email, Feedback Form, Letter, Social Media (Facebook & Twitter only) or Telephone should be included.

14,700

compliments received by HSC Trusts in 2020/21

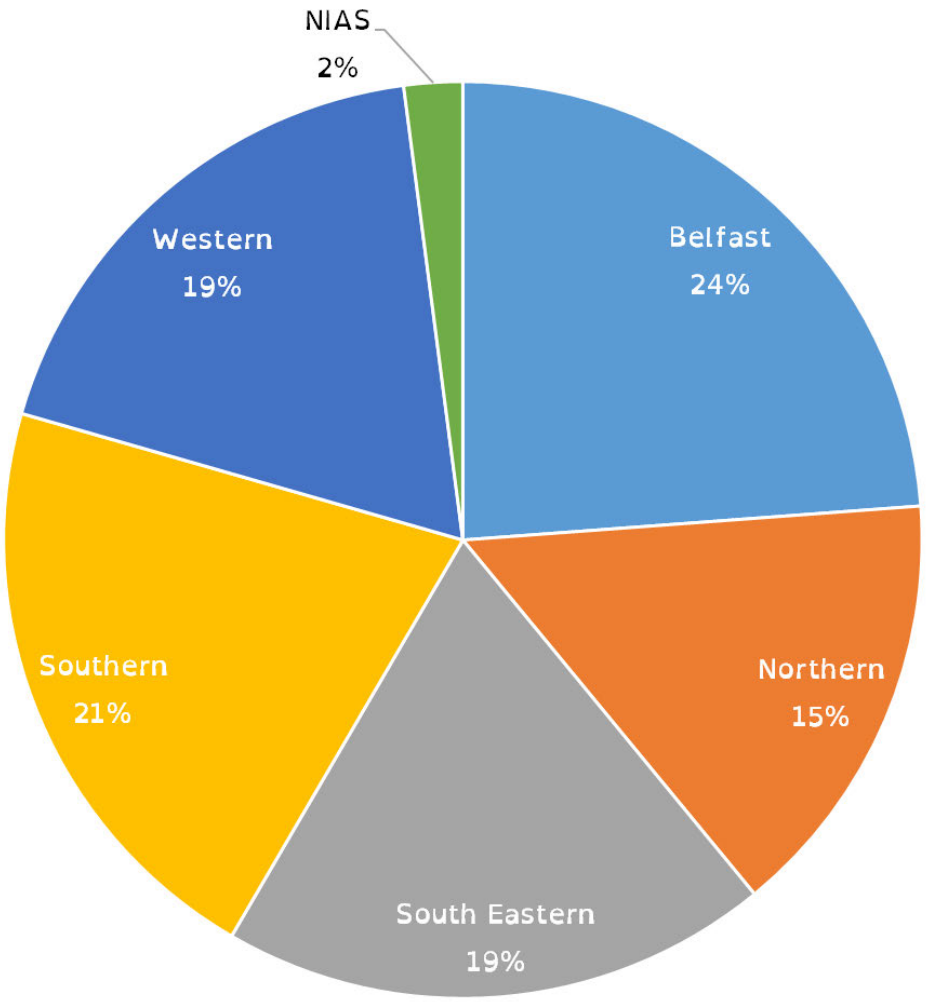
Compliments Received by HSC Trusts

During 2020/21, HSC Trusts received 14,683 compliments.

Almost a quarter (3,497, 23.8%) were received by the Belfast HSC Trust, 3,091 (21.1%) by the Southern HSC Trust, 2,842 (19.4%) by the South Eastern HSC Trust, 2,714 (18.5%) by the Western HSC Trust, 2,236 (15.2%) by the Northern HSC Trust and 303 (2.1%) by NIAS (Table 15, Figure 19).

[13] Additional information on the compliments information collection is detailed in Appendix 1 & 6.

Figure 19: Compliments Received by HSC Trusts (2020/21) [12]

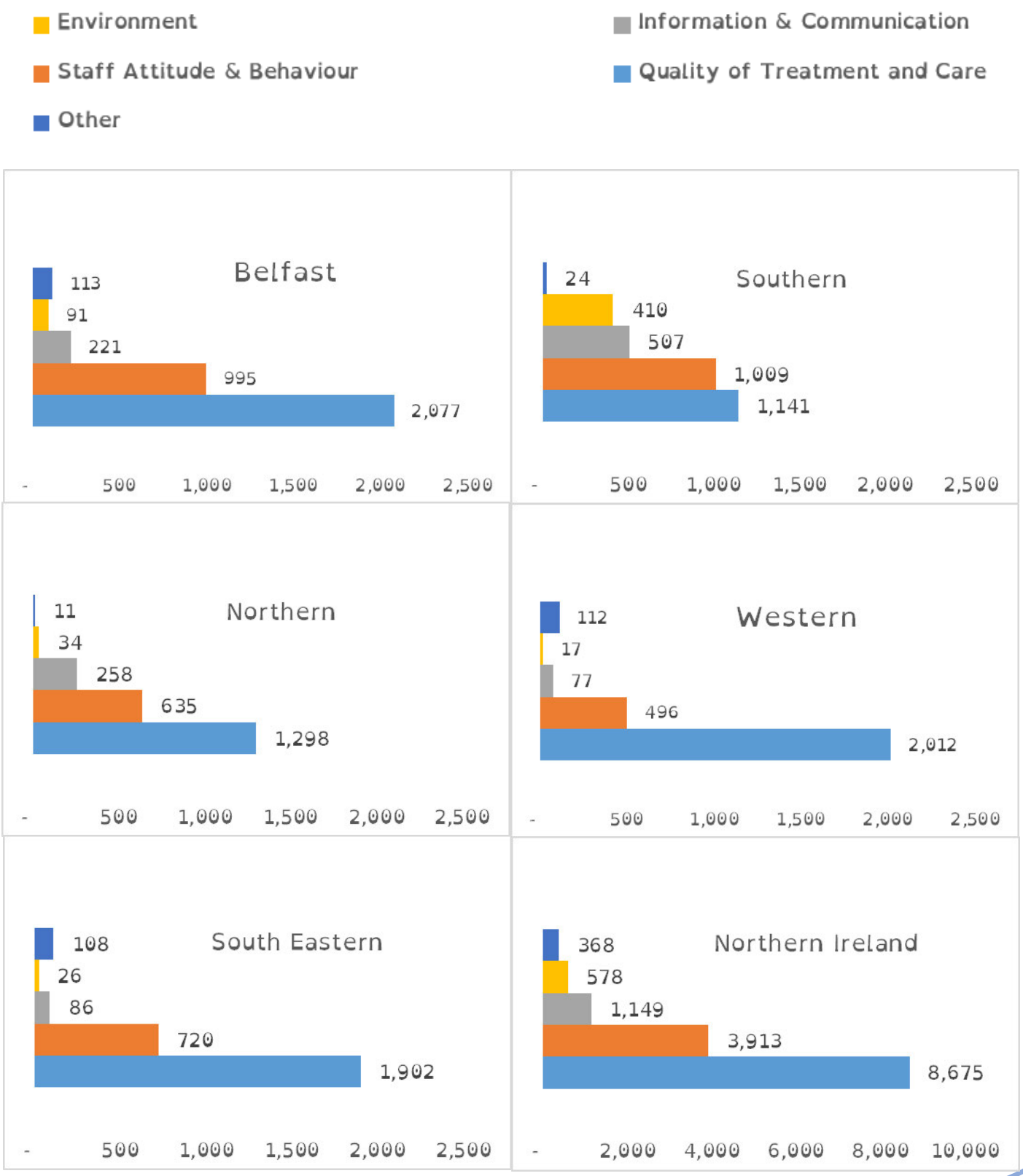


60% of compliments related to Quality of Treatment & Care

Subject of Compliment Received

Of the 14,683 compliments received by HSC Trusts, 8,675 (59.1%) related to 'Quality of Treatment & Care', 3,913 (26.6%) to 'Staff Attitude & Behaviour', 1,149 (7.8%) to 'Information & Communication', 578 (3.9%) to 'Environment', and 368 (2.5%) to 'Other' subjects (Table 15, Figure 20).

Figure 20: Compliments received by HSC Trusts, by Subject and HSC Trust (2020/21)[14]

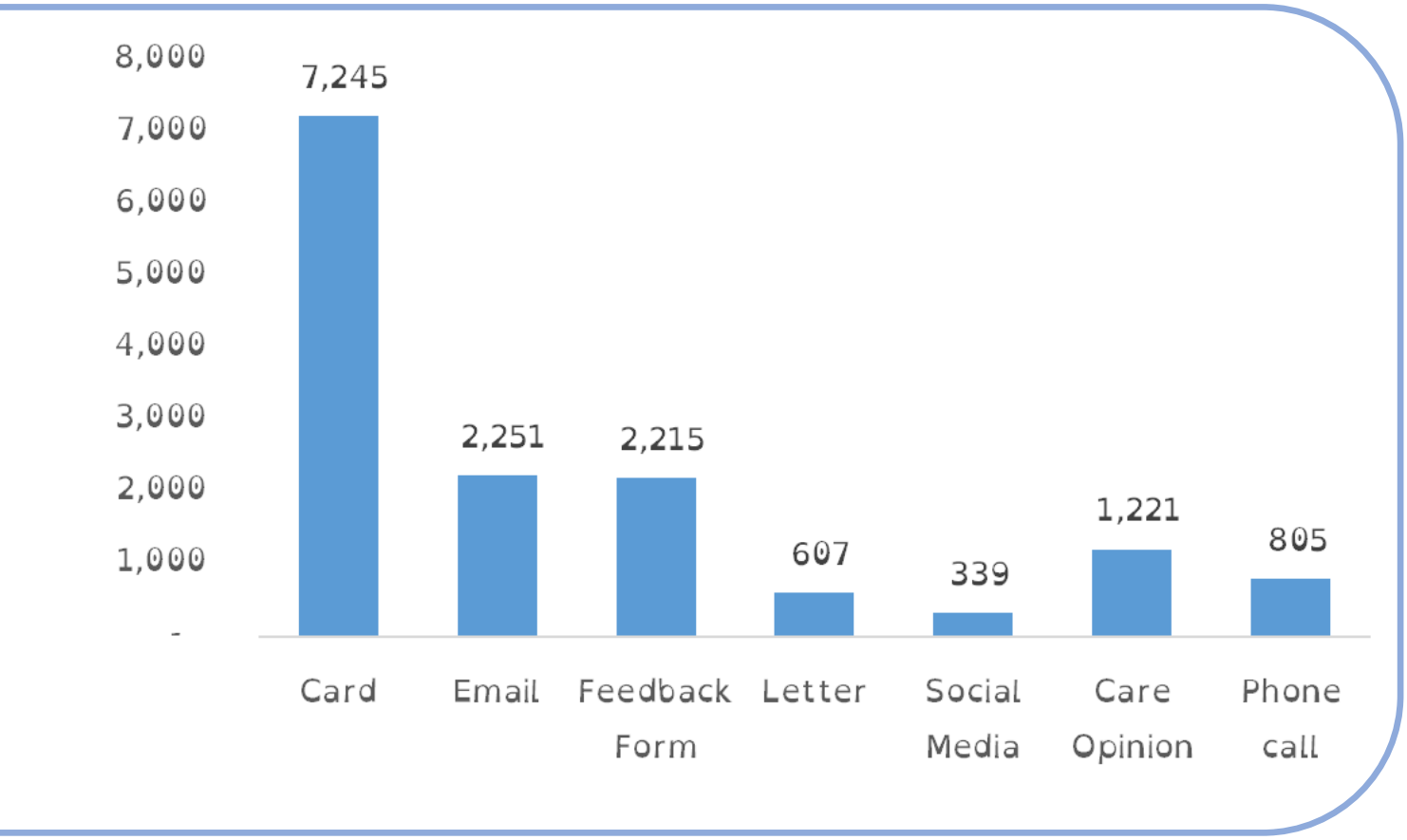


[14] Information for Northern Ireland includes compliments received by all HSC Trusts including the NIAS.

Method of Compliment

Almost half (7,245, 49.3%) of compliments received during 2020/21 were made by card, 2,251 (15.3%) by email, 2,215 (15.1%) by feedback form, 1,221 (8.3%) by Care Opinion, 607 (4.1%) by letter, 339 (2.3%) by social media[15] and 805 (5.5%) by phone call (Figure 21).

Figure 21: Compliments received by HSC Trusts by Method (2020/21)[14]



[15] Only Facebook posts / Tweets linked to the official organisational Facebook / Twitter accounts are included as social media compliments.

SECTION 6: ADDITIONAL TABLES

Table 1: Complaint Issues Received by HSC Trusts (2014/15 - 2020/21)

HSC Trust	2014/15	2016/17	2017/18	2018/19	2019/20	2020/21
Belfast	2,772	2,007	2,026	2,356	2,118	1,610
Northern	890	869	814	760	739	614
South Eastern	1,332	1,076	1,140	1,269	1,392	1,228
Southern	1,166	1,046	955	850	1,067	857
Western	629	1,030	746	690	696	545
NIAS	226	161	133	124	93	151
Northern Ireland	**7,015**	**6,189**	**5,814**	**6,049**	**6,105**	**5,005**

Table 2: Complaint Issues Received by HSC Trusts, by POC (2020/21)[16]

Programme of Care	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Total
Acute	997	292	656	484	266	-	**2,695**
Maternal & Child Health	195	43	120	-	36	-	**394**
Family & Child Care	-	-	-	-	7	-	**524**
Elderly Care	80	74	130	220	13	-	**413**
Mental Health	125	64	89	86	49	-	**368**
Learning Disability	132	108	66	30	32	-	**82**
Sens Impairment & Physical Disability	15	15	32	11	9	-	**28**
Health Promotion & Disease Prevention	4	3	17	1	3	-	**12**
Primary Health & Adult Community	-	-	1	-	11	-	**51**
Prison Healthcare	-	**3**	24	**24**	-	-	**62**
None (No POC assigned)	-	-	62	-	-	-	**376**
Total	**62**	**12**	**31**	**1**	**119**	**151**	**5,005**

[16] The South Eastern HSC Trust is the sole provider of Prison Healthcare in Northern Ireland.

Table 3: Complaint Issues Received by HSC Trusts, by POC (2016/17 - 2020/21)

Programme of Care	2016/17	2017/18	2018/19	2019/20	2020/21
Acute	3,703	3,371	3,626	3,576	2,695
Maternal & Child Health	354	361	281	367	394
Family & Child Care	459	466	429	458	524
Elderly Care	378	370	322	426	413
Mental Health	431	390	412	474	368
Learning Disability	134	119	93	113	82
Sens Impairment & Physical Disability	61	73	58	40	28
Health Promotion & Disease	5	2	4	24	12
Primary Health & Adult Community	167	190	287	113	51
Prison Healthcare	46	51	39	40	62
None (No POC assigned)	451	421	498	474	376
Total	**6,189**	**5,814**	**6,049**	**6,105**	**5,005**

Table 4: Subject of Complaint Issues by HSC Trust (2020/21)

Subject	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Total
Access to Premises	9	4	13	4	2	1	33
Aids/Adaptations/Appliances	16	5	3	6	4	-	34
Children Order Complaints	-	-	-	-	5	-	5
Clinical Diagnosis	59	36	69	34	35	1	234
Communication/Information	370	74	294	217	78	1	1,034
Complaints Handling	1	-	6	-	1	-	8
Confidentiality	20	7	16	8	13	-	64
Consent to Treatment/Care	2	-	2	2	1	-	7
Contracted Regulated Domiciliary Services	-	5	5	-	-	-	10
Contracted Regulated Residential Nursing	-	16	3	-	-	-	19
Other Contratced Services	1	2	-	-	-	-	3
Delay/Cancellation for Inpatients	1	1	2	10	2	-	16
Delayed Admission from A&E	1	-	3	4	5	-	13
Discharge/Transfer Arrangements	48	15	26	18	16	-	123
Discrimination	3	2	6	5	1	-	17
Environmental	18	6	7	10	1	-	42
Hotel/Support/Security Services (Excludes Contracted Services)	6	9	6	10	3	-	34
Infection Control	22	5	10	10	1	3	51
Mortuary & Post-Mortem	-	-	1	-	-	-	1
Policy/Commercial Decisions	16	19	16	11	7	-	69
Privacy/Dignity	3	3	25	3	6	-	40
Professional Assessment of Need	13	17	11	82	7	-	130
Property/Expenses/Finances	50	11	12	14	12	1	100
Records/Record Keeping	20	7	42	7	3	-	79
Staff Attitude/Behaviour	208	102	199	161	95	45	810
Transport, Late or Non-arrival/Journey Time	1	-	1	1	1	56	60
Quality of Treatment & Care	292	217	359	157	164	35	1,224
Quantity of Treatment & Care	107	9	17	34	26	-	193
Waiting List, Delay/Cancellation Community Based Appointments	10	7	22	3	12	-	54
Waiting List, Delay/Cancellation Outpatient Appointments	164	22	18	12	3	-	219
Waiting List, Delay/Cancellation Planned Admission to Hospital	107	5	9	9	14	-	144
Waiting Times, A&E Departments	7	2	8	2	2	-	21
Waiting Times, Community Services	10	1	4	6	2	-	23
Waiting Times, Outpatient Departments	14	5	9	8	2	-	38
Other	11	-	4	9	21	8	53
Total Number of Complaint Issues	1,610	614	1,228	857	545	151	5,005

Table 5: Category of Complaint Issue (2016/17 - 2020/21)

Category of Complaint Issue	2016/17		2017/18		2018/19		2019/20		2020/21	
	No.	%	No.	%	No.	%	No.	%	No.	%
Admissions/Discharges	429	6.9%	374	6.4%	348	5.8%	372	6.1%	280	5.6%
Aids/Adaptations/Appliances	72	1.2%	62	1.1%	51	0.8%	62	1.0%	34	0.7%
Appointments/Waiting Times	896	14.5%	737	12.7%	711	11.8%	688	11.3%	351	7.0%
Children Order	8	0.1%	5	0.1%	2	0.0%	1	0.0%	5	0.1%
Contracted Services	69	1.1%	64	1.1%	63	1.0%	60	1.0%	32	0.6%
Diagnosis/Oper/Treatment	1,775	28.7%	1,733	29.8%	1,920	31.7%	1,855	30.4%	1,631	32.6%
Information & Communication	1,007	16.3%	1,035	17.8%	1,075	17.8%	1,176	19.3%	1,177	23.5%
Mortuary	1	0.0%	0	0.0%	2	0.0%	1	0.0%	1	0.0%
Patient Experience	1,080	17.5%	1,030	17.7%	1,068	17.7%	1,077	17.6%	962	19.2%
Policy/Commercial Decisions	125	2.0%	111	1.9%	99	1.6%	83	1.4%	67	1.3%
Premises	214	3.5%	238	4.1%	317	5.2%	302	4.9%	160	3.2%
Prison Healthcare	46	0.7%	51	0.9%	39	0.6%	40	0.7%	62	1.2%
Professional Assessment of	275	4.4%	237	4.1%	191	3.2%	196	3.2%	130	2.6%
Transport	78	1.3%	61	1.0%	59	1.0%	117	1.9%	60	1.2%
Other	114	1.8%	76	1.3%	104	1.7%	75	1.2%	53	1.1%
Total	**6,189**	100.0%	**5,814**	100.0%	**6,049**	100.0%	**6,105**	100.0%	**5,005**	100.0%

Table 6: Category of Complaint Issue by HSC Trust (2020/21)[17]

Category of Complaint Issue	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	NIAS	Northern Ireland
Admissions/Discharges	156	20	38	31	35	0	**280**
Aids/Adaptations/Appliances	16	5	3	6	4	0	**34**
Appointments/Waiting Times	205	37	57	31	21	0	**351**
Children Order	0	0	0	0	5	0	**5**
Contracted Services	1	23	8	0	0	0	**32**
Diagnosis/Operation/Treatment	461	263	406	237	228	36	**1,631**
Information & Communication	411	88	350	232	95	1	**1,177**
Mortuary	0	0	1	0	0	0	**1**
Patient Experience	264	118	237	183	114	46	**962**
Policy/Commercial Decisions	16	19	14	11	7	0	**67**
Premises	55	24	36	34	7	4	**160**
Prison Healthcare			62				**62**
Professional Assessment of Need	13	17	11	82	7	0	**130**
Transport	1	0	1	1	1	56	**60**
Other	11	0	4	9	21	8	**53**
Total	1610	614	1228	857	545	151	**5,005**

[17] The South Eastern HSC Trust is the sole provider of Prison Healthcare in Northern Ireland.

Table 7: Specialty of Complaint Issues by HSC Trust (2020/21)

Specialty	Belfast	Northern	South Eastern	Southern	Western	NIAS	Total
Accident & Emergency	125	85	100	94	94	87	**585**
Allied Health Professions	41	12	38	26	12	0	**129**
Anaesthetics & Pain Management	13	1	9	0	9	0	**32**
Burns Plastic and Maxillofacial Surgery	1	0	42	0	3	0	**46**
Cardiology	19	13	14	8	9	0	**63**
Child & Adolescent Psychiatry	23	4	0	23	1	0	**51**
Children & Young Peoples Services	63	71	138	124	54	0	**450**
Community Nursing/Midwives	0	9	9	2	6	0	**26**
Community Paediatrics	19	2	1	22	0	0	**44**
Dentistry	18	1	1	1	1	0	**22**
Dermatology	10	2	6	3	1	0	**22**
Domicillary Services	6	11	1	11	25	0	**54**
ENT	46	1	5	6	4	0	**62**
General Medicine	98	60	263	169	45	0	**635**
General Surgery	41	40	61	27	58	0	**227**
Geriatric Medicine	81	10	23	0	9	0	**123**
Gynaecology	64	14	30	13	11	0	**132**
Learning Disability	4	15	22	9	1	0	**51**
Mental Health Acute	103	33	30	12	4	0	**182**
Mental Health Community	1	48	41	19	12	0	**121**
Neurology	48	0	6	4	3	0	**61**
Obstetrics	86	26	122	71	19	0	**324**
Old Age Psychiatry	0	25	9	0	2	0	**36**
Oncology	32	4	11	0	0	0	**47**
Ophthalmology	36	0	2	0	11	0	**49**
Other	230	91	169	132	78	41	**741**
Paediatrics	102	8	19	17	8	0	**154**
Physical Disability/ Sensory Support	14	0	11	2	4	0	**31**
Radiology	37	12	12	11	7	0	**79**
Rehabilitation	0	4	0	10	11	0	**25**
Residential Care	13	9	5	8	3	0	**38**
Trauma & Orthopaedics	198	3	24	19	29	0	**273**
Urology	38	0	4	14	11	0	**67**
NIAS - Emergency Ambulance Control	0	0	0	0	0	23	**23**
Total	1,610	614	1,228	857	545	151	**5,005**

Table 8: Complaints by Age Group and Gender of Patient / Client (2020/21)[18]

Age Group	Female	Male	Total
Under 16	194	184	**378**
16 - 18	37	23	**60**
19 - 24	91	43	**134**
25 - 34	291	113	**404**
35 - 44	184	95	**279**
45 - 54	148	129	**277**
55 - 64	149	141	**290**
65 - 74	138	134	**272**
75 +	290	227	**517**
Total	**1,522**	**1,089**	**2,611**

Table 9: Time Taken to Provide a Substantive Response to Complaints Received, by HSC Trust (2020/21)

HSC Trust	20 Working Days or Less		More Than 20 Working Days		Total No.	Mean No. of Working Days
	No.	%	No.	%		
Belfast	617	53%	551	47%	**1,168**	29.0
Northern	386	70%	163	30%	**549**	20.4
South Eastern	141	29%	346	71%	**487**	50.7
Southern	253	49%	264	51%	**517**	28.9
Western	195	46%	225	54%	**420**	27.0
NIAS	35	23%	116	77%	**151**	58.4
Northern Ireland	**1,627**	49%	**1,665**	51%	**3,292**	**31.4**

[18] Includes only those complaints where both age and gender of the patient / client was recorded.

Table 10: FPS Complaints Handled (2015/16 - 2020/21)

FPS Complaints	2016/17	2017/18	2018/19	2019/20	2020/21
GP	226	215	252	193	154
Dental	20	17	60	14	17
Pharmacy	3	8	5	3	2
Ophthalmic	0	0	0	0	0
Total	**249**	**240**	**317**	**210**	**173**

Table 11: FPS Complaints Handled Under Local Resolution (2015/16 - 2020/21)[19]

Local Resolution	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
GP	194	192	171	151	131	99
Dental	15	13	10	26	9	5
Pharmacy	1	1	5	0	0	1
Ophthalmic	0	0	0	0	0	0
Total	**210**	**206**	**186**	**177**	**140**	**105**

Table 12: FPS Complaints Handled Under Local Resolution, by Subject (2020/21)

Local Resolution	GP	Dental	Pharmacy	Total
Treatment & Care	35	5	0	**40**
Appointments	11	0	0	**11**
Prescriptions	9	0	0	**9**
Communication / Information	16	0	0	**16**
Staff Attitude	13	0	0	**13**
Other	15	0	1	**16**
Total	**99**	**5**	**1**	**105**

[19] There were no ophthalmic complaints handled under local resolution in 2020/21.

Table 13: FPS Complaints where the HSC Board Acted as an Honest Broker (2016/17 - 2020/21) [20]

Honest Broker	2016/17	2017/18	2018/19	2019/20	2020/21
GP	34	44	101	62	55
Dental	7	7	34	5	12
Pharmacy	2	3	5	3	1
Ophthalmic	0	0	0	0	0
Total	**43**	**54**	**140**	**70**	**68**

Table 14: FPS Complaints where the HSC Board Acted as an Honest Broker, by Subject (2020/21)

Honest Broker	GP	Dental	Pharmacy	Total
Treatment & Care	23	8	0	**31**
Appointments	0	0	0	**0**
Prescriptions	2	0	0	**2**
Communication / Informa	5	2	0	**7**
Staff Attitude	6	0	0	**6**
Other	19	2	1	**22**
Total	**55**	**12**	**1**	**68**

[20] There were no ophthalmic complaints handled in 2020/21.

Table 15: Subject of Compliments by HSC Trust (2020/21)

Subject of Compliment	Belfast	Northern	South Eastern	Southern	Western	Nias	Total
Quality of Treatment and Care	2,077	1,298	1,902	1,141	2,012	245	**8,675**
Staff Attitude & Behaviour	995	635	720	1,009	496	58	**3,913**
Information & Communication	221	258	86	507	77	-	**1,149**
Environment	91	34	26	410	17	-	**578**
Other	113	11	108	24	112	-	**368**
Total Compliments	**3,497**	**2,236**	**2,842**	**3,091**	**2,714**	**303**	**14,683**

Table 16a: Source of Complaint

Is Complainant the Patient/Client	No.
Yes	**1,623**
No	**1,669**
Total	**3,292**

Table 16b: Source of those complaints not from the Patient/Client

Relationship of Complainant	No.
Son / Daughter	**511**
Parent	**496**
Spouse / Partner	**202**
Other Relative	**143**
Elected Representative	**118**
Sibling	**81**
Legal Representative	**44**
Patient Client Council	**12**
Other	**59**
Relationship Unknown	**3**
Total	**1,669**

APPENDIX 1: TECHNICAL NOTES

This statistical release presents information on complaint issues received by HSC Trusts in Northern Ireland. It details the number of HSC Trust complaint issues received, by the programme of care, category, subject, specialty of the complaint and the time taken to provide a substantive response.

Information is also included on the number of complaints received by the HSC Board regarding Family Practitioner Services in Northern Ireland.

Data Collection

The information presented in this statistical release derives from the Departmental CH8 Revised statistical return provided by the six HSC Trusts, (including the NIAS) in Northern Ireland. The CH8 return was originally introduced in 1998 and updated in 2007 to take account of the structural changes within the HSC system following the Review of Public Administration (RPA). In 2014, the CH8 return was redesigned to allow the collection of patient level data on all complaints received by HSC Trusts. The patient level collection was titled CH8 Revised to distinguish it from the original CH8 aggregate return. This return is submitted on a quarterly basis by HSC Trusts, in respect of the services for which they have responsibility.

Information presented on FPS complaints forwarded to the HSC Board derives from CHB statistical return. The CHB is collected on a quarterly basis by the HSC Board, in respect of the services for which they have responsibility.

Data presented on compliments is collected from the six HSC Trusts on a quarterly basis using the compliments information return (CP1). The compliments information return was developed in consultation with HSC Trusts to ensure regional consistency, and enable comparisons across HSC Trusts.

Data providers are supplied with technical guidance documents outlining the methodologies that should be used in the collection, reporting and validation of each of these data returns. These documents can be accessed at the following link:

https://www.health-ni.gov.uk/publications/trust-complaints-form-ch8

https://www.health-ni.gov.uk/publications/trust-compliments-form-cp1

Rounding

Percentages have been rounded to one decimal place and as a consequence some totals may not sum to 100.

Data Quality

All information presented in this bulletin has been provided by HSC Trusts / Board and has been validated and quality assured by Hospital Information Branch (HIB) prior to release.

For the CH8 Revised information collection, HSC Trusts are given a set period of time to submit the information. At the end of the financial year HIB carry out a detailed series of validations to verify that the information is consistent both within and across returns. Trend analyses are used to monitor annual variations and emerging trends. Queries arising from validation checks are presented to HSC Trusts for clarification and if required returns may be amended and/or re-submitted. This report incorporates all returns and amendments received up to 8th September 2020.

The compliments information collection was introduced in December 2017 and took some time to embed, with data first being published in the 2018/19 report. In 2018/19, information had to be estimated for two of the six Trusts as they were only able to provide a partial return for the year because their monitoring systems had not been fully implemented. For

2020/21, full year's data was available for all Trusts. However for 2019/20, it should be noted that Belfast HSC Trust's telephone system to capture compliments was only effective from 1 October 2019, Western HSC Trust did not have a system in place to record compliments received by phone call and NIAS did not monitor compliments via social media.

Main Uses of Data

The main uses of these data are to monitor and report the number of HSC Trust compliments, HSC Trust and FPS complaints received during the year, to help assess performance, for corporate monitoring, to inform and monitor related policy, and to respond to assembly questions and ad-hoc queries from the public.

Contextual Information for Using Complaint and Compliment Statistics

Readers should be aware that contextual information about Northern Ireland and the health services provided is available to read while using statistics from this publication.

This includes information on the current and future population, structures within the Health and Social Care system, the vision for future health services as well as targets and indicators. This information is available at the following link:

https://www.health-ni.gov.uk/publications/contextual-information-using-hospital-statistics

Contact Information

As we want to engage with users of our statistics, we invite you to feedback your comments on the publication to:

Hospital Information Branch Email: statistics@health-ni.gov.uk

APPENDIX 2: DEFINITIONS

Programme of care

Programmes of care are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. There are nine programmes of care as follows:

POC1 Acute

POC2 Maternity and Child Health

POC3 Family and Child Care

POC4 Elderly Care

POC5 Mental Health

POC6 Learning Disability

POC7 Sensory Impairment and Physical Disability

POC8 Health Promotion and Disease Prevention

POC9 Primary Health and Adult Community

Complaint Issues

For the purposes of the CH8 return, a complaint may be understood as 'an expression of dissatisfaction requiring a response'. This return includes information on all formal complaints only, informal complaints or communications criticising a service or the quality of care but not adjudged to require a response, are not included on this form.

A single communication regarding a complaint may refer to more than one issue. In such cases each individual complaint issue is recorded separately for Programme of Care (POC) and Subject.

Only complaints received from/on behalf of patients/clients or other 'existing or former users of a Trust's services and facilities' are included. Complaints from staff are not included.

Where separate communications in respect of a single patient / client refer to one episode, they are treated as a single complaint issue for the purposes of this publication. In other words, if two relatives complain about the same subject/episode in respect of the same patient, this will be treated as one complaint issue only. However, if two relatives complain about separate subjects/episodes but in the care of the same patient, these will be treated as separate complaint issues.

Where separate unconnected communications refer to the same episode/issue, they will be treated as separate complaint issues. In other words, if separate individuals complain about a matter they have all experienced, this would be treated as separate complaint issues, e.g. if ten clients complain individually about conditions in a day centre, these will be treated as ten separate complaint issues.

The logic of the complaints procedure is that it should afford a speedy resolution of cases of individual dissatisfaction of service. This differs from the case of petitions where the concern is primarily the collective representation of views, e.g. if a single complaint is received from a group of users, it will be treated as a single complaint issue.

Where a complainant is dissatisfied with the Trust's response to his/her complaint and enters into further communications about the same matter/s, this is not a new complaint, rather it will be the same complaint reopened. Such a complaint would only be recorded once in the CH8 Revised, i.e. in the quarter it was initially received. However, if this complainant were to then complain about a separate/different matter, this would be a new complaint.

APPENDIX 3: SUBJECT OF COMPLAINT ISSUES

1. Access to Premises

This heading includes all issues concerning ease of movement inside and outside the buildings, e.g. signage, car parking, etc. Problems of wheelchair access / disabled parking etc. should also be included under this heading, if not covered under '*Discrimination*' (17).

2. Aids / Adaptations / Appliances

This heading refers to the suitability / availability of any aids / adaptations, once they have been recommended. Complaint issues about waiting for assessment should be included under '*Waiting Lists, Delay/Cancellation Community Based Appointments*' (32).

3. Children Order Complaints

This heading refers to all formal complaint issues received under the Children Order Representations and Complaint Issues Procedure, irrespective of their subject or content.

4. Clinical Diagnosis

This heading covers clinical diagnosis only and is to be distinguished from '*Professional Assessment of Need*' (24).

5. Communication / Information

This heading includes all issues of communication and information provided to patients / clients / families / carers regarding any aspect of their contact with staff. However, this should be distinguished from complaint issues about the attitude of staff when communicating with patients / clients, which would be logged under '*Staff Attitude / Behaviour*' (27).

6. Complaint Handling

This refers to handling of a complaint issue at any point up to and including the conclusion of local resolution stage, e.g. a complainant complains that he/she did not receive a response within the timescale. However, a complaint issue would not be included under this heading if it obviously falls under another heading, e.g. if the complaint issue is about attitude of staff handling the complaint issue, it would be logged under '*Staff Attitude / Behaviour*' (27).

7. Confidentiality

This heading includes any issues of confidentiality regarding patients / clients, e.g. (i) complaint by a patient regarding a breach of confidentiality or (ii) complaint by the parents of a young adolescent who are denied information by staff on the grounds of that adolescent's right to confidentiality.

8. Consent to Treatment / care

This refers to complaint issues made regarding consent to treatment/care.

9. Contracted Regulated Children's Services

10. Contracted Regulated Domiciliary Agency

11. Contracted Regulated Residential Nursing

These three headings refer to complaints about services that are provided by Trusts via contractual / commissioned arrangements. Establishments may be children's homes, nursing or residential homes, while Agencies may be a domiciliary care agency, fostering agency or nursing agency. For a full list of Regulated Establishments and Agencies please refer to 'Quality & Improvement Regulation NI Order 2003, Article 8'.

In the first instance, the service provider is expected to deal with complaints, however, where the complainant, Trust or RQIA wishes, the matter may be investigated by the Trust under the HSC Complaint Procedure.

Examples: (i) the Trust (as the commissioner) is asked by either RQIA or a relative, to investigate a complaint about the care or treatment provided to a resident in a Residential Home; (ii) a patient / client asks the Trust (as the commissioner) to investigate a complaint about the attitude of a member of staff of a Voluntary Agency with whom the Trust has contracted a home care service (e.g. personal care).

12. Contracted Independent Hospital Services

This heading refers to complaints about services that are provided by Trusts via contractual / commissioned arrangements with independent hospitals.

13. Contracted Services – Other

This heading refers to complaint issues about services that are provided by Trusts via contractual / commissioned arrangements that are not captured in *'Contracted Regulated Children's Services/Domiciliary Agency/Residential Nursing' (9, 10 & 11).* In the first instance, the service provider is expected to deal with complaint issues, however, where the complainant or Trust wishes, the matter may be investigated by the Trust under the HSC Complaint Procedure.

Example: Attitude of a member of staff of facilities services operating under contract on Trust premises, (e.g. car clamping company or catering).

14. Delay/Cancellation for Inpatients

This heading includes all aspects of delay or cancellation of operation or procedure once the patient is in hospital, e.g. Radiology investigation cancelled, or theatre cancelled due to lack of ICU beds, theatre overrun, no anaesthetist, etc. This should be distinguished from the cancellation or delay of admission for the procedure captured under *'Waiting List, Delay/Cancellation Planned Admission to Hospital' (34).*

15. Delayed Admission from A&E

This refers to patients waiting in Accident & Emergency, following decision to 'admit', before being allocated a bed in a ward. This should be distinguished from '*Waiting Times, A&E Departments' (35)* and '*Waiting List, Delay/Cancellation Planned Admission to Hospital' (34).*

16. Discharge / Transfer Arrangements

This heading refers to the adequacy of arrangements and includes early discharges or delayed discharges. It does not include failure to communicate discharge arrangements, which would be included under '*Communication / Information' (5).*

17. Discrimination

This heading refers to complaint issues regarding disadvantageous treatment. It includes discrimination under the 9 Equality categories (i.e. age, gender, marital status, political opinions, religious belief, racial group, sexual orientation, persons with or without a disability, persons with or without dependents) and under the Human Rights Act (e.g. Article 1, Right to Life; Article 3, Right to Freedom from Torture, Inhuman or Degrading Treatment; Article 8, Right to Respect for Private or Family Life). Complaint issues about patient choice should also be included under this heading.

18. Environmental

Complaint issues referring to the general condition or repair of the premises should be included under this heading. It also covers wider environmental issues, e.g. smoking.

19. Hotel / Support / Security Services

This heading includes any complaint issue referring to ancillary or support services, e.g. portering, facilities, catering. It also refers to security issues, e.g. stolen vehicles parked on Trust property.

20. Infection Control

This heading refers to compliance with infection control standards, e.g. hand hygiene; aseptic procedures; inappropriate use of personal protective equipment; incorrect disposal of waste or soiled linen; equipment / furniture not decontaminated. It covers issues around all infections but especially resistant micro-organism infections, e.g. MRSA, VRE. However, complaint issues about lack of information or not being informed would not be included in this heading, but would be logged under '*Communication / Information' (5).*

21. Mortuary & Post-Mortem

This category refers to complaint issues in relation to the mortuary and/or post-mortem.

22. Policy / Commercial Decisions

This category refers to complaint issues related to policy and/or commercial decisions.

23. Privacy / Dignity

This heading includes complaint issues specifically relating to the privacy or personal dignity of patients/clients.

24. Professional Assessment of Need

This heading refers to the assessment of need in either clinical or non-clinical contexts, however, should be distinguished from '*Clinical Diagnosis'* (4).

25. Property / Expenses / Finance

This heading refers to issues of the personal property, expenses or finance of patients/clients, e.g. due money for fostering; issues around direct payments; concerns about Trust charging / invoicing for clients in Nursing/Residential Home (either Private or Trust Home); broken hearing aid; lost spectacles / dentures.

Property damaged by staff arising in the course of care / treatment would fall into this category; however, property stolen from a patient's locker (as not being entrusted to or in the custodianship of

staff and not known to be attributable to staff) would come under the heading of *'Hotel/Support/Security Services' (19).* Complaint issues about stolen vehicles (visitor or patient) and property lost or stolen from visitors should similarly be logged as a *'Hotel/Support/Security Services' (19).*

26. Records / Record Keeping

This refers to cases where records (such as medical notes, case files, X-rays) are unavailable, e.g. records have been mislaid or misfiled. Complaint issues about access rights to deceased patients' health records (governed by Access to Health Records (1993) NI Order) should be included under this heading. Complaint issues about any aspect of content of records or right of access should only be included under this heading, if they are not more appropriately dealt with under other procedures, such as Data Protection Act or Freedom of Information Act appeals processes.

27. Staff Attitude / Behaviour

This category refers to complaint issues related to staff attitude and/or staff behaviour.

28. Transport, Late or Non-arrival / Journey Time

This heading refers to complaint issues about the late arrival or non-arrival of transport or about the length of journey.

29. Transport, Suitability of Vehicle / Equipment

This heading refers to the appropriateness of the vehicle assigned and will include issues such as comfort, ease of access for the client group served. Complaint issues about the appropriateness of equipment would also be logged under this heading.

30. Quality of Treatment & Care

This refers to the quality or standard of treatment and care provided. It also covers complaint issues relating to patient / client safety. However, it is to be distinguished from *'Quantity' of Treatment & Care, (31)* which refers to the quantity or amount of treatment and care.

31. Quantity of Treatment & Care

This refers to the amount of treatment and care provided or available, e.g. someone receiving good quality home help but feel they are receiving inadequate number of hours.

32. Waiting Lists, Delay/Cancellation Community Based Appointments

This heading refers to the time spent waiting for either assessment or for the delivery of services following assessment, e.g. waiting list for an OT assessment, waiting list for a care package. 'Unmet need' should also be logged under this heading. This heading should be distinguished from '*Waiting Times, Community Services' (36).*

33. Waiting Lists, Delay/Cancellation Outpatient Appointments

This heading refers to delay or cancellation in securing an outpatient appointment, i.e. outpatient waiting lists. It is to be distinguished from '*Waiting Lists, Delay/Cancellation Community Based Appointments'* (32) and '*Waiting Times, Outpatient Departments' (37).*

34. Waiting Lists, Delay/Cancellation Planned Admission to Hospital

This refers to delay or cancellation of a planned admission to hospital, e.g. waiting list for surgery. Delayed admissions from A&E should not be included in this category but under '*Delayed Admission from A&E' (15).*

35. Waiting Times, A&E Departments

Complaint issues regarding waiting time for initial assessment or waiting time to be treated should all be logged under this heading. Complaint issues about delayed admission from A&E are not included here but should be listed under '*Delayed Admission from A&E' (15).*

36. Waiting Times, Community Services

This heading refers to waiting time during delivery of community services. It would include such issues as erratic timing, failure of professional staff to turn up at the specified time for

an appointment. It should be distinguished from '*Waiting Lists, Delay/Cancellation Community Based Appointments' (32).*

37. Waiting Times, Outpatient Departments

This heading refers to the time waiting at an outpatient appointment, other than at A&E. It should be distinguished from '*Waiting Lists, Delay/Cancellation Outpatient Appointments (33)'.*

38. Other

This is a residual heading for any complaint issues, which do not fall into any categories listed above.

APPENDIX 4: SUBJECT GROUPED BY GENERAL CATEGORY

Admissions/Discharges

Delayed Admission from A&E

Discharge/Transfer Arrangements

Waiting Lists, Delay/Cancellation Planned Admission to Hospital

Aids/Adaptations/Appliance

Aids/Adaptations/Appliances

Appointments/Waiting Times

Waiting Lists, Delay/Cancellation Community Based Appointments

Waiting Lists, Delay/Cancellation Outpatient Appointments

Waiting Times, A&E Departments

Waiting Times, Community Services

Waiting Times, Outpatient Departments

Children Order

Children Order Complaint Issues

Contracted Services

Contracted Regulated Children's Services

Contracted Regulated Domiciliary Agency

Contracted Regulated Residential Nursing

Contracted Independent Hospital Services

Other Contracted Services

Diagnosis/Operation/Treatment

Clinical Diagnosis

Consent to Treatment/Care

Delay/Cancellation for Inpatients

Treatment & Care, Quality

Treatment & Care, Quantity

Information & Communication

Communication/Information to Patients

Complaints Handling

Confidentiality

Records/Records Keeping

Mortuary

Mortuary & Post-Mortem

Patient Experience

Discrimination

Privacy/Dignity

Property/Expenses/Finance

Staff Attitude/Behaviour

Policy/Commercial Decisions

Policy/Commercial Decisions

Premises

Access to Premises

Environmental

Hotel/Support/Security Services

Infection Control

Prison Health Care

Prison Healthcare Related Complaint Issues

Professional Assessment of Need

Professional Assessment of Need

Transport

Transport, Late or Non-arrival/Journey Time

Transport, Suitability of Vehicle/Equipment

Other

Other

APPENDIX 5: HSC BOARD COMPLAINTS

The information presented within this release relating to FPS complaints derives from the HSC Board CHB statistical return. The CHB is collected on a quarterly basis by the HSC Board, in respect of the services for which they have responsibility.

Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services.

Under HSC Complaints Procedure all FPS practices are required to forward to the HSC Board anonymised copies of each letter of complaint received along with the subsequent response, within 3 working days of this being issued.

The first stage of the HSC Complaints Procedure is known as 'local resolution'. The purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint. In the case of FPS practices, local resolution involves a practitioner seeking to resolve the complaint through discussion and negotiation.

Where a complainant does not wish to approach the FPS practice directly, HSC Board Complaints staff, with the agreement of both the practice and complainant, may act as an intermediary or 'honest broker' with the aim of assisting in the local resolution of the complaint.

The HSC Board has a responsibility to record and monitor the outcome of all complaints lodged with them. It will provide support and advice to FPS in relation to the resolution of complaints and it will also appoint independent experts, lay persons or conciliation services, where appropriate.

APPENDIX 6: COMPLIMENTS GUIDANCE / DEFINITIONS

Introduction

1. The purpose of the CP1 return is to record the number of compliments received by Trusts during the quarter, the subject areas to which they referred and how the compliment was received.

2. The form should be returned quarterly by Trusts in respect of services for which they have responsibility. Deadline for receipt by Hospital Information Branch is no later than the last working day of the month after the end of the quarter to which the information refers.

Compliments

1. For the purposes of this return a compliment may be understood as 'an expression of praise, commendation or admiration'.

2. Only compliments received from/on behalf of patients/clients or other 'existing or former users of a Trust's services and facilities' should be included. Compliments from staff should not be included on this form.

3. A singe communication may include more than one compliment. In such cases each distinct compliment should be recorded separately on the return.

4. Only compliments pertaining to the services of the Trust returning the form to Hospital Information Branch (DoH) should be recorded on the CP1 return. Compliments received by a Trust, which properly refer to the services of another Trust, should be recorded on the return of the relevant Trust to which the compliment/s pertains.

5. Where separate communications (whether from a single party or from several parties in respect of a single patient) refer to one subject only, they should be treated as one

compliment for the purposes of this form. In other words, if two relatives submit a compliment about the same subject/episode in respect of the same patient, this should be treated as one compliment only. However, if two relatives submit compliments about separate subjects/episodes in the care of the same patient, these should be treated as separate compliments.

Subjects

1. This part deals with the subject of the compliment. The subject of the compliment is to be assigned on the basis of the subject that best describes the nature of the patient / client's praise.

Definitions of Subjects:

i. **Quality of Treatment & Care**

This refers to the quality or standard of treatment and care provided. It also covers compliments relating to patient/client safety.

ii. **Staff Attitude & Behaviour**

This category refers to compliments related to staff attitude and/or staff behaviour.

iii. **Information & Communication**

This heading includes all issues of communication and information provided to patients / clients / families / carers regarding any aspect of their contact with staff. However, this should be distinguished from compliments about the attitude of staff when communicating with patients / clients, which should be logged under *'Staff Attitude & Behaviour'*.

iv. **Environment**

Compliments referring to the general condition or repair of the premises should be included under this heading.

v. **Other**

This is a residual heading for any compliments which do not fall into any of the categories listed above. Where the subject is recorded as '*Other*' a brief description of the compliment should be provided in part 2 of the return.

Method of Compliment

The CP1 return should include (A) written compliments received by (i) Card, (ii) Email, (iii) Feedback Form, (iv) Letter or (v) Social Media (Facebook & Twitter only), or (B) compliments received by telephone, whereby the primary purpose of the phone call is to express a compliment. Only Facebook posts / Tweets linked to the official organisational Facebook/Twitter accounts should be included.

APPENDIX 7: ABOUT HOSPITAL INFORMATION BRANCH

Hospital Information Branch is responsible for the collection, quality assurance, analysis and publication of timely and accurate information derived from a wide range of statistical information returns supplied by the Health & Social Care (HSC) Trusts and the HSC Board. Statistical information is collected routinely from a variety of electronic patient level administrative systems and pre-defined EXCEL survey return templates.

The Branch aims to present information in a meaningful way and provide advice on its uses to customers in the HSC Committee, Professional Advisory Groups, policy branches within the DoH, other Health organisations, academia, private sector organisations, charity/voluntary organisations as well as the general public. The statistical information collected is used to contribute to major exercises such as reporting on the performance of the HSC system, other comparative performance exercises, target setting and monitoring, development of service frameworks as well as policy formulation and evaluation. In addition, the information is used in response to a significantly high volume of Parliamentary / Assembly questions and ad-hoc queries each year.

Information is disseminated through a number of key statistical publications, including: Inpatient Activity, Outpatient Activity, Emergency Care, Mental Health & Learning Disability and Waiting Time Statistics (Inpatient, Outpatient, Diagnostics, Cancer and Emergency Care). A detailed list of these publications is available from:

https://www.health-ni.gov.uk/topics/doh-statistics-and-research

The 'Complaints and Compliments Received by HSC Trusts in Northern Ireland (2020/21)' publication was originally due to be published on 8th July but was delayed due to pressures associated with the COVID-19 outbreak.

APPENDIX 8: ADDITIONAL INFORMATION

Further information on HSC Trust Complaint Issues and Compliments in Northern Ireland is available from:

Hospital Information Branch

Information & Analysis Directorate

Department of Health

Stormont Estate

Belfast, BT4 3SQ

Email: statistics@health-ni.gov.uk

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Updated April 2022

REVISIONS TO HSC COMPLAINTS PROCEDURE

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

AMENDMENTS TO COMPLAINTS DIRECTIONS

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

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

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

Update – 01 April 2022

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

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

SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

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

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

Local resolution

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

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

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

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

Principles of an effective Complaints Procedure

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

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

Learning

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

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

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

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

What the HSC Complaints Procedure covers

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

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

1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[1] as an alternative to making an application to the courts.

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

What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care[2] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

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

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

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

[2] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/
[3] Public Interest Disclosure (Northern Ireland) Order 1998

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

Staff Grievances

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

Disciplinary Procedure

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

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

1.18 The Chief Executive (or designated senior person[4]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part

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

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

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

Investigation by a Professional Regulatory Body

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

Services Commissioned by the DoH

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

Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[5] and requests for access to health or social care records under the UK General Data Protection Regulation (GDPR)[6] and Data Protection Act 2018.

[5] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[6] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

Independent Inquiries and Criminal Investigations

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

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

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 14. The HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[7].

Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[8]) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016[9]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[10]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint

[7] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[8] Adult Safeguarding Operational Procedures: Adult Safeguarding (hscni.net)
[9] Protocol for Joint Investigation of Adult Safeguarding Cases: DRAFT (hscni.net)
[10] Information about and contact details for HSC Trusts can be accessed at the following link - https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect

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

Child Protection Procedures

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

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

Coroners Cases

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

Legal Action

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

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

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

Serious Adverse Incidents (SAI)

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

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

Whistleblowing

1.34 The Department of Health has a framework and model policy in place for HSC organisations on Whistleblowing[11]. All HSC organisations should have their own separate procedures in place.

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

SECTION 2 – MAKING A COMPLAINT

What is a complaint?

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

Promoting access

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

Who can complain?

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

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

Consent

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

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

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

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance[12].

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

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

Confidentiality

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

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

Third Party Confidence

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

[13] DoH Code of Practice:
https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

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

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

Use of Anonymised Information

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

How can complaints be made?

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

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

It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery[14]. (See Flowchart page 45)

Options for pursuing a complaint

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

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

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

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

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the SPPG Complaints Team[15], if he/she does not feel able to approach immediate staff (see flowchart page 46).

[14] Section 75 of the Northern Ireland Act 1998 https://www.legislation.gov.uk/ukpga/1998/47/section/75
[15] SPPG Complaints Team acting on behalf of the DoH.

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

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

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

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

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies[16] must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

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

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

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

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

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

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

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

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

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

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

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

Independent Sector Providers

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

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

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

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

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

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

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

2.36 In complaints investigated by the ISP:

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

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

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

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

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

What information should be included in the complaint?

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

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

Supporting complainants and staff

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

What are the timescales for making a complaint?

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

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

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

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

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

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

SECTION 3 – HANDLING COMPLAINTS

Accountability

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

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

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

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

Performance Management

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

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

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

Co-operation

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

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

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

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions[17] and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

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

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

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

- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)[18] to assist staff requiring professional indemnity[19];
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

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

[18] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).
[19] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

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

Publicity

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

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

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

3.12 Local information should:

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

Training

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

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

Actions on receipt of a complaint

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

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

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

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

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

Acknowledgement of Complaint

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

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

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

3.21 The acknowledgement should:

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

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

Joint Complaints

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

Out of Area Complaints

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

Investigation

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

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

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

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

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

Assessment of the complaint

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

Investigation and resolution

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

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

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

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

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

Completion of Investigation

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

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

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

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

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

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

Circumstances that might cause delay

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

Periods of acute mental illness

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

Physical Injury

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

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

Responding to a complaint

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

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

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

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

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

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

Concluding Local Resolution

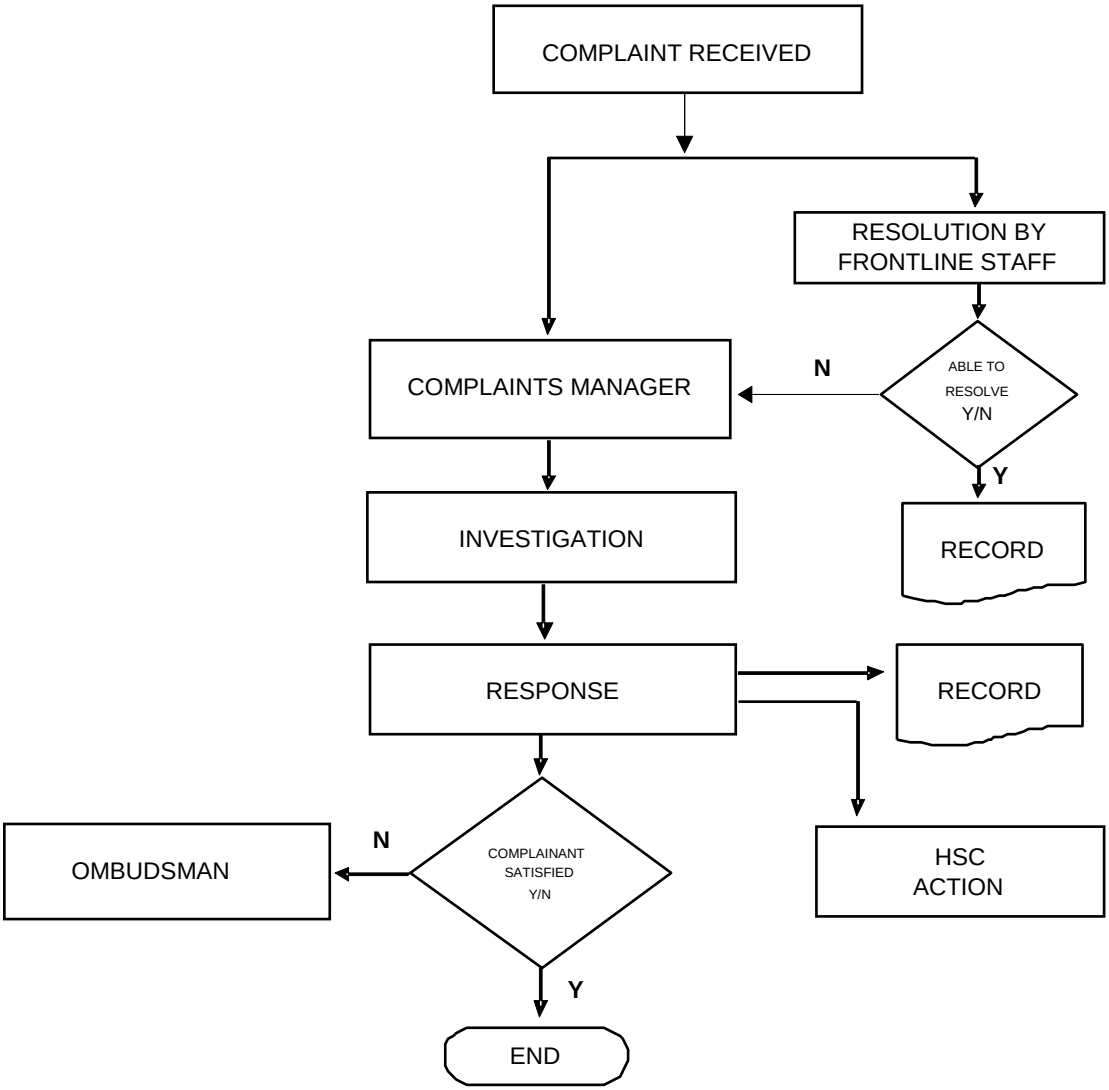
3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants should contact the organisation within one month of the organisation's response if they are dissatisfied with the response or require further clarity[21]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

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

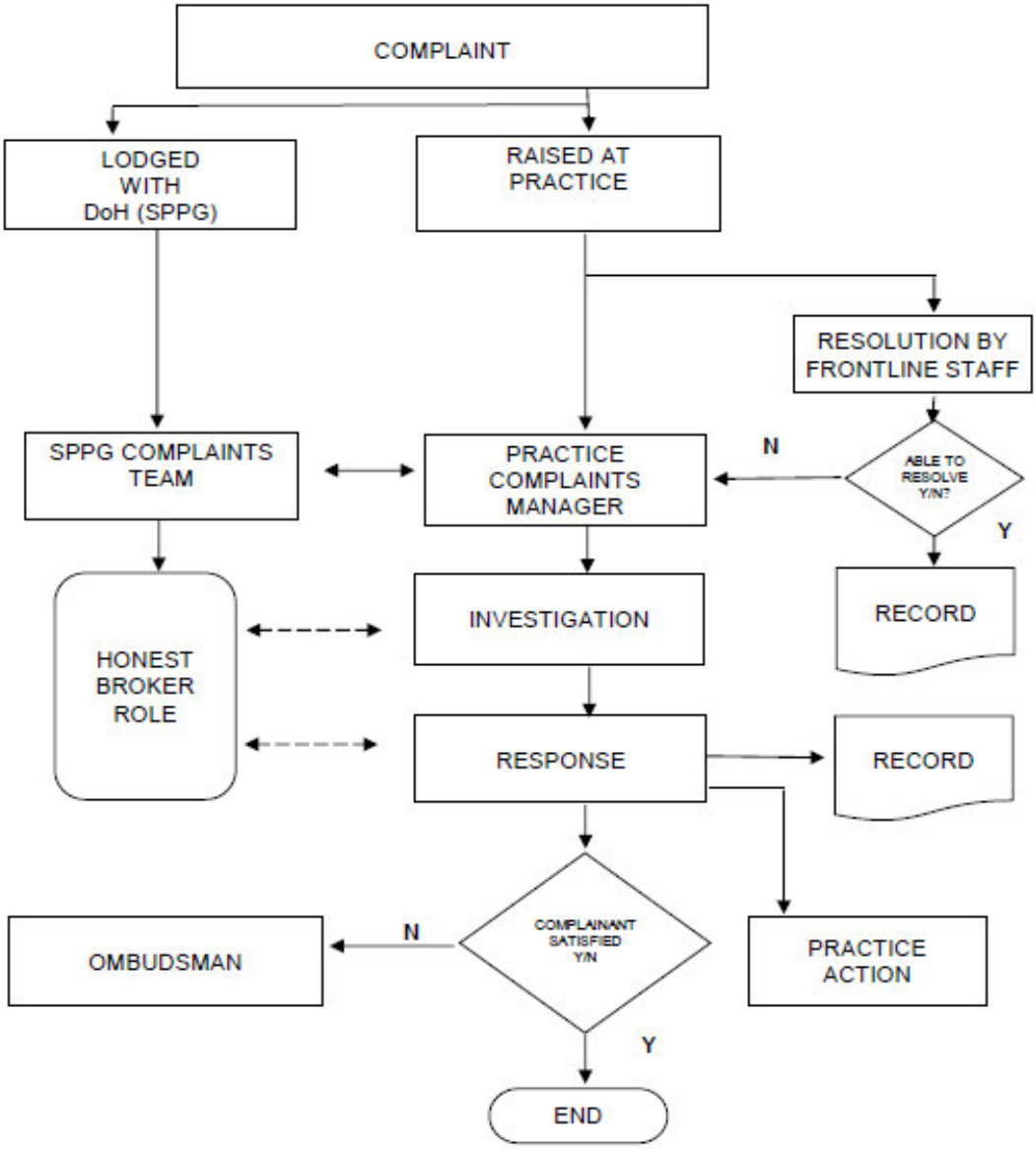
3.47 This completes the HSC Complaints Procedure. There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

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

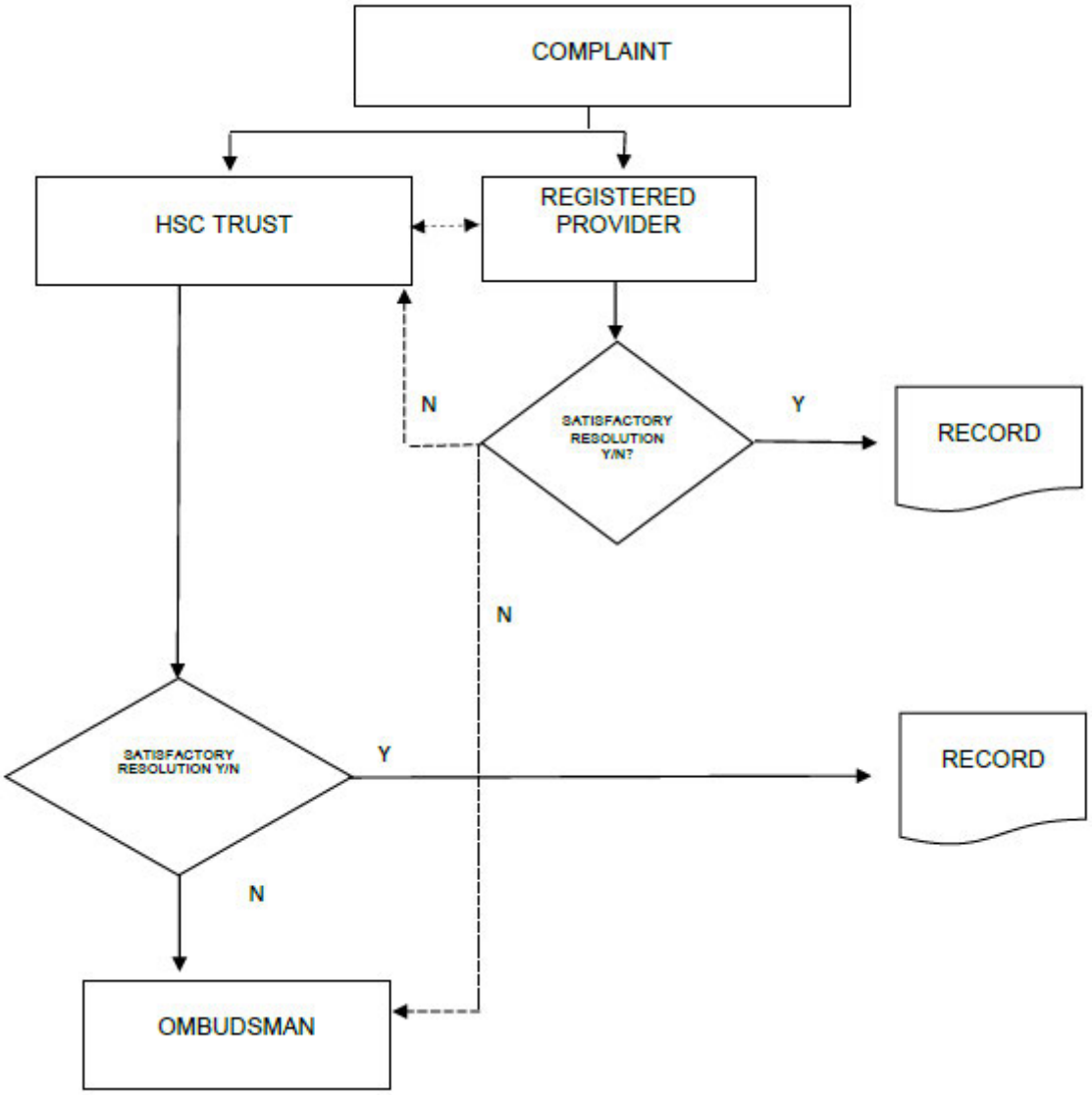
HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



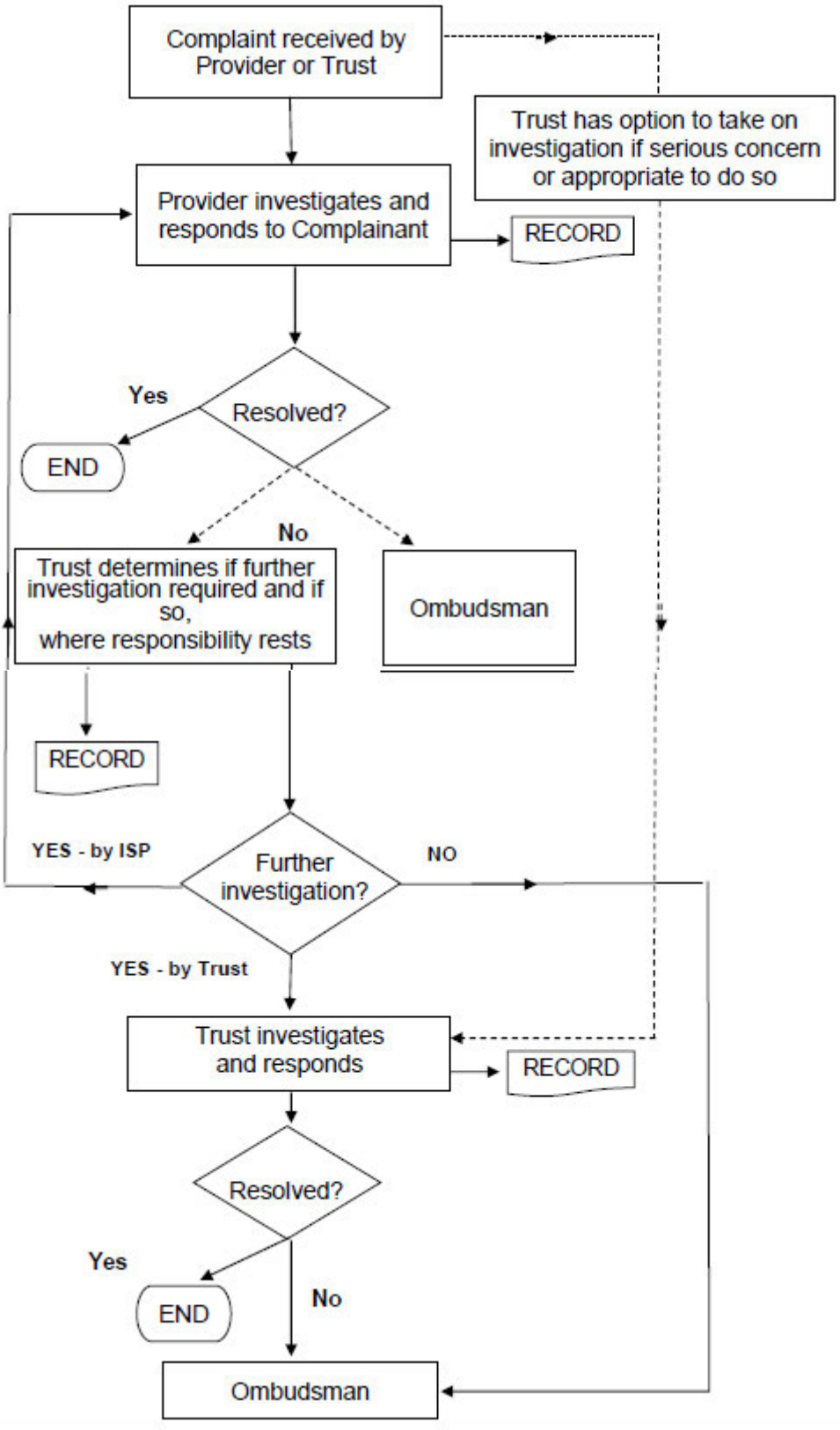
FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



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



INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



SUMMARY OF TARGET TIMESCALES

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

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

SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

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

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

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

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

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

DoH

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

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

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

HSC Trusts

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

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

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

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

Quarterly reports

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

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

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

Family Practitioner Services

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

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

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

Other HSC organisations

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

Regulated establishments and agencies

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

Learning

4.18 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[22].

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

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

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

SECTION 5 - ROLES AND RESPONSIBILITIES

DoH

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

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

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

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

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

HSC Organisations

5.5 HSC organisations must:

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

The Patient and Client Council (PCC)

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

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

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

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

5.8 All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from: www.patientclientcouncil@hscni.net or Freephone 0800 917 0222

WHO CAN HELP ME RAISE MY COMPLAINT?

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

You can contact a PCC Officer at:

Phone: 0800 917 0222
Email: complaints.pcc@hscni.net

For more information, visit PCC's website:
www.patientclientcouncil.hscni.net

The PCC Complaints Support Service is there to:

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

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

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

Phone: 0800 343 424

Email: nipso@nipso.org.uk

For more information, visit NIPSO's website:
www.nipso.org.uk

ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

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

STANDARD 1: ACCOUNTABILITY

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

Rationale:

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

Criteria:

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

STANDARD 2: ACCESSIBILITY

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

Rationale:

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

Criteria:

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

STANDARD 3: RECEIVING COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

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

Rationale:

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

Criteria:

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

STANDARD 5: INVESTIGATION OF COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 6: RESPONDING TO COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 7: MONITORING

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

Rationale:

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

Criteria:

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

STANDARD 8: LEARNING

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

Rationale:

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

Criteria:

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

ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

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

The Children (NI) Order 1995:

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

HSC Complaints Procedure Directions:

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

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

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

ANNEX 3: PROFESSIONAL REGULATORY BODIES

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

ANNEX 4: HSC PRISON HEALTHCARE

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

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

ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman[23] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

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

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

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

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

2. The Ombudsman's contact details are:

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

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

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

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

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

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

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

4. The RQIA may be contacted at:

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

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

ANNEX 7: ADVOCACY

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

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

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

ANNEX 8: CONCILIATION

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

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

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

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

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

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

FPS arrangements

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

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

Agreement by parties involved

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

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

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

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

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

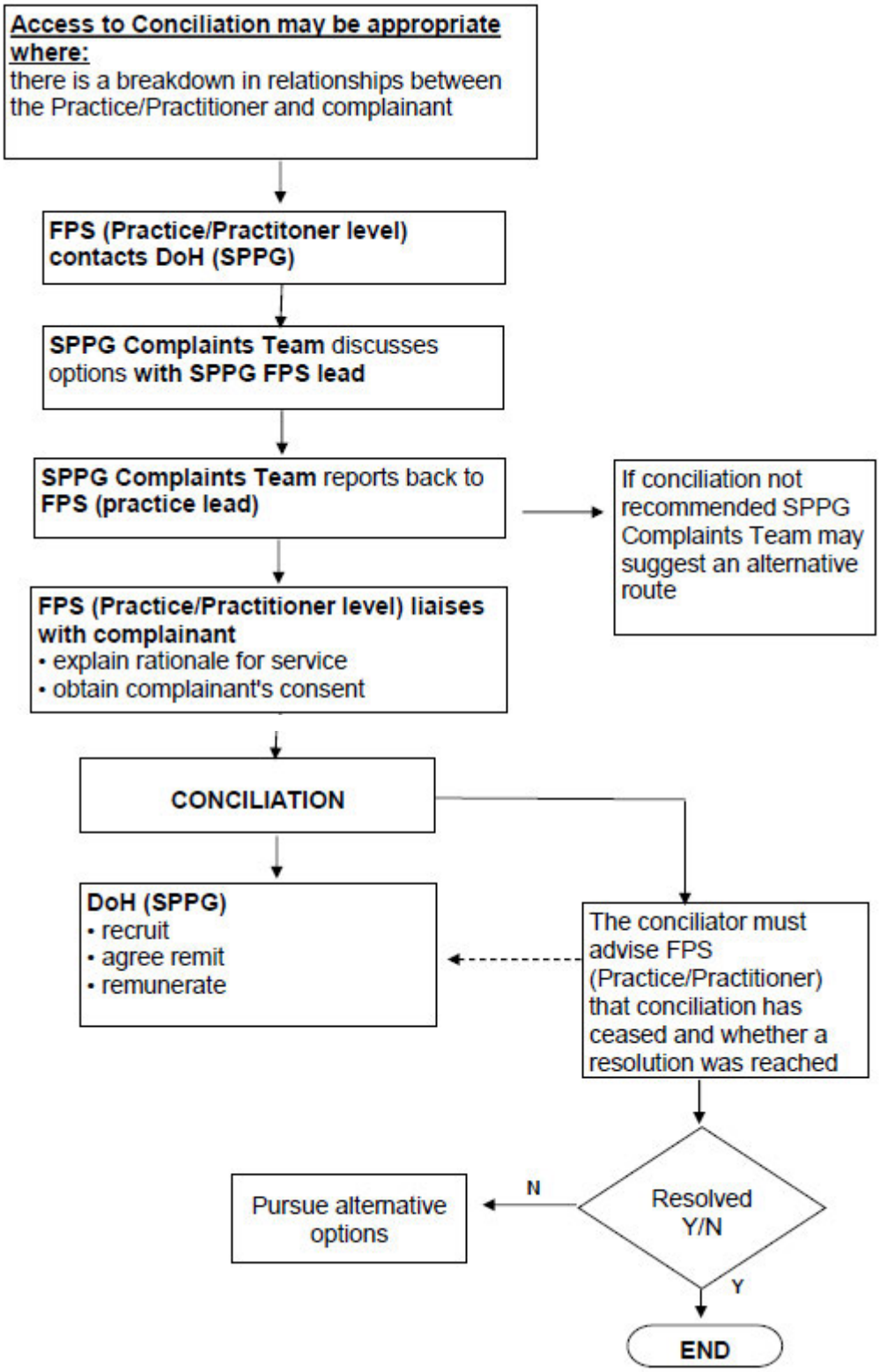
Appointment of conciliators

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

Monitoring

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

Conciliation – FPS



ANNEX 9: INDEPENDENT EXPERTS

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

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

FPS arrangements

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

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

Agreement and consent

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

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

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

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

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

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

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

Appointment of Independent Experts

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

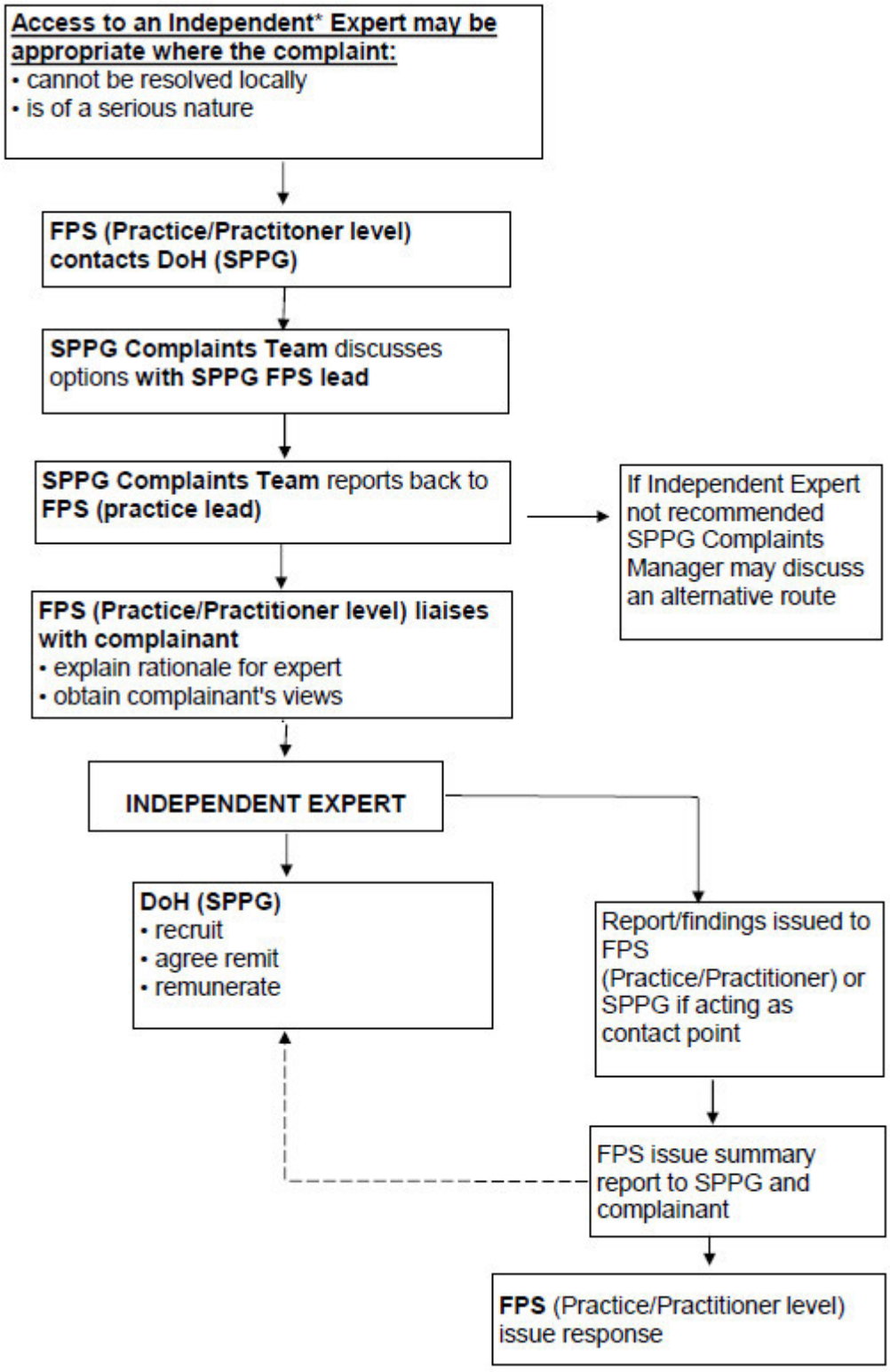
10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

11. The SPPG Complaints Team will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

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

Independent Experts – FPS Access



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

ANNEX 10: LAY PERSONS

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

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

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

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

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

FPS arrangements

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

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

Agreement and consent

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

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

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

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

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

Appointment of lay persons

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

Monitoring

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

ANNEX 11: HONEST BROKER ROLE

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

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

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

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

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

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

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

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate;
- provide advice to the complainant and the Practice/Practitioner on target timescales[24]; and
- where there is a delay, ensure the complainant is advised as set out in paragraph 3.39.

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

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

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

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

ANNEX 12: ADULT SAFEGUARDING

Definition of vulnerable adult

1. The regional policy 'Adult Safeguarding – Prevention and Protection in Partnership' defines the terms 'adult at risk of harm' and 'adult in need of protection[25]'.

2. The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

3. An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

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

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

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

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

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

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

AND

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

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

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

Reportable offences and allegations of abuse

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

ANNEX 13: UNREASONABLE OR ABUSIVE COMPLAINANTS

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

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

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

3. The following *Unacceptable Actions Policy*[26] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Actions Policy

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

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

Aggressive or abusive behaviour

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

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

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

Unreasonable demands

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

9. Examples of actions grouped under this heading include:

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

10. An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

11. Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the organisation or inundates the organisation with copies of information that has been sent already or that is irrelevant to the complaint.

12. The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

Unreasonable use of the complaints process

13. Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about an organisation with which they have a continuing relationship, if subsequent incidents occur.

14. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a complaints system to be important and it will only be in exceptional circumstances that

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

Unreasonable refusal to co-operate

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

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

Examples of how the HSC manage aggressive or abusive behaviour

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

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

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

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

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

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

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

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

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

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

The process the HSC follows to make decisions about unreasonable behaviour

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

How the HSC lets people know it has made this decision

26. When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[28] why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

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

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

must advise the complainant in writing[27] that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

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

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

ANNEX 14: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995[28] (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987[29].

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996[30].

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

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

[28] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[29] Adoption Order (NI) 1987: http://www.legislation.gov.uk/nisi/1987/2203/contents
[30] Representations Procedure (Children) Regulations (NI) 1996: http://www.legislation.gov.uk/nisr/1996/451/contents/made

CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

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

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

OR

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

If **YES** to **EITHER** of above

If **NO** to **EITHER** of above → Progress via HSC Complaints Procedure

↓

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

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

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

If **YES** to **ANY** of above

If **NO** to **ALL** of above → Progress via HSC Complaints Procedure

↓

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

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

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

c. A parent **of his**;

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

e. Any Trust foster parent;

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

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

If **<u>YES</u>** to **ANY** of above → **Progress via Children Order Procedure**

If **<u>NO</u>** to **ALL** of above → Progress via HSC Complaints Procedure

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

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

Definitions of Key Terms

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

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

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

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

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

Department of Health

An Roinn Sláinte

Männystrie O Poustie

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GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Updated April 2023

REVISIONS TO HSC COMPLAINTS PROCEDURE

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

AMENDMENTS TO COMPLAINTS DIRECTIONS

Directions	Details	Date Effective
Health and Social Care Complaints Procedure Directions	The Main Directions were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions: ▪ omit the definition of "HSC Board". ▪ in the definition of "HSC Body" omit "HSC Board". ▪ in the definition of "Serious Adverse Incident" omit "HSC Board's". [1]	28 October 2022 **2022 No. 4**

([1]) Also refers to the 2013 Amendment Directions

Directions	Details	Date Effective
	• Paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1988" substitute "the Data Protection Act 2018([2])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious Adverse Incident review". • In paragraph 15(4) (Monitoring), for "HSC Board" at each place it occurs, substitute "Department of Health" and for the "Data Protection Act 1998" substitute "Data Protection Act 2018". • In paragraph 16(2) (Learning), for "HSC Board" substitute "Department of Health". • In paragraph 17 (Annual Reports) omit sub-paragraph (2).	
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The Directions to the Health and Social Care Board on Procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers 2009 are revoked.	28 October 2022 **2022 No. 4**

([2]) 2018 c. 12

Directions	Details	Date Effective
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the second time at: • In paragraph 2 (Interpretation) in the definition of "Serious Adverse Incident" omit "HSC Board's". • In paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1998" substitute "the Data Protection Act 2018([3])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious Adverse Incident review".	28 October 2022 **2022 No. 5**
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the second time at: • In paragraph 2 (Interpretation), in the definition of "Serious Adverse Incident" omit "HSC Board's". • In paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1998" substitute "the Data Protection Act 2018([4])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious	28 October 2022 **2022 No. 3**

([3]) 2018 c. 12
([4]) 2018 c. 12

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

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

Update – 01 April 2022

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

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

SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

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

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

Local resolution

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

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

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

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

Principles of an effective Complaints Procedure

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

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

Learning

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

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

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

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

What the HSC Complaints Procedure covers

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

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

1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[5] as an alternative to making an application to the courts.

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

What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care[6] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

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

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by DoH
- requests for information under Freedom of Information or access to records under the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[7]

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

[6] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/
[7] Public Interest Disclosure (Northern Ireland) Order 1998

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

Staff Grievances

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

Disciplinary Procedure

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

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

1.18 The Chief Executive (or designated senior person[8]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part

[8] A designated Senior Person should be a Director (or Nominee)

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

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

Investigation by a Professional Regulatory Body

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

Services Commissioned by the DoH

1.21 Correspondence raising an issue on the availability, commissioning and/or the purchasing of services arising as a result of a decision taken by the Department, should be addressed directly to the Department of Health.

Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[9] and requests for access to health or social care records under the UK General Data Protection Regulation (GDPR)[10] and Data Protection Act 2018.

[9] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[10] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

Independent Inquiries and Criminal Investigations

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

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

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 14. The HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[11].

Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation, or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[12]) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016[13]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[14]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint

[11] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[12] Adult Safeguarding Operational Procedures: Adult Safeguarding (hscni.net)
[13] Protocol for Joint Investigation of Adult Safeguarding Cases: DRAFT (hscni.net)
[14] Information about and contact details for HSC Trusts can be accessed at the following link - https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect

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

Child Protection Procedures

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

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

Coroners Cases

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

Legal Action

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

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

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

Serious Adverse Incidents (SAI)

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

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

Whistleblowing

1.34 The Department of Health has a framework and model policy in place for HSC organisations on Whistleblowing[15]. All HSC organisations should have their own separate procedures in place.

[15] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-whistleblowing.PDF

SECTION 2 – MAKING A COMPLAINT

What is a complaint?

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

Promoting access

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

Who can complain?

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

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

Consent

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

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

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

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance[16].

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

[16] https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care

Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the UK General Data Protection Regulations (GDPR) and Data Protection Act 2018 which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. More detailed information can be found in the DoH guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information*[17] published January 2012.

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

Third Party Confidence

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

[17] DoH Code of Practice:
https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

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

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

Use of Anonymised Information

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

How can complaints be made?

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

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

It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery[18]. (See Flowchart page 45)

Options for pursuing a complaint

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

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

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

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

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the SPPG Complaints Team[19], if he/she does not feel able to approach immediate staff (see flowchart page 46).

[18] Section 75 of the Northern Ireland Act 1998 https://www.legislation.gov.uk/ukpga/1998/47/section/75
[19] SPPG Complaints Team acting on behalf of the DoH.

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

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

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

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

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies[20] must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

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

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

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

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

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

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

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

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

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

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

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

Independent Sector Providers

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

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

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

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

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

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

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

2.36 In complaints investigated by the ISP:

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

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

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

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

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

What information should be included in the complaint?

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

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

Supporting complainants and staff

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

What are the timescales for making a complaint?

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

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

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

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

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

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

SECTION 3 – HANDLING COMPLAINTS

Accountability

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

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

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

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

Performance Management

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

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

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

Co-operation

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

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

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

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions[21] and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

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

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

[21] DoH Complaints Directions: https://www.health-ni.gov.uk/publications/hsc-complaints-directions

- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)[22] to assist staff requiring professional indemnity[23];
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

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

[22] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).
[23] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

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

Publicity

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

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

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

3.12 Local information should:

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

Training

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

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

Actions on receipt of a complaint

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

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

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

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

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

Acknowledgement of Complaint

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

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

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

3.21 The acknowledgement should:

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

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

Joint Complaints

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

Out of Area Complaints

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

Investigation

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

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

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

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

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

Assessment of the complaint

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

Investigation and resolution

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

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

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

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

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

Completion of Investigation

3.32 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[24] will assist HSC organisations in ensuring the completeness and readability of such reports.

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

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

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

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

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

Circumstances that might cause delay

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

Periods of acute mental illness

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

Physical Injury

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

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

Responding to a complaint

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

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

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

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

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

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

Concluding Local Resolution

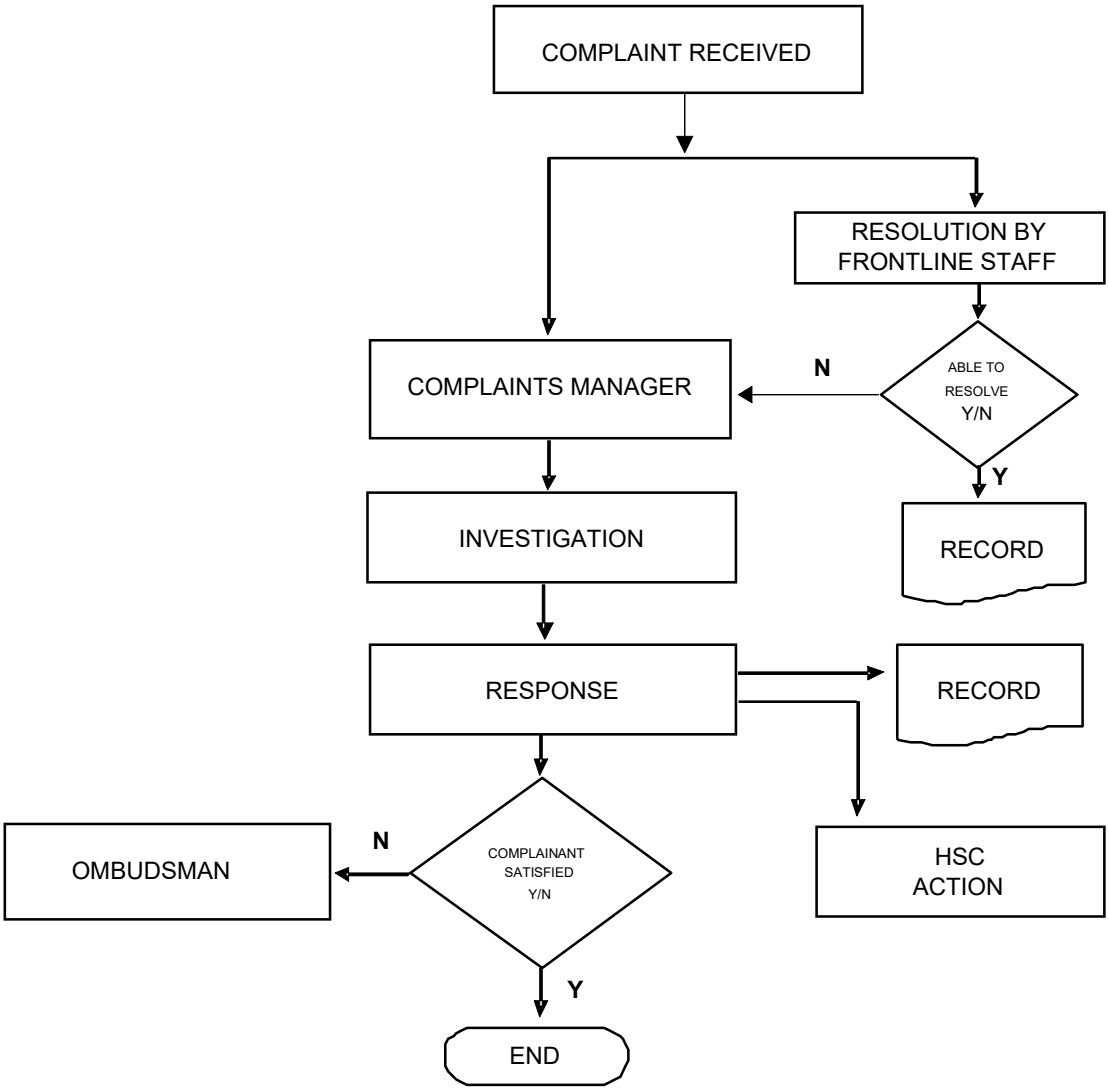
3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants should contact the organisation within one month of the organisation's response if they are dissatisfied with the response or require further clarity[25]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

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

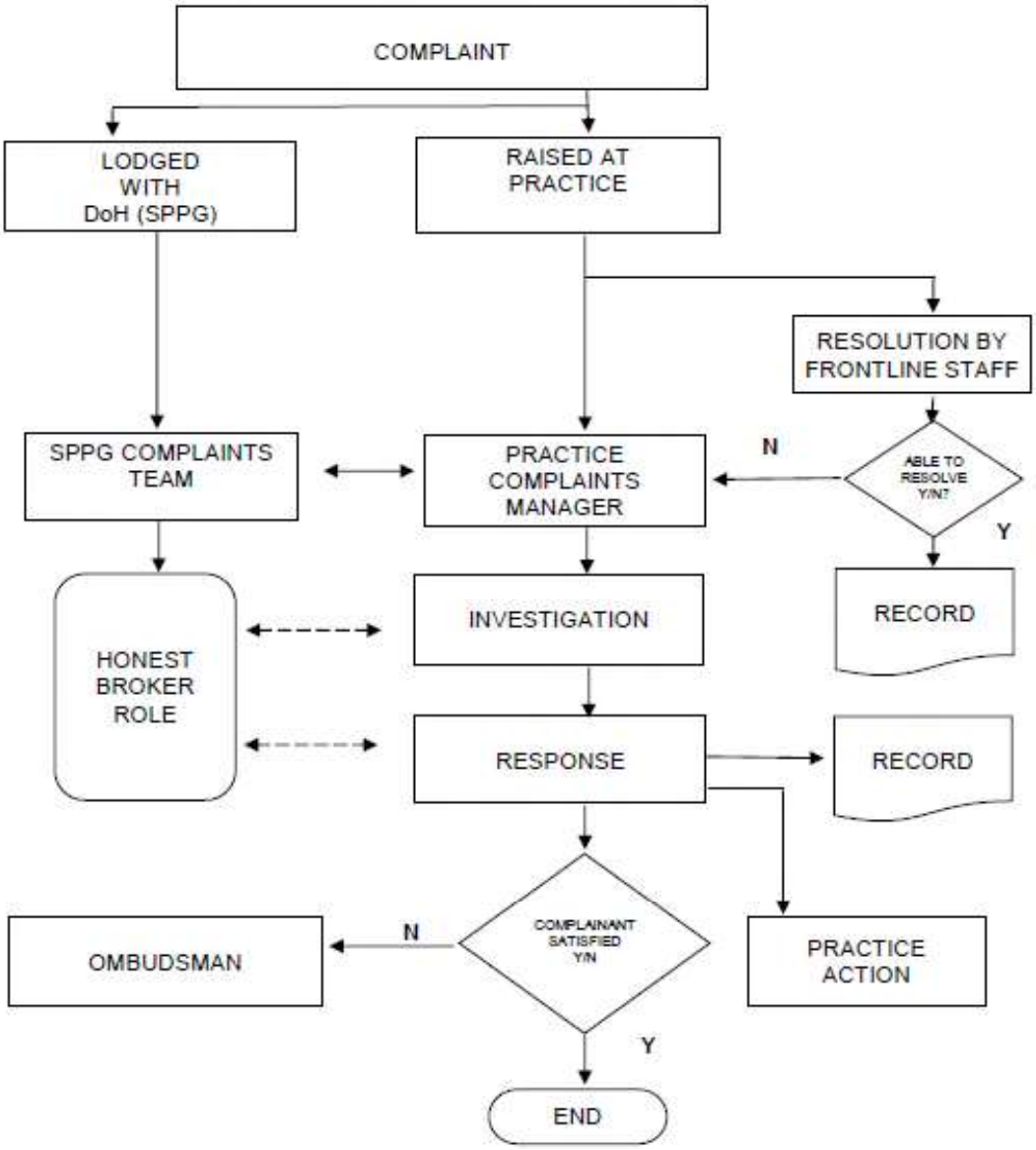
3.47 This completes the HSC Complaints Procedure. There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

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

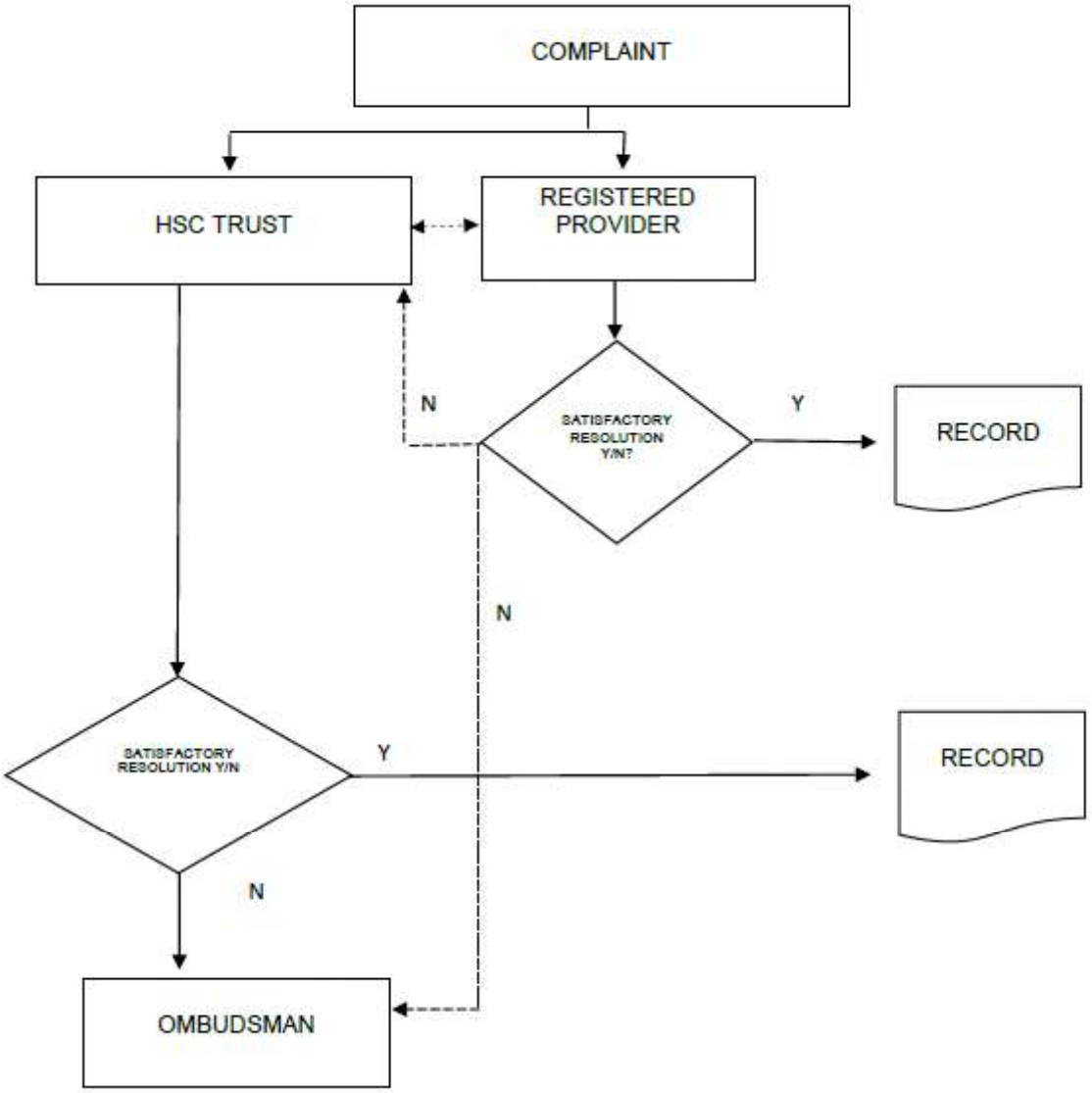
HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



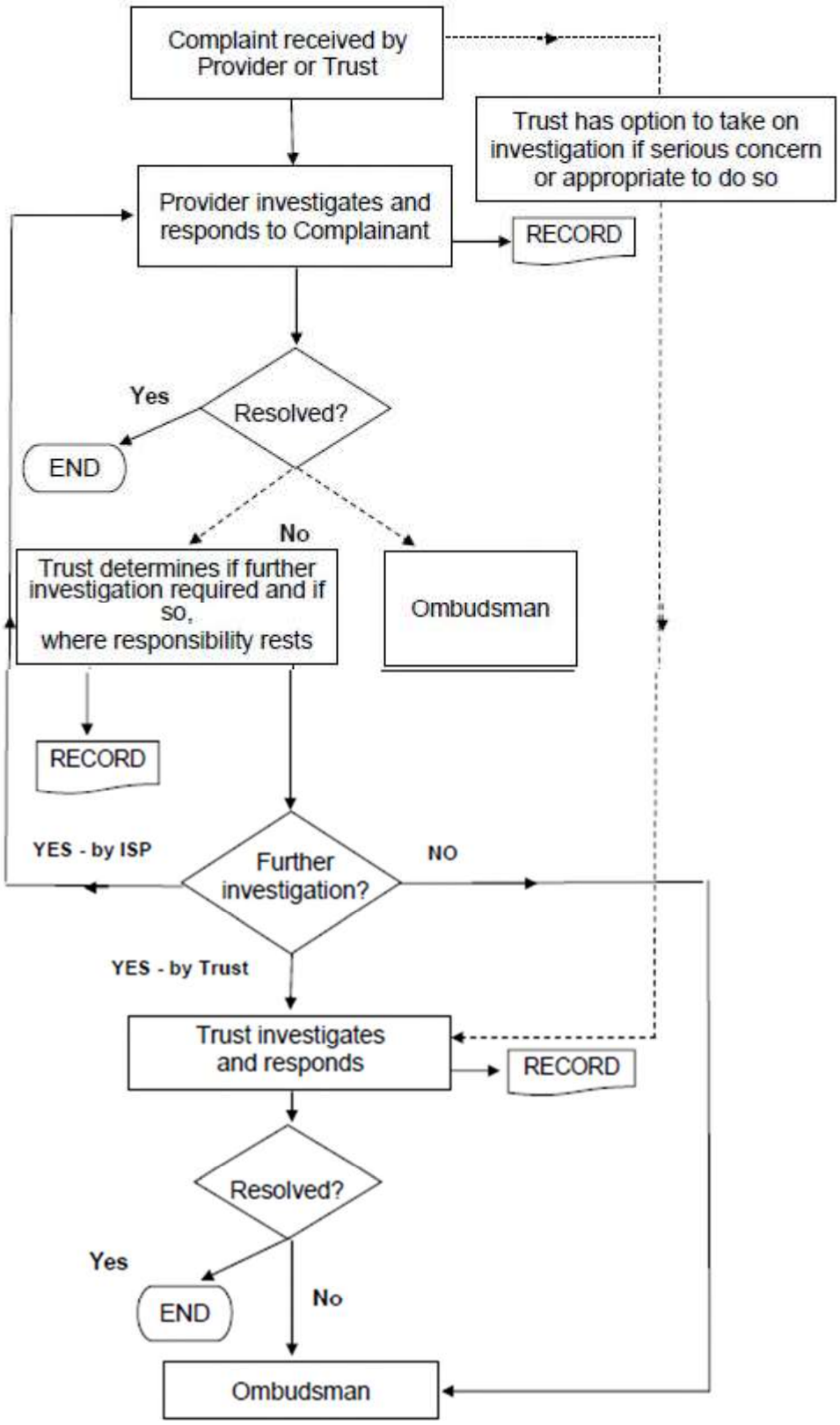
FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



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



INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



SUMMARY OF TARGET TIMESCALES

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

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

SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

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

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

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

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

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

DoH

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

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

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

HSC Trusts

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

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

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

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

Quarterly reports

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

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

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

Family Practitioner Services

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

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

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

Other HSC organisations

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

Regulated establishments and agencies

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

Learning

4.18 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[26].

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

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

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

SECTION 5 - ROLES AND RESPONSIBILITIES

DoH

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

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

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

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

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

HSC Organisations

5.5 HSC organisations must:

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

The Patient and Client Council (PCC)

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

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

- undertaking research into best methods and practices for consulting and engaging the public.

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

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

5.8 All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from: pcc-ni.net or Freephone 0800 917 0222

Where can I get support

If you wish to raise a concern or issue relating to a Health or Social Care service the PCC can provide advocacy to support and assist you.

You can contact the PCC in the following ways

Free phone number 0800 91702222

Or email the PCC on

info@pcc.ni.net

The PCC can support and assist you through our advocacy service to seek a resolution to the concern you have. You can view the PCC website for additional information on the PCC.

www.pcc-ni.net

ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

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

STANDARD 1: ACCOUNTABILITY

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

Rationale:

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

Criteria:

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

STANDARD 2: ACCESSIBILITY

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

Rationale:

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

Criteria:

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

STANDARD 3: RECEIVING COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

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

Rationale:

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

Criteria:

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

STANDARD 5: INVESTIGATION OF COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 6: RESPONDING TO COMPLAINTS

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

Rationale:

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

Criteria:

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

STANDARD 7: MONITORING

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

Rationale:

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

Criteria:

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

STANDARD 8: LEARNING

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

Rationale:

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

Criteria:

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

ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

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

The Children (NI) Order 1995:

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

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
- Health and Social Care Complaints Procedure Directions (NI) 2009 (Amended 2013);
- Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009) (Honest Broker Timescales) (Amended 2013);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010);
- Health and Social Care Complaints Procedure Directions (Amended 2019);
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) (Amended 2019);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (Amended 2019);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (Amended 2019);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (Amended 2022);

- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (Amended 2022);
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) (Revoked 2022);
- Health and Social Care Complaints Procedure Directions (Amended 2022).

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

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

ANNEX 3: PROFESSIONAL REGULATORY BODIES

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

ANNEX 4: HSC PRISON HEALTHCARE

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

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

ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman[27] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

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

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

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

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

2. The Ombudsman's contact details are:

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

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

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

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

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

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

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

4. The RQIA may be contacted at:

James House
2-4 Cromac Avenue
Belfast
BT7 2JA
Tel: 028 9536 1111

http://www.rqia.org.uk

ANNEX 7: ADVOCACY

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

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

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

ANNEX 8: CONCILIATION

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

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

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

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

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

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

FPS arrangements

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

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

Agreement by parties involved

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

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

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

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

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

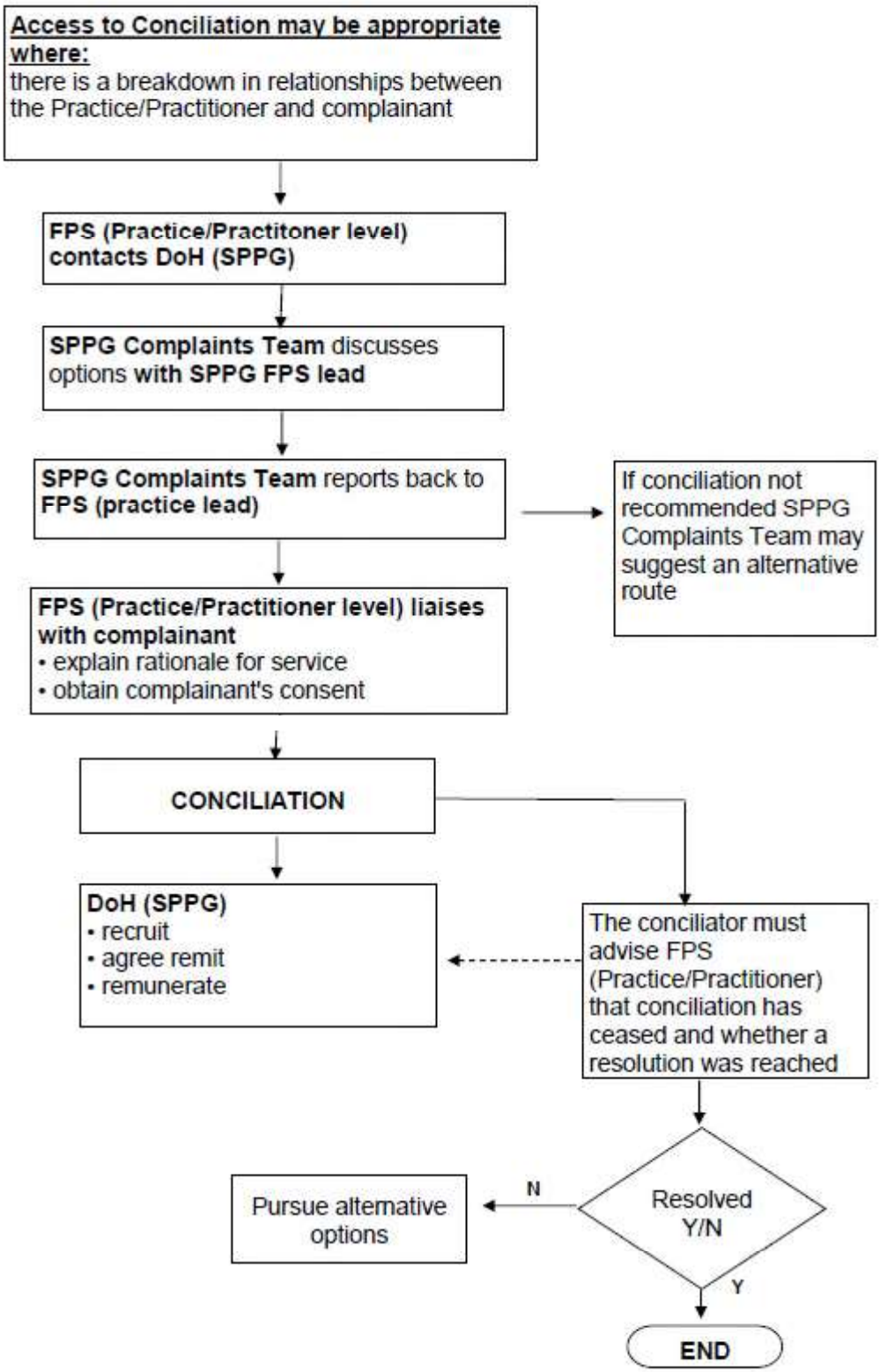
Appointment of conciliators

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

Monitoring

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

Conciliation – FPS



ANNEX 9: INDEPENDENT EXPERTS

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

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

FPS arrangements

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

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

Agreement and consent

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

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

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

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

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

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

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

Appointment of Independent Experts

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

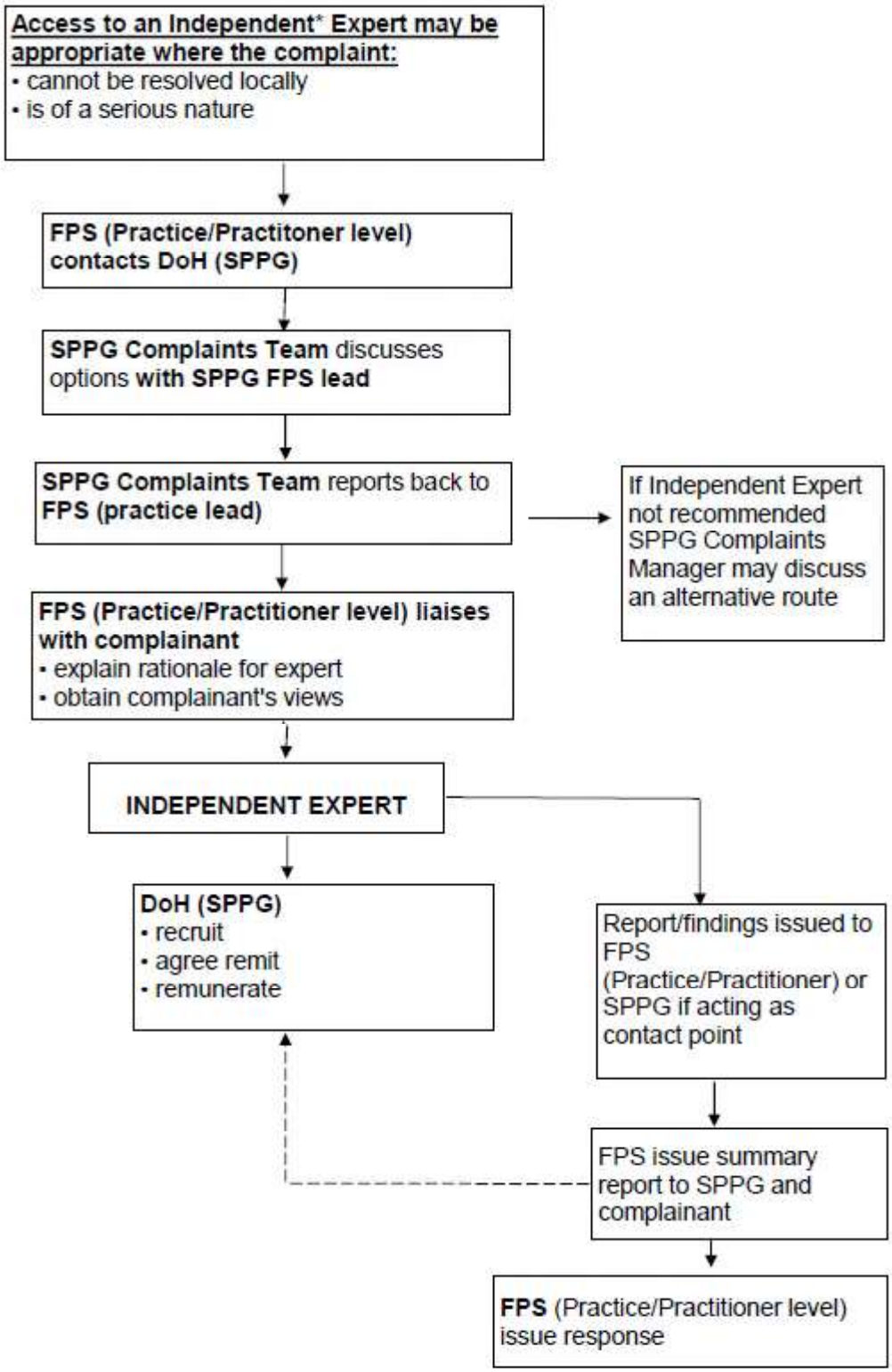
10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

11. The SPPG Complaints Team will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

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

Independent Experts – FPS Access



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

ANNEX 10: LAY PERSONS

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

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

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

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

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

FPS arrangements

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

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

Agreement and consent

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

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

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

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

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

Appointment of lay persons

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

Monitoring

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

ANNEX 11: HONEST BROKER ROLE

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

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

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

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

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

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

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

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate;
- provide advice to the complainant and the Practice/Practitioner on target timescales[28]; and
- where there is a delay, ensure the complainant is advised as set out in paragraph 3.39.

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

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

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

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

ANNEX 12: ADULT SAFEGUARDING

Definition of vulnerable adult

1. The regional policy 'Adult Safeguarding – Prevention and Protection in Partnership' defines the terms 'adult at risk of harm' and 'adult in need of protection[29]'.

2. The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

3. An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**
AND/OR
b) **life circumstances**

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

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

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

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

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

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

AND

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

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

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

Reportable offences and allegations of abuse

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

ANNEX 13: UNREASONABLE OR ABUSIVE COMPLAINANTS

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

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

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

3. The following *Unacceptable Actions Policy*[30] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Actions Policy

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

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

Aggressive or abusive behaviour

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

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

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

Unreasonable demands

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

9. Examples of actions grouped under this heading include:

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

10. An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

11. Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the organisation or inundates the organisation with copies of information that has been sent already or that is irrelevant to the complaint.

12. The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

Unreasonable use of the complaints process

13. Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about an organisation with which they have a continuing relationship, if subsequent incidents occur.

14. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a complaints system to be important and it will only be in exceptional circumstances that

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

Unreasonable refusal to co-operate

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

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

Examples of how the HSC manage aggressive or abusive behaviour

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

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

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

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

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

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

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

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

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

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

The process the HSC follows to make decisions about unreasonable behaviour

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

How the HSC lets people know it has made this decision

26. When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[28] why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

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

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

must advise the complainant in writing[31] that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

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

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

ANNEX 14: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995[32] (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987[33].

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996[34].

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

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

[32] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[33] Adoption Order (NI) 1987: http://www.legislation.gov.uk/nisi/1987/2203/contents
[34] Representations Procedure (Children) Regulations (NI) 1996: http://www.legislation.gov.uk/nisr/1996/451/contents/made

CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

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

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

OR

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

If **YES** to **EITHER** of above

If **NO** to **EITHER** of above → Progress via HSC Complaints Procedure

↓

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

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

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

If **YES** to **ANY** of above

If **NO** to **ALL** of above → Progress via HSC Complaints Procedure

↓

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

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

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

c. A parent **of his**;

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

e. Any Trust foster parent;

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

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

If **<u>YES</u>** to **ANY** of above

If **<u>NO</u>** to **ALL** of above → Progress via HSC Complaints Procedure

↓

Progress via Children Order Procedure

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

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

Definitions of Key Terms

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

Complaint	"an expression of dissatisfaction that requires a response"
Complainant	an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	the Chief Executive of the HSC organisation
Complaints Manager	the person nominated by an HSC organisation to handle complaints
DoH[35]	Department of Health in Northern Ireland
Family Practitioner Service (FPS)	family doctors, dentists, pharmacists and opticians
Honest Broker	this is the term used to describe the role of the SPPG on behalf of DoH in FPS complaints
HSC Organisation	an organisation which commissions or provides health and social care services and for the purpose of this guidance includes HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the Business Services Organisation (BSO), the Public Health Agency (PHA), Family Practitioner Services (FPS), Out-of-Hours Services, and pilot scheme providers
Local Resolution	the resolution of a complaint by the organisation, working closely with the service user

[35] Formally the Department for Health, Social Services and Public Safety (DHSSPS)

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

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

The Regulation and Quality Improvement Authority

Review of the Operation of Health and Social Care Whistleblowing Arrangements

September 2016

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting against four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

Public Concern at Work

Public Concern at Work (PCaW)[2] is an independent charity and legal advice centre. The cornerstone of the charity's work is a confidential advice line for workers who have witnessed wrongdoing, risk or malpractice in the workplace but are unsure whether or how to raise their concern. The advice line has advised over 20,000 whistleblowers to date; this unique insight into the experience of whistleblowers informs their approach to organisational policy development and campaigns for legal reform.

In February 2013, PCaW established the Whistleblowing Commission to examine the effectiveness of whistleblowing in the United Kingdom and to make recommendations for change. The Whistleblowing Commission published its report in November 2013.[3] The key recommendation of the Commission was the creation of a statutory Code of Practice, which sets out the principles for effective whistleblowing, which can be taken into account by courts and tribunals considering whistleblowing claims.

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[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf
[2] Public Concern at Work - http://www.pcaw.org.uk/
[3] The Whistleblowing Commission report, November 2013 - http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf

Membership of the Review Team

Gary Walker	Former National Health Services Trust Chief Executive; self-employed interim and turnaround specialist
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Cathy James	Chief Executive, Public Concern at Work
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Table of Contents

Executive Summary

Encouraging staff to raise concerns openly as part of day to day practice, is an important part of improving quality of service and providing assurance of patient safety. When concerns are raised and dealt with appropriately, at an early stage, corrective action can be put in place to ensure the continued delivery of high quality and compassionate care.

This however, has not always been the case in the health service. The public inquiry into poor standards of care at the Mid Staffordshire National Health Service (NHS) Foundation Trust found that staff voices had been consistently ignored by the Trust Board. Freedom to Speak Up, the report of a review led by Sir Robert Francis was published in February 2015 and concluded that although many cases are handled well, too many are not. If this leads to others being deterred from speaking up in the belief that nothing will be done, patients may be put at risk.

Employers, if they truly want to know about malpractice, risk, abuse or wrongdoing in their organisation must take steps to encourage workers to raise concerns. Effective arrangements for raising those concerns should be a part of every healthy organisations culture.

It is essential that all organisations work towards developing an open and honest reporting culture. Staff must have the confidence to bring forward any concerns they may have, without fear and with the knowledge that any genuine concern will be treated seriously and investigated appropriately.

The findings from this review demonstrate that whistleblowing is mostly seen as a very negative term, which has not been helped by media portrayal. Focus groups highlighted that the only stories published seemed to be those where the whistleblower had suffered personally, creating an image that all whistleblowing ended negatively. There is also confusion as to what the term ‘whistleblowing’ actually referred to. Some staff considered that it was only whistleblowing if the issue being raised was very serious or was being raised outside the organisation.

The review team considers that the first step in encouraging the normalisation of raising concerns is the development of a model policy for health and social care in Northern Ireland that reflects current thinking. This should be supported by increasing the awareness for all staff about the needs and benefits of raising concerns.

A positive step in encouraging the raising of concerns would be the development of an independent helpline to provide advice and support for health and social care staff in Northern Ireland. It is recommended that this should be run as a pilot, with a subsequent evaluation to decide on whether or not to continue it.

Extremely positive steps have been taken in the area of visible leadership, but further development in this area is necessary. The review team considers that it is important to assess the effectiveness of any developments in this area.

For a system of raising concerns to work effectively, training needs to be available for staff who receive the concerns. They must be appropriately skilled in relation to managing and investigating concerns. Organisations must also assess how recording and reporting concerns fits in the overall governance process, including incident reporting and complaints

The Freedom to Speak Up report considered that feedback was an important part of the process. The review team was told that organisations generally provided feedback on action that was taken as a result of raising a concern. They considered that any method of feedback is to be supported, but feedback to individuals is essential.

Evidence from this review suggests that while many staff do raise concerns, a significant minority do not, for a variety of reasons, including feeling that nothing will be done and fear of reprisal. Most organisations had not effectively promoted raising concerns or looked for evidence of the effectiveness of their strategies.

It is not acceptable for organisations to assume a low level of raising concerns is positive; they must each ‘test the silence’ to gain assurance that the process of raising concerns is working well in their organisation.

This report makes 11 recommendations to improve whistleblowing arrangements within HSC organisations in Northern Ireland.

Section 1 - Introduction

1.1 Introduction

Health and social care services have been developed to promote the health, wellbeing and dignity of patients and service users. The people who deliver these services generally want to do the best they can for those they serve. However, for a variety of reasons, there will be occasions when things go wrong in the workplace. Encouraging staff to raise concerns openly as part of day to day practice is an important part of improving quality of service and providing assurance of patient safety.

When concerns are raised and dealt with appropriately, at an early stage, corrective action can be put in place to ensure the continued delivery of high quality and compassionate care. It is essential that all organisations should work towards development of an honest and open reporting culture, where staff have the confidence to bring forward any concerns they may have, without fear and with the knowledge that any genuine concern will be treated seriously and investigated appropriately and properly.

The term whistleblowing has no legal definition and is not enshrined in any legislation. Originally, the term developed from British police officers (bobbies) blowing their whistles to alert the public to criminals, while later, private business owners would use their own whistles to alert the police to the fact that a crime was being committed. US civic activist Ralph Nader is said to have coined the phrase in the early 1970s to avoid the negative connotations associated with other words such as informers and snitches. However, more recent media coverage, emphasising negative outcomes for whistleblowers, has led to whistleblowing being seen as a generally negative term, which could have a detrimental effect on the way staff approach raising concerns within their organisations.

The whistleblowing charity, PCaW defines whistleblowing as “A worker raising a concern about wrongdoing, risk or malpractice with someone in authority either internally and/or externally (i.e. regulators, media, MPs).”

Whistleblowing, or raising a concern, should be welcomed by public bodies as an important source of information that may highlight serious risks, potential fraud or corruption. Workers are often best placed to identify deficiencies and problems before any damage is done, so the importance of their role as the eyes and ears of organisations cannot be overstated.

Whistleblowing best practice and legislation[4] to protect workers raising concerns developed following a number of disasters and public scandals in the late 1980s and the early 1990s:

- capsizing of the passenger ferry the Herald of Free Enterprise (1987)
- the explosion on the Piper Alpha oil platform (1988)
- the train collision at Clapham Junction London (1988)
- the Bristol Royal Infirmary (1991-1995)

In each of these cases, workers had been aware of dangers but did not know what to do or who to approach, were too frightened to speak out due to fear of losing their jobs or being victimised, or spoke out but weren't listened to. Raising concerns or whistleblowing is therefore essential to:

- safeguard the integrity of an organisation
- safeguard employees
- safeguard the wider public
- prevent damage

Employers, if they truly want to know about malpractice, risk, abuse or wrongdoing in their organisation, must take steps to encourage workers to raise concerns. Effective arrangements for raising those concerns should be a part of every healthy organisation's culture. Workers who are prepared to speak up about wrongdoing should be recognised as one of the most important sources of information for any organisation seeking to enhance its reputation, by identifying and addressing problems that disadvantage or endanger other people.

The benefits of encouraging staff to report concerns include:

- identifying wrongdoing as early as possible
- exposing weak or flawed processes and procedures which make an organisation vulnerable to loss, criticism or legal action
- ensuring critical information gets to the right people who can deal with concerns
- avoiding financial loss and inefficiency
- maintaining a positive corporate reputation
- reducing the risks to the environment or the health and safety of employees or the wider community
- improving accountability
- deterring workers from engaging in improper conduct

The public inquiry into poor standards of care at the Mid Staffordshire NHS Foundation Trust[5] found that staff voices had been ignored by the Trust Board.

[4] Public Interest Disclosure (Northern Ireland) Order 1998 - http://www.legislation.gov.uk/nisi/1998/1763/contents
[5] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - 6 February 2013 - https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Robert Francis QC concluded that:

"The board did not listen sufficiently to its patients and staff, or ensure the correction of deficiencies brought to the trust's attention.
Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities."

In his report he went on to recommend that the:

"Reporting of incidents of concern relative to patient safety, compliance with the law and other fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting."

Dame Janet Smith in the inquiry[6] which followed the conviction of Harold Shipman, a GP who had killed at least 215 patients over a period of 24 years, commented in her report:

"To modern eyes, it seems obvious that a culture in all healthcare organisations that encourages the reporting of concerns would carry great benefits. The readiness of staff to draw attention to errors or near misses by doctors and nurses and the facility for them to do so, could have a major impact upon patient safety and upon the quality of care."

Subsequently in her report she stated:

"I believe the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance, or health of another could make a greater contribution to patient safety than any other single factor."

A whistleblowing commission was established in February 2013 by PCaW to examine the effectiveness of existing arrangements for workplace whistleblowing in the United Kingdom and to make recommendations for change.

The commission made 25 recommendations,[7] including a recommendation that a code of practice drafted by the commission be adopted.

[6] The Shipman Inquiry - 27 January 2005 http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/reports.asp

[7] Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK - November 2013 http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf

The code of practice sets out standards to assist with development of effective arrangements for raising concerns and provides advice for organisations in relation to:

- written procedures
- training, review and oversight of arrangements for raising concerns
- dealing with anonymity and confidentiality
- legislation related to raising concerns

In November 2014, Whistleblowing in the Public Sector – a good practice guide for workers and employees[8], developed in conjunction with PCaW, was published by the four United Kingdom audit offices. It was designed to provide information for public sector workers on how to raise concerns and what they should expect in turn from their employers. It also provided guidance for public sector employers on the benefits of having a robust system for raising concerns and on how to encourage workers to raise concerns and deal effectively with those concerns.

Freedom to Speak Up[9], the report of a review led by Sir Robert Francis was published in February 2015. The review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by staff and the treatment of some of those who have spoken up.

The review concluded that although many cases are handled well, too many are not. If this leads to others being deterred from speaking up in the belief that nothing will be done, patients may be put at risk. It also emphasised the importance of all who raise concerns, and those who respond to them, the need for behaving with empathy and understanding towards others, focusing together on patient safety and the public interest.

Organisations should have an ethos where genuine concerns are investigated objectively and learning shared, while supporting those who have raised the concerns. Genuine issues about an individual's performance or conduct should be dealt with separately and fairly.

The report set out a number of principles and actions under the following headings:

- culture change
- better handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- enhancing the legal protection

[8] Whistleblowing in the Public Sector - A good practice guide for workers and employers – November 2014 - http://www.niauditoffice.gov.uk/wb_good_practice_guide.pdf
[9] Freedom to Speak Up - An Independent Review into Creating an Open and Honest Reporting Culture in the NHS – February 2015 - http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

The report emphasised the need for a change in culture, with boards devoting both time and effort to achieve this change. As part of the culture change, raising concerns should be part of the routine business of any organisation and speaking up should become part of what everyone does and is encouraged to do. The report considered that policies and procedures should not distinguish between reporting incidents and making protected disclosures and that visible leadership at all levels of the organisation was essential in supporting the culture of raising concerns.

All organisations should have systems in place to support the raising of concerns both formally and informally and organisations should have a range of staff available to whom concerns may be reported. All staff should receive training in their organisation's approach to raising concerns and there should be transparency about incidents and concerns and how an organisation has responded to them.

The report also recommended that there should be an external review of systems for raising concerns, in the form of an Independent National Officer. The Care Quality Commission (CQC) was also encouraged to take account in the well-led domain of its hospital inspections, of how organisations handle concerns that are raised.

In its response to the Freedom to Speak Up review, the Scottish Government decided that:

- non-executive whistleblowing champions would be introduced in each NHS Scotland Board
- further national whistleblowing events would be provided to designated policy contacts within boards, with a view to roll out locally
- the Cabinet Secretary would write to all NHS Scotland Boards to draw attention to relevant local actions identified within the review report and ask that Health Board Chairs and Chief Executives consider how these recommendations can be implemented locally
- the Cabinet Secretary would write to Healthcare Improvement Scotland as the relevant scrutiny body in NHS Scotland, to ask it to consider and feedback on how the report's recommendation on scrutiny may be implemented

Additionally, the Scottish Government committed to: "The development and establishment of an Independent National (Whistleblowing) Officer (INO), to provide an independent and external review on the handling of whistleblowing cases".

In November 2015, a consultation paper regarding the establishment of an INO was produced by the Scottish Government[10].

[10] Consultation on proposals for the introduction of the role of an Independent National (Whistleblowing) Officer for NHSScotland Staff - http://www.gov.scot/Publications/2015/11/5123

Regarding professional regulation, in his report, The Handling by the General Medical Council of Cases Involving Whistleblowers[11], the Right Honourable Sir Anthony Hooper noted that it is sometimes said that a whistleblower is a person who raises concerns externally, that is with persons other than his or her employer. In his opinion that was not correct. He went on to say that many people who raise concerns, do not, at the time of raising concerns see themselves as whistleblowers. They may be ignorant of the protections afforded to those who raise such concerns. They are more likely to come to regard themselves as whistleblowers if they suffer detriment as a result of raising concerns or if no action is taken in response to their concerns. The report made a number of recommendations regarding the position of raising concerns in relation to professional regulation.

1.2 Context for the Review

The Public Interest Disclosure (Northern Ireland) Order 1998[12] sets out the legislative basis for those workers who raise concerns about wrongdoing and makes provision about the kinds of disclosures that may be protected; the circumstances in which such disclosures are protected and the persons who may be protected. The Order also lists the organisations to which disclosures of information may be made under the Order.

On 17 February 2009, Circular HSS (F) 07/2009[13] provided whistleblowing guidance for HSC organisations, setting out their responsibilities and providing a model policy template for all organisations to adapt to their own circumstances. The circular stated that organisations should have clear arrangements in place to assist staff with reporting concerns. If these were not in place, organisations were to take steps to devise and implement them in line with the model policy template.

In March 2012, the then Minister for Health, Mr Edwin Poots, wrote to Chief Executives of all HSC bodies, asking them to bring the contents of his letter to the attention of all employees and make it available alongside each organisational whistleblowing policy. The letter set out a number of principles that every employee should expect in relation to raising concerns within their own organisation, which included:

- The right to whistleblow - every member of staff should be confident that managers at all levels would respond positively to expressions of concern and should it be necessary they would be protected from victimisation.

[11] The handling by the General Medical Council of cases involving whistleblowers – 19 March 2015 - www.gmc-uk.org/Hooper_review_final_60267393.pdf

[12] The Public Interest Disclosure (Northern Ireland) Order 1998 - https://www.dhsspsni.gov.uk/articles/public-interest-disclosure-northern-ireland-order-1998

[13] Circular Reference: HSS (F) 07/2009 - 17 February 2009 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hssf-2009-07.pdf

- The right to be heard by management and a responsibility to speak up – staff should feel empowered to speak up if they see, or become aware of practice which is unsafe, or creates unacceptable risks to patients or clients. Managers and leaders at all levels would then be responsible for creating and maintaining an atmosphere of mutual support and mutual learning.

The letter concluded with encouragement for staff to raise genuine concerns where appropriate and emphasised that this was a vital element of good public service based on the values and principles that are at the heart of Health and Social Care.

In December 2014, the then Department of Health, Social Services and Public Safety (DHSSPS) commissioned Sir Liam Donaldson to carry out a review of the arrangements for assuring and improving the quality and safety of care in Northern Ireland. His report, The Right Time the Right Place[14], made a number of recommendations including that "the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the minister".

In August 2015, Dr Paddy Woods, Deputy Chief Medical Officer, commissioned RQIA to undertake a review of the operation of HSC whistleblowing arrangements.

This review forms part of the Department of Health's (DoH) overall review of HSC whistleblowing arrangements.

The report makes 11 recommendations in order to continue the journey towards normalisation of raising of concerns within HSC organisations in Northern Ireland.

1.3 Terms of Reference

The terms of reference for this review were:

1. The review will consider the:
    a. existence (current, consistent, robust)
    b. operation (understanding, training, learning)
    c. accessibility, availability, support
    d. governance

    of Arm's Length Bodies' whistleblowing arrangements.

2. In light of the findings of the review RQIA will identify any recommendations for improvement to the arrangements.

[14] The Right Time the Right Place - An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland – December 2014 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf

1.4 Exclusions

The review has excluded the whistleblowing arrangements within the Northern Ireland Fire and Rescue Service and RQIA.
The Northern Ireland Guardian Ad Litem Agency has also been excluded from the review. These organisations will be assessed by the DoH[15] at a later stage.

Circulars, guidance, standards, reviews and reports which arise during the course of this review will not be assessed as part of this review and will be highlighted for consideration in the future.

1.5 Review Methodology and Scope

The scope of the review included the following organisations:

DoH – Arm's Length Bodies *	
Belfast Health and Social Care Trust	Patient and Client Council
South Eastern Health and Social Care Trust	Business Services Organisation
Northern Health and Social Care Trust	Northern Ireland Blood Transfusion Service
Southern Health and Social Care Trust	Public Health Agency
Western Health and Social Care Trust	Northern Ireland Medical and Dental Training Agency
Northern Ireland Ambulance Service Health and Social Care Trust	Northern Ireland Practice & Education Council for Nursing and Midwifery
Health and Social Care Board	Norther Ireland Social Care Council

PCaW, a whistleblowing charity, is accepted as a leading authority in this field. They:

- advise individuals with whistleblowing dilemmas at work
- support organisations with their whistleblowing arrangements
- inform public policy and seek legislative change

[15] On 9 May 2016, as part of the restructuring of the Northern Ireland government departments, Department of Health, Social Services and Public Safety has been renamed the Department of Health.

RQIA engaged PCaW to assist with a number of pieces of work to inform the review.
The review included the following stages, designed to gather information about the presence and operation of HSC whistleblowing arrangements:

- A review of relevant literature set out the context for the review and identified appropriate lines of enquiry.

- Meetings with professional regulatory and representative organisations to obtain their views about whistleblowing arrangements, to help inform the review.

- A review of each organisation's whistleblowing policy and procedures against best practice guidance.

- Staff engagement and obtaining their views was a key element of this review. A staff questionnaire was developed and distributed to staff in the organisations subject to the review. Secondly, RQIA worked in partnership with PCaW to hold focus groups with a range of staff groups in each of the organisations.

- Information was obtained from the HSC staff survey which included a number of questions about whistleblowing arrangements.

- Validation visits to each of the organisations were undertaken, to meet with staff who have responsibility for the operation of whistleblowing arrangements and other senior staff including board members.

- A stakeholder event to present the initial findings from the review to representatives from each of the organisations. The majority of organisations involved in the review were represented, with 40 delegates attending the event. The findings from the review were discussed, and delegates made suggestions for enhancing and taking forward the recommendations from the review.

Findings from questionnaires, meetings with organisations and feedback from the stakeholder event were collated, and the information used to inform this report. The report is an overview report and provides a regional view of arrangements for raising concerns and provides general recommendations to improve the process for raising concerns in Northern Ireland. No organisation is reported individually.

Section 2 - Findings from the Review

2.1 Engagement with Interested Stakeholders

During the planning stages of the review, RQIA met with several professional regulatory and representative organisations, including the General Medical Council[16], the Pharmaceutical Society of Northern Ireland[17], the Royal College of Nursing[18], the Chair of the Trade Union Forum, UNITE[19], and UNISON[20]. The meetings were designed to obtain their views about current whistleblowing arrangements within health and social care, with the intention of using the information to inform the review.

Professional Regulatory Organisations

The General Medical Council and the Pharmaceutical Society of Northern Ireland are the professional regulatory organisation for doctors and pharmacists respectively. They have legal powers to set guidance, and have done so in relation to the raising of patient safety concerns and in the professional duty of candour.

Both organisations have guidance[21,22] in relation to raising concerns, which places a duty on the professionals they regulate to raise concerns where they believe that patient safety has been compromised. They also state that professionals must be open and honest with their regulators, and with each other to ensure that concerns are raised where appropriate.

Both regulators provided advice and support to members who were considering raising a concern or had already done so. They generally did not raise a concern on behalf of a member, but supported them to raise their concern through the mechanisms within their own organisation.

Unions

Not all Unions representing workers in health and social care engaged with RQIA during the review. The Royal College of Nursing, UNITE and UNISON did take the time to engage.

The Unions represent the professional interests of staff working in a range of health and social care specialties and settings.

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[16] General Medical Council - http://www.gmc-uk.org/
[17] Pharmaceutical Society of Northern Ireland - http://www.psni.org.uk/
[18] Royal College of Nursing - https://www.rcn.org.uk/
[19] UNITE - http://www.unitetheunion.org/
[20] UNISON - https://www.unison.org.uk/
[21] General Medial Council guidance on whistleblowing - http://www.gmc-uk.org/DC5900_Whistleblowing_guidance.pdf_57107304.pdf
[22] Pharmaceutical Society of Northern Ireland guidance on whistleblowing - http://www.psni.org.uk/wp-content/uploads/2012/09/Guidance-on-Raising-Concerns.pdf

They provide advice and support to members who were considering raising a concern or had already done so, but generally did not raise a concern on their behalf. They encourage their members to raise concerns through mechanisms already in place within their own organisation.

All Unions provide guidance[23,24,25] on whistleblowing for their members. During discussions, Unions were able to cite many examples where staff were afraid or unwilling to raise concerns.

Outcome of the Discussions

The outcome of these discussions was consistent with the themes that were uncovered during the review. In summary all organisations considered:

- the term whistleblowing as being negative and not conducive to encouraging staff to raise concerns
- the current arrangements were not suitable and many cases were not managed appropriately
- there was a lack of awareness and training in relation to whistleblowing

All organisations welcomed any improvements to the arrangements for raising concerns. They expressed a willingness to be involved in the development of new arrangements, as well as becoming a more integrated part of these new arrangements.

2.2 Review of Whistleblowing Policies

In the initial stage of the review, all HSC organisations were asked to submit their whistleblowing policies. In order to review these documents, PCaW adopted the methodology used by the United Kingdom National Audit Office (NAO), following their review of a number of United Kingdom government departmental and Arm's Length Bodies' whistleblowing policies in 2014. This methodology was devised following wide consultation by the NAO, and closely follows the requirements on best practice for whistleblowing arrangements, encapsulated in the Whistleblowing Commission's Code of Practice[26] and the British Standards Institution's whistleblowing guidance.[27]

[23] Royal College of Nursing guidance on whistleblowing - https://www.rcn.org.uk/employment-and-pay/raising-concerns/guidance-for-rcn-members
[24] UNITE guidance on whistleblowing - http://wbhelpline.org.uk/resources/raising-concerns-at-work/?doing_wp_cron=1395055349.5939080715179443359375
[25] UNISON guidance on whistleblowing - https://www.unison.org.uk/get-help/knowledge/disputes-grievances/whistleblowing/
[26] The Whistleblowing Commission was established by PCaW in early 2013. The Independent Commissioners took evidence from stakeholders in whistleblowing and published a report in November 2013 that included a proposed Code of Practice, which forms the basis of PCaW's best practice guidelines. Copies of the full Commission report, including the Code of Practice are available on http://www.pcaw.co.uk/
[27] BSI publicly available specification 1998:2008 http://shop.bsigroup.com/forms/PASs/PAS-1998/

Each organisation's whistleblowing policy was assessed against eight criteria, which are based on good practice and current whistleblowing legislation. The NAO review criteria[28] are summarised below. While each policy has been reviewed against the detailed criteria, this report contains general trend analysis and a summary of main findings. The categories for review adopted by the NAO and used to assess the policies reviewed for this report are:

Setting a Positive Environment for a Whistleblowing Policy

a. **Commitment, clarity and tone from the top**
This involves making it clear to staff that any concern will be welcomed; it should reassure the reader, who may be thinking of raising a concern that the organisation's leadership will take it seriously and will not punish the employee if the concern turns out to be untrue, as long as the employee had reasonable suspicion of wrongdoing.

b. **Structure**
It is also important that guidance is easy to use so that readers are clear how they should raise a concern. The policy should include information relating to all areas of whistleblowing and provide comprehensive guidance for employees. It should be clear, concise and avoid including irrelevant detail that might confuse readers.

c. **Offering an alternative to line management**
Concerns may relate to behaviour of line managers or an employee may be unwilling or unable to discuss concerns with immediate management. Thus, alternative channels inside the organisation should be offered. Staff may be unwilling to approach extremely senior people with a concern, so the alternatives offered should be suitable.

d. **Reassuring potential whistleblowers**
Guidance should make clear that it is serious misconduct to victimise employees who are preparing to raise a concern, or have already done so. Similarly, it should make clear that employees who knowingly disclose false information will be subject to disciplinary action.

e. **Addressing concerns and providing feedback**
Whistleblowing policies should set out procedures for handling concerns. This will reassure readers that their concern will be taken seriously and also that wrongdoing can be identified and dealt with appropriately. The organisation should be clear about the actions it will take to investigate the concern and the feedback it will be able to provide to whistleblowers. Best practice will also give a general indication of the timescales involved in handling concerns, e.g. how long it will take to arrange an initial meeting, provide feedback etc.

[28] National Audit Office – Assessment criteria for whistleblowing policies – January 2014 - https://www.nao.org.uk/wp-content/uploads/2014/01/Assessment-criteria-for-whistleblowing-policies.pdf

Supporting Whistleblowers

a. **Openness, confidentiality and anonymity**
Guidance should make sensible and realistic statements about respecting whistleblowers' confidentiality. It should also outline the potential issues that could arise from employees reporting a concern anonymously.

b. **Access to independent advice**
Employees may need advice where they feel unsure or unaware of how to raise a concern. Guidance should address the point and identify how to contact potential advisers.

c. **Options for whistleblowing to external bodies (prescribed persons)**
Guidance should make employees aware of how they can raise a concern outside the organisation, e.g. to an external auditor or regulator. This may be a legal obligation in certain circumstances, for example where there is evidence of a criminal act. Guidance that follows best practice should encourage internal reporting, as this is where the concern can be addressed most effectively and where employees will receive the greatest protection. However, guidance should also identify the procedure for external reporting as well as outline potential bodies that employees can raise a concern with.

Assessment of Whistleblowing Policies

With these criteria in mind, an overall assessment is now provided of the organisations' policies as a whole against each of the above criteria, commenting on common trends and gaps in the policy wording overall.

a. Commitment, clarity and tone from the top
In order to achieve an excellent rating: there should be a stated commitment to maintaining high ethical standards and taking concerns seriously; the language should be inviting and reassuring; and there should be a clear distinction between whistleblowing and other concerns or grievances. Only a small number of the policies (two out of 14) scored an excellent rating in this category.

As a general rule, there was a lack of evidence of senior leadership contained in the policies reviewed. While many of the policies referred to a commitment on the part of the organisation to ensure that the policy and accompanying processes work in practice, rarely did this specifically refer to the leadership of the organisation. This is essential if the policy aims to instil trust and confidence in the process for all staff.

While in many of the policies reviewed, there was language stating that the organisation was committed to operating at very high standards, rarely was a specific body (such as the organisational board or equivalent) referred to.

Many of the policies referred to the Public Interest Disclosure Order as the starting point for the introduction to the policy or as the reason for having the policy. If the aim of the policy is to encourage staff to speak up and to ensure that it is safe and acceptable to do so, then this will not set the right tone from the start. In this category, two policies were rated as excellent, eight as satisfactory and four as poor.

b. **Structure**

An excellent rating in this category required the policy to be concise and well-presented, provide clear guidance that is both factual and informative, and guide the reader through the process in easy to follow language (flowcharts are recommended).

A third of the policies reviewed achieved an excellent rating in this category. One of the problems with many of the policies reviewed was a legalistic approach to the policy wording (i.e. leading with the Public Interest Disclosure Order as the introductory wording). Using the language of complaints and grievances and or/mixing management guidance for handling a concern were also issues with a number of the policies scrutinised.

An impersonal approach with a focus on an individual's responsibilities as opposed to focusing on the organisation's commitment to protect those raising a concern or disclosing information, would also have resulted in a low score for this category. Of the 14 policies, four were rated excellent, six satisfactory and four poor in this category.

c. Alternative to line management

Suggesting that workers consider raising a concern with their manager, but at the same time offering alternatives to the line management are both essential for any whistleblowing policy to be effective. It is clearly important that the line management process is included in the 'how to' section of any whistleblowing policy, as this will often be the starting point for raising a concern for most workers. However, it is also vital that any policy includes an alternative to line management, as the concern may relate to the behaviour of the line manager or it may be that line management is involved in the wrongdoing.

To gain an excellent rating, the policy should consider inclusion of appropriate contacts for the types of concerns being raised, have a flexible approach to when a concern might be raised outside of the management line and provide name and contact details for those designated to receive concerns. A number of the policies required individuals to raise the issue with their line manager first; this would have resulted in a low score because although it is proper to go through line management it should never be an absolute requirement. Six policies scored highly in this category, five were satisfactory and three were rated as poor.

d. **Reassuring potential whistleblowers**
An excellent policy will include language to assure the individual that they will not face sanctions for honestly raising a genuine concern, irrespective of whether they later turn out to be wrong. It will confirm that there are sanctions for victimising those who raise a concern or for preventing a concern being raised, and will also confirm that it is an abuse of the policy, and therefore a disciplinary offence, to knowingly raise a false concern.

Only one policy scored an excellent rating in this category. The main reason why many policies received a low score was the fact that disciplinary sanction was applied to frivolous/malicious/vexatious concerns. In order to strike the right balance, policy wording should only apply sanctions to the knowingly false concern. Extending sanctions more broadly, risks adding to the already numerous hurdles that whistleblower's experience, without necessarily reducing the number of concerns raised which lack merit.

e. **Addressing concerns and providing feedback**
In order to score highly, the policy wording should reassure readers that their concern will be taken seriously and also that wrongdoing will be identified and dealt with appropriately. It should include a summary of the procedures for handling concerns, an indication of how long before feedback is provided (noting that this will depend on the nature of the concern), an outline of the type of feedback whistleblowers can expect (while respecting the confidentiality of those being investigated), and clear guidance to managers on how to handle concerns (which may be published as a separate document[29]).

In this category, five policies scored highly, six satisfactory and three were rated as poor. Examples of difficulties in the policies reviewed include a lack of clarity around timescales (or no mention of this at all), using the language of a grievance process, requiring written statements from those using the policy, and long detailed manager's guidance which could confuse the concerned member of staff wishing to use the policy.

f. Openness, confidentiality and anonymity
An excellent rating clearly explains the difference between anonymity and confidentiality, and outlines where confidentiality cannot be maintained (e.g. where legal obligations mean that the identity of the person providing the information will have to be disclosed). It will encourage open disclosure and outline the difficulties with raising a concern anonymously (namely difficulties investigating, providing feedback, and protecting an individual's identity). The NAO review also requires a statement that anonymous disclosures are preferable to silence about wrongdoing.

[29] Public Concern at Work would suggest that this should be published as a separate document in order to keep the messaging in the policy itself as clearly aimed at those considering raising a concern.

It might also be sensible to say that anonymous concerns will be investigated in any event, but that there may be limitations on the protection available if the identity of the person raising the concern is unknown.

Difficulties with the wording of policies reviewed, included reference to the duty of confidentiality being more important than anything else, in terms of how the individual approached the raising of concerns and/or limited assurances around the protection of the individual's identity. In the latter case, the most common problem identified was that the policy stated that the organisation will use 'all reasonable steps' (or similar wording) to protect identity rather than confirming that if asked, the individual's identity will not be disclosed unless required by law. Other common issues with this category included use of confusing language about data protection, and patient confidentiality being referred to, at the same time as explaining the key policy assurance around the worker's identity. Four of the policies scored highly in this category, nine had a satisfactory rating and one had a poor rating.

g. Access to independent advice

To score highly here, a policy will address how an individual can obtain independent advice, and list relevant bodies, such as, PCaW, trade unions and professional associations, along with their contact details. The majority of the policies reviewed contained information about advice services including PCaW. In this category, 12 policies scored an excellent rating, and three satisfactory. The latter rating was applicable where only one source of external advice is referred to.

h. Options for whistleblowing to external bodies (prescribed persons)

An excellent rating will be achieved by policies which include external sources for raising a concern, including a comprehensive list of regulatory and oversight bodies relevant to the organisations and discussion on wider disclosures and the risks involved. The majority of the policies reviewed included reference to external bodies, but surprisingly many did not refer to the relevant healthcare regulators for Northern Ireland, RQIA and the Northern Ireland Social Care Council (NISCC), as organisations prescribed in the Public Interest Disclosure Order to which a protected disclosure may be made. Eleven policies scored an excellent rating in this category and four were satisfactory (usually because key regulators were not mentioned).

2.3 Staff Surveys

During the planning stage of the review, trust representatives reported that a staff survey specifically in relation to whistleblowing arrangements had been carried out in the Southern Health and Social Care Trust (Southern Trust). A decision was taken to carry out a similar survey in the other Arm's Length Bodies, as part of the RQIA review.

Subsequently, a questionnaire was issued to all staff from Arm's Length Bodies, via Survey Monkey, based on the Southern Trust questionnaire. The process was not repeated in the Southern Trust, as they had agreed to allow their results to be included in the final report. The regional HSC survey, which contained a number of questions related to whistleblowing, had just been conducted prior to the RQIA review.

3085 staff completed the RQIA questionnaire and a breakdown of numbers per organisation[30] is shown in the Table 1 below.

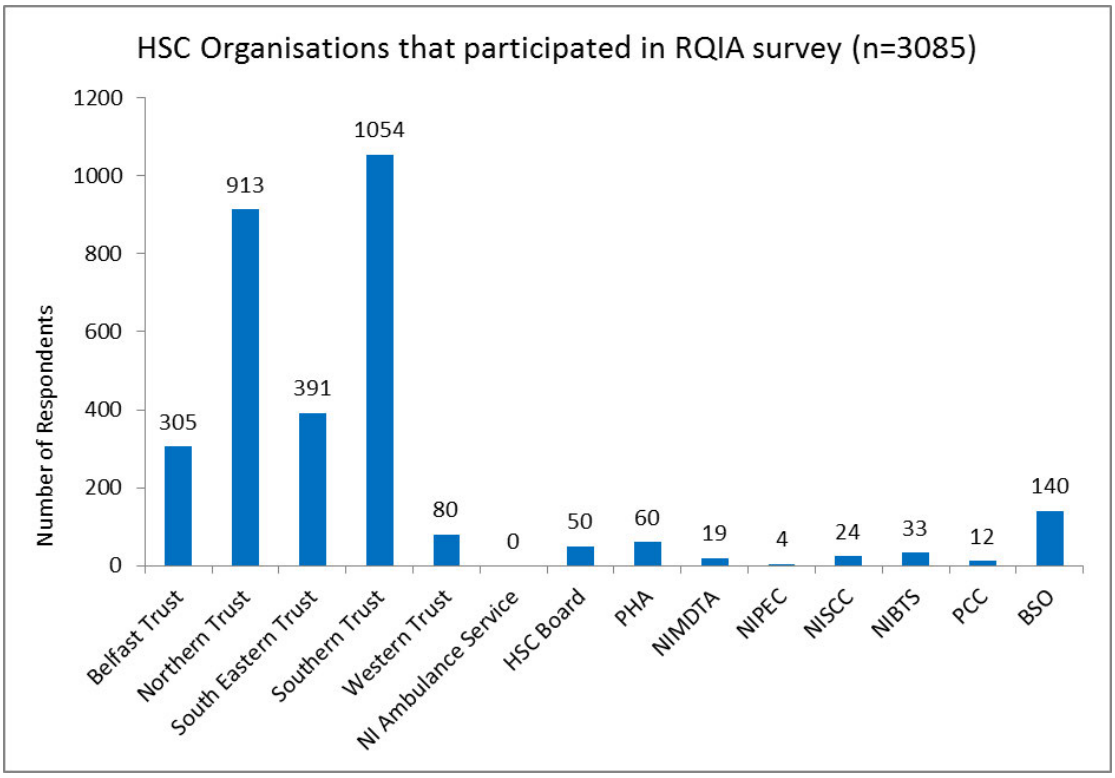

Table 1 – Number of responses per organisation

The RQIA questionnaire asked a number of questions that were similar to those asked by the regional HSC survey; however, the RQIA questionnaire allowed staff to enter freetext in order to explain the reasons, if any, as to why they had given a particular answer.

2559 (82.9%) respondents were aware that their organisation had a whistleblowing policy in place that provided guidance on how to raise a concern. However, only 1709 (55.4%) had confidence that their organisation would carry out a robust investigation of any concern they might raise.

Staff were asked if they would feel comfortable raising a concern with a senior manager/director in their organisation.

[30] It was reported by the Northern Ireland Ambulance Service that due to an administrative oversight, the survey was not distributed to their staff.

1632 (52.5%) answered yes to this question. A number of reasons were given as to why those who answered no would not feel comfortable. A summary of these responses included:

- afraid of the consequences
- afraid of repercussions
- afraid to be seen/labelled as a trouble maker
- afraid of harassment, victimisation and bullying
- fear of intimidation
- fear of reprisal
- fear of being isolated
- fear of losing job
- impact on career development and promotion
- lack of support and protection
- lack of confidentiality
- concerns were ignored
- raised concern before and it was ignored
- seen how cases were handled in the past
- don't have confidence in the process or management to deal with the concern appropriately

1553 (50.34%) respondents felt they would be more likely to raise a concern using a web based system that guaranteed anonymity.

841 (27.3%) respondents had experience of raising a concern within their organisation. The majority of those (681) had raised the concern with their line manager. 572 (68%) had not referred to the organisation's whistleblowing policy and the majority 745 (88.6%) had not raised the concern anonymously.

477 (56.7%) of those who had raised a concern felt that the concern had not been dealt with appropriately. The reasons given by respondents as to why they felt their concern had not been dealt with appropriately were:

- concern was ignored or not investigated
- poor investigation
- the concern was covered up
- the issue was put on hold, but never revisited
- got punished for raising the concern
- nothing happened/changed, and the issue persists
- issues still ongoing
- never got any feedback
- don't know the outcome

Of the 841 staff who had raised a concern, 372 (44.2%) considered that they had suffered detriment as a result of raising that concern. The key areas where staff believe they suffered detriment as a result of raising a concern:

- no action was taken and the person continues to do what they were doing
- person got moved or was transferred after raising concern

- disciplined for raising concern
- career has suffered - got overlooked for jobs and promotion
- financially worse off - fighting the case, impact on salary and pension
- damage to reputation
- was isolated/ignored by colleagues
- got bullied at work
- suffered from stress
- victimised after raising concern
- health has suffered - emotionally and physically

However, the majority – 627 (74.6%) reported that they would be very likely or likely to again raise a concern if they suspected wrondoing which is a positive result, showing that staff understand the importance of raising concerns.

Staff were also asked a number of questions specifically regarding fraud. The vast majority were aware that fraud falls within the scope of whistleblowing, were aware of a fraud policy within their organisation and would feel comfortable raising a concern regarding fraud with a senior manager/director within their organisation**.**

Finally staff were asked what would have improved the experience for them. The key points staff rasied were:

- a dedicated liaison person as a contact
- support from management
- counselling and support
- being listened to
- professional respect
- confidentiality
- the concerns being taken seriously
- formal process
- assurance that something will get done/ investigated
- having the whole process completed quicker
- a robust investigation
- a more open and transparent process
- appropriate action
- honesty from people involved
- feedback on the outcome
- a fair outcome

A regional staff survey was conducted in all HSC organisations in Northern Ireland from October to December 2015. This was conducted prior to the RQIA review and its questionnaire contained a number of questions regarding whistleblowing/raising concerns. The relevant questions were as follows:

- Are you aware of your organisation's policy and process for raising concerns about negligence or wrongdoing?
- Would you have the confidence to speak up within your organisation and raise concerns if you had cause to do so?

- Do you have confidence that your organisation would appropriately handle the investigation of any concerns raised?
- Are you aware of your organisation's whistleblowing process?
- Do you understand your responsibility under your organisation's whistleblowing process?

All organisations surveyed a full census of staff, with sample sizes ranging from 19 to 22,567. The overall number of staff surveyed was 70,213. 17,798 completed questionnaires were returned from this sample, which is a response rate of 26%. The key results from the regional survey were:

- 88% of staff reported that they are aware of their organisation's policy and process for raising concerns about negligence or wrongdoing
- 80% of staff reported that they would be confident to speak up and raise concerns if they had cause to
- 65% of staff reported that their organisation would appropriately handle the investigation that resulted
- 81% of staff reported that they are aware of their organisation's whistleblowing process
- 79% of staff reported that they understood their responsibility under their organisation's whistleblowing policy

Although the results from the HSC survey presented a positive reflection of whistleblowing, the review team was concerned that 35% of staff who responded were not confident that their organisation would appropriately handle the investigation of any concerns raised.

2.4 Focus Groups

As part of the review, staff were engaged in a series of focus groups and one-to-one appointments across all of the organisations involved in the review. The aim of these sessions was to determine staff perception and knowledge of, as well as trust and confidence in, their respective organisation's whistleblowing arrangements.

PCaW was commissioned to undertake this part of the review, in conjunction with RQIA staff. It was considered that as an organisation, they brought the necessary expertise, as their advice line has advised over 20,000 whistleblowers to date. This gives them a unique insight into the problems workers regularly face, when trying to raise a whistleblowing concern and when seeking action in relation to the issue raised. It was also considered that staff might raise a concern with them more readily than they would with RQIA alone.

Methodology

Over a four week period, 13 organisations were involved in the focus groups, with 368 individuals from a cross section of different staff groups participating in sessions.

This is a small number compared to the total number of staff working in health and social care. However, the review teams consider that the feedback provided a fair representation of staff understanding of the existence, operation and accessibility of whistleblowing arrangements across the sector.

Due to the size of the task (60,000 staff across the 14 organisations), it was not practical for PCaW to meet with every organisation. For several of the smaller Arm's Length Bodies, focus groups were undertaken solely by representatives from RQIA. For the larger Arm's Length Bodies, such as the trusts, PCaW facilitated the focus groups with RQIA in attendance. Within the trusts, focus group sessions were held at several locations. Following a low turn-out at one of the health trusts visited, repeat sessions were again undertaken solely by RQIA staff.

All focus group sessions were structured around a series of basic questions, intended to elicit discussion and thought on the broad themes of the engagement, i.e. perception, understanding, trust and confidence. However, these questions were only the starting point for an informal group discussion, and in most instances the conversation took unique, interesting and sometimes disparate turns. Nevertheless, across sessions, several consistent and strong themes emerged and these are detailed in the body of this report.

In addition to the focus groups, at each site an opportunity was provided for those with experience of whistleblowing to speak to PCaW staff. These experiences have been referenced where appropriate in the main body of this report, but also form the content of Appendix 3, where a number of anonymised case studies focusing on the experience of those involved have been included. A number of case studies were excluded, as individuals were seeking ongoing advice about their particular circumstances and the sensitive nature of such cases prevents inclusion of even an anonymised version of events. The inclusion of the case studies in Appendix 3 were discussed with those involved, and their permission was granted for inclusion in this report.

During the focus group sessions, all staff who attended were asked to write down suggestions on how whistleblowing arrangements could be improved. These suggestions have been collated and are set out in Appendix 2.

Themes and Perceptions

The almost universal perception was that the term whistleblowing was viewed as being a negative label for the process of raising a concern.

The terms 'touting', 'squealing' and 'telling tales' were regularly cited as being linked to the term 'whistleblowing' and for many, these appeared to be inextricably linked to the history of the Troubles in Northern Ireland. Indeed, this theme, while not always explicitly expressed, seemed to touch upon various aspects of the general discussion around whistleblowing. From an outside perspective, this period in Northern Ireland's history seemed to permeate a culture of silence from community level through to the workplace with respect to questioning wrongdoing.

It should be noted, that in no sessions did the question of religious or political affiliation get raised; the relevant issue appeared to be how you were seen to interact with authority in a generalised sense.

It was notable that there was a clear trend with younger workers, who may have been less influenced by this political history, to have slightly more positive views surrounding the issue. Several of this group made comments to the effect that they believed their peers saw whistleblowing/raising concerns for what it was; a necessary ingredient in carrying out your job. Clinicians (especially representatives from nursing and pharmacy) were on the whole, more positive in relation to raising concerns, and a large part of this seemed to be from recent pushes towards a more 'open and honest culture' within their teams. This also appeared to be closely linked to the incident reporting and quality improvement agenda in several of the organisations involved. It was identified that in the medical records and pharmacy departments, which were often held accountable for issues, such as, missing charts or wrong prescriptions, staff had a clearer understanding of the need and process for raising concerns.

There was, however, an interesting nuance to these views. While there was almost universal agreement that whistleblowing was seen negatively, only a small proportion of participants were prepared to ascribe those views to themselves. In other words, they saw whistleblowing as 'doing the right thing', but believed others would see it in a negative light and too often the individual will be seen to be part of the problem. Perhaps this is in part because individuals may have felt uncomfortable expressing a view they felt would paint them in a negative light (i.e. not doing anything about a serious issue they had witnessed). It was also possible that those who attended sessions may not have been a fully representative subset of the work force. Nevertheless, it seemed that there was a clear disjoint between how whistleblowers were actually seen and how they were perceived to be seen.

There was a strong view that the act of whistleblowing resulted in negative consequences for the whistleblower.

The most prevalent negative outcome discussed was that of blacklisting, or general stalling of career prospects. Many participants seemed resigned to the fact that this was in many ways a natural and expected outcome of becoming known as a whistleblower. Equally, however, there was also a fear of retribution, although in many instances it was assumed that this would come from colleagues more than management. In one group, a threat to physical safety to both the individual and their family was discussed; however, this was very much a fringe view.

In several sessions, it was commented on how this fearful view was to a large degree driven by the media's portrayal of whistleblowers' fortunes. Participants referenced how the only stories published were those where the whistleblower had suffered personally and that this in turn built an image that all whistleblowing ended negatively.

In fact, as most participants had no personal or direct experience of whistleblowing, it may well be that the only factor currently driving such a perception of negative outcomes is the media. Where individuals had been involved in whistleblowing (see Appendix 3), the overriding experience was negative, whether as the individual who had reported an issue, or as an accused. There were, however, a small number of participants who had been involved in the investigation or oversight of the whistleblowing process and these individuals had more positive views and better overall understanding of the process.

Understanding of the term 'whistleblowing' was inconsistent, confused and in many cases, wrong.

One of the strongest themes to emerge from the sessions was the almost universal confusion as to what the term 'whistleblowing' referred to. Almost all participants understood it to be some form of raising concerns but the 'how/where/what' varied hugely. There were almost as many variations and combinations as there were groups; however, certain common factors were consistently mentioned during the discussions.

Many participants considered that whistleblowing was only used if the issue being raised was very serious. Others considered that it was when the concern was being raised outside of the organisation (perhaps to the media), and some believed it was when the concern was raised anonymously. A less widespread but still prevalent understanding was that whistleblowing referred to those incidents of reporting which were likely to result in a specific individual being put under scrutiny. Additionally, another common view was that whistleblowing was an option of last resort; a means of raising concerns when all other routes had been tried. Many staff thought that the starting point for whistleblowing would be with a line manager. When asked, very few individuals knew what was in their organisation's policy itself and only one participant had received specific training.

This lack of conviction in what whistleblowing might refer to manifested itself sharply in participants' conception of how whistleblowing fitted in with existing reporting procedures, which is to say what circumstances required whistleblowing as opposed to recording on Datix[31] or serious adverse incident reports[32]. This was of particular interest given that, while most individuals had difficulty differentiating between reporting streams, whistleblowing was seen negatively whereas everything else was just part of the job. This felt like a very significant area of confusion for the participants. Most staff were unable to conceptualise when or how a whistleblowing policy might be invoked.

[31] Datix is the leading supplier of patient safety software for healthcare risk management, incident and adverse event reporting. The software is widely used within both public and private healthcare organisations around the world. - http://www.datix.co.uk/

[32] This sort of confusion was less prevalent in those participants based in non-clinical environments given that they very rarely used the clinical reporting lines. That being said, generally understanding of whistleblowing was actually better in clinical groups as opposed to non-clinical.

Another common, although less pervasive area of confusion, was the difference between grievances and whistleblowing. Even those participants, who claimed to have a better understanding of the distinction, on further discussion, rarely had any confidence in their assertions.

Although there is no specific and universal definition of the term whistleblowing, especially in a complex medical environment where it must interact with multiple other reporting streams, what is important is a degree of consistency in understanding across the workforce. When this misunderstanding of the term is combined with the background of historic influences and the sense of potential negative outcomes, it seems that for the most part, staff would not consider using a whistleblowing process.

It was the view of many of the staff groups that whistleblowing was often seen as a process intended as a safety net for when the usual reporting systems do not work. Without more effort in the communication process, it would seem that there is a dangerous tendency towards a culture of silence. This was despite the view that to report risk or wrongdoing was the right thing to do. This may present a risk that where existing reporting structures do not capture a concern, it may be lost and harm to patients may potentially ensue.

Throughout the sessions, a popular suggestion was to do away with the term 'whistleblowing' given both the confusion and negativity that surrounds it. Unfortunately language does not work like this, and removing a word from internal publications will not stop the public and the media continuing to use it. The risk here is that you entrench negative views towards some of the rarer, but often entirely appropriate, ways of raising concerns. Some participants saw the value in incorporating whistleblowing into the wider family of raising concerns rather than not using it at all.

Some of the group discussions centred on the perception that one of the barriers to raising concerns might be that the issue raised would not be addressed. This results in a sense of futility, therefore discouraging the individual from raising a concern in the first place. There were mixed views expressed around this theme. In many of the discussions about raising an issue with an immediate line manager, there was a sense that the issue would be addressed; however, it was less clear that raising the issue further up the line management chain would be as easy. In a minority of the discussions, the difficulties and problems surrounding other reporting mechanisms, such as Datix, and confusion where raising concerns fits within the system, were mentioned as a more fundamental problem with safety reporting mechanisms in the health service generally.

Knowledge

Although rarely explicitly stated, it was clear that whistleblowing policies were misunderstood and a lack of knowledge about the content of such polices was almost universal.

Almost all participants knew that their trust had a whistleblowing policy and the vast majority could find it if needed. However, very few participants had actually ever read it, knew the content of it, or understood it.

This appeared to be part of a wider trend with respect to policies. A consistent message was that the overbearing number of policies made it impractical to read them all and so policies were only accessed when they were needed. For the majority of participants, this was a satisfactory state of events; however, several groups recognised that this approach presented a problem if the policy was intended to convey messages relevant at a point before things had gone wrong.

Of those that had read the policy, all but a negligibly small number belonged to the following groups:

- their job role meant they had frequent contact with policies
- they had been in a situation in which they believed the policy applied
- they had read it in preparation for the focus group

Of those that had not seen the policy, there was usually little idea of what it might contain. Commonly, it was suggested that the policy allowed a worker to contact someone higher in the line management chain where their concerns had not been dealt with by direct management. Some participants suggested that the policy might contain a list of individuals who could be approached with concerns, although there was generally little idea how this might extend outside of the line management chain.

Where a policy only fulfils its function when actively sought out by workers, it naturally follows that it does not serve that function if individuals are unaware of when it might be relevant to their situation. This is obviously the case with respect to the widespread confusion as to what whistleblowing refers to (see above) but also relevant where there is little conception of what the policy might contain. Most of the organisations' policies contain commitments about protection of whistleblowers, options for raising concerns outside of line management and assurances that their concerns will be properly investigated. These messages will be of no use to staff who make their decisions not to access the policy because they are: scared of the consequences; do not consider their line manager an appropriate contact; and do not believe their views will be valued.

It is of note that only one individual advised of receiving any training on the issue of whistleblowing. This was provided by the Royal College of Nursing as part of an external training resource, as opposed to being part of any in-house training module.

Outside of the line management chain, where experiences were generally positive, knowledge of other forums for raising concerns was sparse.

Most participants mentioned their line manager as the natural starting point for raising a concern they may have. Several groups touched upon the challenge involved in escalating an issue to the line manager's line manager. This was seen to be problematic as the senior manager may well have a personal relationship with the line manager. Indeed, multiple participants told us of circumstances where an issue that had been escalated had been passed straight back down to the line manager, rendering the escalation beyond the line manager not only pointless, but also problematic and potentially confrontational. When asked, several line managers involved in the focus groups had negative attitudes toward the concept of being circumvented by those staff members they manage. Lack of knowledge of the routes open to staff through whistleblowing arrangements was as prevalent among managers as it was with those with no management responsibilities.

Most commonly, staff referred to Human Resources (HR) as an alternative to the management line. A point of contact in Risk and Governance was also suggested, and when put forward as an alternative; some participants saw value in this idea. Likewise a role with independence was often suggested by participants, such as a Board member or a Non-Executive Director, but only with some prompting beforehand.

Many participants mentioned their union as a possible alternative for raising concerns, although in discussion it was recognised that unions may not be able to deal with the issue themselves. In the course of a couple of sessions, union representatives commented on how the unions were perhaps poorly placed to deal with concerns raised with them. There may be a conflict of interest relating to those accused in some matters, as well as the fact that they would be looking to protect the worker, not deal with the concern raised.

It was particularly surprising how little the regulators within the sector, RQIA and NISCC, were proposed during discussions as a forum for concerns. Even where they were cited as a body that could be approached in the organisation's whistleblowing policy, there was generally confusion as to how this might be achieved. This seemed to be a distinct gap in reporting structures.

There was a strong and consistent message from participants that the media had little role to play in getting concerns dealt with effectively. A number of media shows and personalities were the subject of particular comment and criticism. Several participants commented on how the media's agenda of entertainment rarely aligned with the whistleblower's aim to get problems solved, and that this often resulted in a lack of responsibility and proportionality when handling the issue.

Although the topic was only covered in a small number of sessions, it appeared as if there was a complete lack of knowledge that there was legislation protecting whistleblowers from detriment, or any legal element to the protection of those who raise concerns within the workplace. Hence there was a very low awareness of the Public Interest Disclosure Order 1998.

Trust and Confidence

The only consistent message from the groups on how whistleblowers could be protected from negative consequences was by the protection of their identity.

Generally, the only way that participants felt they could be protected, was by their identity not being associated with the concern. There was confusion around the difference between a concern being raised anonymously (where no-one knows who it is that has provided the information) and confidentially (where one or more individuals know the identity of the whistleblower but protects that identity during the course of the investigation).

Views were mixed on whether confidentiality would be respected by those handling the concern. One prominent view was that confidentiality in the Northern Ireland's health service didn't really exist; communities were too closed and interlinked. Several participants commented on how multiple members of a family might commonly work in the same unit or the same trust, and so the likelihood of the 'rumour mill' operating to uncover the identity of the person who raised the concern, was considered to be very high.

For many, the option of confidentiality was seen to be a desirable element of protection for staff that raised a concern; they commented on how they had no reason to believe that managers wouldn't protect their confidence in these situations.

It was stated consistently from those tasked with handling investigations, that in most instances, it was almost impossible to investigate anonymous concerns. Additionally, those involved in a number of investigations advised that anonymous concerns can be extremely damaging to team morale.

From this perspective, it appeared that raising concerns anonymously was appealing from a protection point of view, but it was not generally an effective way of getting problems dealt with. Furthermore, one individual who contacted PCaW talked passionately about the effect that anonymous concerns can have on the wider workforce and the potential for them to be used vexatiously. This participant described how a series of anonymous disclosures had bred a culture of paranoia and had eroded staff confidence.

In response to how whistleblowers can be protected, participants rarely suggested that managers have a role to play.

Very few participants put forward the idea that the actions of management played a role in protecting whistleblowers from victimisation. That said, once the idea was put to groups, individuals generally agreed that managers could directly support the whistleblower. Generally, it was suggested that the best way this could be achieved was by being seen to take firm action against those who victimised whistleblowers, rather than actually being able to stop the victimisation in the first place.

Many participants commented on how this no tolerance approach needed to extend to management, especially in cases where no action had been taken by them after a concern had been raised.

While staff having confidence that their concerns will be dealt with is an important piece of the puzzle, several groups commented on how it was also important to have confidence that the receiver of concerns would not overreact. This formed the basis of some discussion in several of the groups interviewed, particularly in relation to minor issues raised anonymously. It was felt that there could sometimes be a lack of proportionality when the whistleblowing policy had been invoked, and those accused in these circumstances were subsequently not sufficiently supported. This was a theme that was raised at several of the groups and at different organisations. There is clearly a need for proportionality and fairness for those accused of wrongdoing, as well as for the individual raising the concern.

Participants regularly commented on how the most common aim of the whistleblower was to have the concern addressed and not for there to be serious repercussions for staff or the unit. A fear of unnecessary repercussions was highlighted as a factor which may prevent people from highlighting concerns.

Generally participants were confident that if they raised serious issues with their managers then they would be dealt with.

In some groups, however, there was an understanding that this might not be so true of concerns that were linked to funding, such as understaffing.

Several non-senior auxiliary staff that attended the focus groups, expressed doubts as to whether they would be listened to if they raised concerns. This could be a missed opportunity, given that these staff are very much the eyes and the ears of the organisations, and will often be the first to observe any problems.

Conclusions

From the outcomes highlighted in this section of the report: the combination of a lack of understanding around what is contained within whistleblowing policies; a fear of negative repercussions; and a sense that raising a concern may be futile; do not facilitate effective whistleblowing arrangements.

The review team considers that as a minimum, training or awareness raising sessions should be developed to improve staff awareness and understanding of the whistleblowing process, together with communication focusing on how the whistleblowing policy is more than a safety net for other every day reporting mechanisms. Furthermore, it should be considered whether work can be done at an organisational level, to make potential whistleblowers feel supported and protected, reducing the reliance on anonymity for safety.

It is to be hoped that such work may go some way to normalising the whistleblowing process and overcoming the existing staff perceptions and misunderstanding of whistleblowing.

2.5 Meetings with Senior Teams

As part of the review, the review team met with senior managers from each of the organisations, who had responsibility for oversight of whistleblowing arrangements. The discussions focused on the operation of their respective whistleblowing arrangements and what could improve whistleblowing across health and social care. The discussions were very constructive and form the basis of the conclusion section of this report.

2.6 Stakeholder Event

In April 2016, as part of the review methodology, RQIA hosted a stakeholder event which was themed 'Raising Concern, Raising Standards'. It provided an opportunity for a range of staff working across different HSC organisations to discuss the initial findings from the review, identify arrangements for whistleblowing in other jurisdictions and discuss potential next steps that may be included in the final report.

During the event, one reviewer shared their own personal experience of being involved in a whistleblowing case; a representative from the Scottish Government outlined the development and current arrangements for raising concerns in Scotland; PCaW presented the initial findings in relation to the assessment of the whistleblowing policies and the staff engagement; finally, the review team presented the initial findings from the review.

Participants discussed the findings with members of the review team and were also involved in group discussions regarding next steps, in relation to:

- changing culture within organisations
- arrangements for recording and reporting concerns
- future oversight arrangements

Changing Culture within Organisations

Participants accepted there was a need to change the culture within organisations in relation to raising concerns. As the organisations were fundamentally different, a single solution would not fit. Some participants proposed that the equality and diversity agenda may be a suitable mechanism to facilitate this.

It was acknowledged that further clarity on raising concerns needs to be provided for staff. This could be achieved through improved communication about raising concerns and training for all staff within the organisations.

Participants suggested that more advertising and promotion of raising concerns was needed, such as, posters or campaigns to increase awareness. Encouragement and praise would also be required to demonstrate the positive outcomes of raising concerns. This should be supported by a more visible demonstration of management's commitment to raising concerns.

Participants all understood that changing organisational culture was a huge task, and would not be achieved immediately. However, implementing some of the areas they proposed would be an initial step in the right direction.

Arrangements for Recording and Reporting Concerns

Participants felt this was an area that could not be solved in a single workshop, due to its complexity. However, they proposed many very sensible and useful suggestions.

Putting in place appropriate mechanisms for recording and reporting was acknowledged as a task which would require input from all stakeholders. Given the size and complexity of the different organisations, it was recognised that the mechanism may be different for each organisation.

In relation to what, when and how often things should be recorded and reported, participants considered that individual organisations and stakeholders would have to determine how this was taken forward. Key areas for further discussion and development were proposed, such as:

- formal or informal reporting and the exceptions
- differentiating between concerns and other issues, such as, grievances or complaints
- methods of raising concerns and how these are captured
- internal or external reporting and the mechanisms to achieve this
- lessons that could be learned from the concerns raised and how this could be shared

Participants highlighted that there are many existing mechanisms for recording and reporting activities throughout all organisations. Rather than invent something new, existing mechanisms should be considered as possible ways to support recording and reporting of concerns. Learning arising from appropriate recording and reporting of concerns should be shared throughout the organisations.

Future Oversight Arrangements

During the stakeholder event, presenters outlined the details of the oversight arrangements for raising concerns in England and Scotland. Participants then discussed the merits of the different arrangements within the context of Northern Ireland.

In conclusion, it was acknowledged that oversight arrangements for whistleblowing already exist in Northern Ireland, through DoH. Participants considered that some clarity on any proposed oversight arrangements was required, to determine what they were designed to achieve. It was proposed that rather than setting up new bodies or developing new arrangements, existing arrangements should be revised to ensure they provide appropriate outcomes in relation to raising concerns.

Participants acknowledged that much work was required in relation to setting up appropriate arrangements and mechanisms for raising concerns, which would require input from all stakeholders.

Section 3 – Conclusions and Recommendations

3.1 Overall Conclusions

Policy Development

Throughout the review, a recurring theme was the use of the term whistleblowing. Whistleblowing was universally seen as a very negative term, which was not helped by the media's portrayal of cases of whistleblowers. Focus groups highlighted that the only stories published seemed to be those where the whistleblower had suffered personally, creating an image that all whistleblowing ended negatively. There was also confusion as to what the term actually referred to; some staff considered that it was only whistleblowing if the issue being raised was very serious or was being raised outside the organisation. Other staff considered that whistleblowing was about something that involved criminal wrongdoing such as fraud, rather than being about a patient safety concern. There was also confusion as to where whistleblowing fitted into existing reporting procedures such as incident reporting. Focus group participants saw incident reporting as just part of their job but were not really aware as to when their organisation's whistleblowing policy might be used.

In his review of whistleblowing in the NHS, Freedom to Speak Up, Sir Robert Francis gave consideration to recommending that the term whistleblower should be dropped. Even though there were reservations about its continuing use, he had been persuaded that the term was now so widely used that removing it would not succeed. PCaW considered that removing a word from internal publications would not stop the public and the media from using it. There is a danger that the word may shift its meaning to denote only those rarer forms of raising concerns, which may only further entrench the stigma towards whistleblowing.

The review team is aware that removing a single word from the vocabulary of HSC policy will not automatically lead to an improved culture of raising concerns. However, they consider that in light of the overwhelming negative view of the term whistleblowing and the fact that it might be actively preventing proper reporting of the full range of concerns, it should not be the main title of any policy in relation to raising concerns, as this immediately takes the reader to the end point of what should be a spectrum of raising concerns.

All organisations subject to the review had a whistleblowing policy in place. Although a number had been updated, it seemed that most policies were based on guidance provided by DHSSPS in February 2009. In its review of existing HSC policies, PCaW considered that a number were overly legalistic and tended to use language associated with handling of complaints or grievances, which is not conducive to encouraging staff to use the policy.

The review team considers that whistleblowing is only one step along a continuum or spectrum of raising concerns and may be seen as the end point of raising a concern. Concerns are raised and dealt with daily and most may be resolved quickly and informally. However, for more serious concerns, there needs to be a more formal process. The process needs to provide clarity to the person raising the concern as to what will actually happen next, to how they will be kept informed of progress, and eventually how they will be informed of the outcome as a result of their raising a concern. Any policy should reflect the reporting of both formal and informal concerns and should culminate in providing advice about other organisations a member of staff may go to when they feel it is appropriate. The policy should also easily distinguish between raising concerns and incident reporting and act as a signpost as to where concerns would be best addressed.

The review team considers that the first step in encouraging the normalisation of raising concerns is the development of a model policy for Northern Ireland that reflects current thinking. The policy should consider the negative connotations associated with the term whistleblowing and take account of the whistleblowing code of practice and recent policies such as the Department of Finance and Personnel Whistleblowing Policy[33] and the new policy – Freedom to Speak Up: raising concerns (whistleblowing) policy for the NHS, which was developed following the Robert Francis Review[34].

The review team considered feedback that indicated that a one size does not fit all and one policy would therefore not be the best way forward; however, this approach has already been taken in both England and Scotland and the review team considered this would be the best approach for Northern Ireland. It should be emphasised that all organisations could individualise the policy to take account of their particular situation.

The review team has made recommendations for improvement to the arrangements to whistleblowing across health and social care. The recommendations have been prioritised in relation to the timescales in which they should be implemented, following the publication of the report:

- Priority 1 - completed within 6 months of publication of report
- Priority 2 - completed within 12 months of publication of report
- Priority 3 - completed within 18 months of publication of report

Recommendation 1	**Priority 1**
The Department of Health should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary.	

[33] Department of Finance and Personnel – April 2011 - https://www.dfpni.gov.uk/publications/dfp-whistleblowing-policy
[34] Freedom to speak up: raising concerns (whistleblowing) policy for the NHS - April 2016 - https://improvement.nhs.uk/uploads/documents/whistleblowing_policy_30march.pdf

Effective Leadership

All organisations provided evidence of having extensive governance arrangements in place, with some demonstrating good integration with quality improvement and organisational learning programmes.

There was an awareness of the need to create an open and honest culture, and many organisations demonstrated their understanding of the need for visible leadership. A number of methods were used to achieve this, with senior management and board member walk rounds being the most popular. Other methods included staff open forums where senior staff were available to listen to staff concerns. In one organisation these concerns were logged in order to try to facilitate feedback. This was considered to be a very positive development which also led to better feedback to those who raised a concern.

A learning and development steering group has been developed in an organisation, chaired by a non-executive board member, which discusses concerns and uses scenarios to elicit learning which is then passed through the organisation.

The review team considered that these were extremely positive steps but that further development in this area was necessary. The review team also considered that it was important to assess the effectiveness of any developments in this area.

Recommendation 2	**Priority 1**
All organisations should develop or continue to develop and support behaviours which promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	

Reporting to organisational boards is also an important step in assuring that raising concerns is seen as an integral piece of organisational governance. It was unclear to the review team that this was happening to any great extent and it seemed to be very much left to individual judgement as to what was or was not reported.

The very extreme examples of what would ordinarily be termed whistleblowing would be brought to boards, but the review team considered that the principle of normalising raising of concerns had not yet become part of day to day practice.

Concerns that had not reached a particular threshold were not being recorded or passed up the chain to organisational boards. However, there were areas of good practice where service users and employees were offered the opportunity to attend board meetings to report on their experiences.

To ensure further development in this area, the review team considered that a non-executive board member should be appointed to have responsibility for overseeing the culture of raising concerns within each organisation.

Recommendation 3	**Priority 1**
Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.	

Staff Training and Awareness

Policy development and leadership are important steps in development of a culture that openly normalises the raising of concerns, making it part of day to day business. Staff awareness and ability to understand and be comfortable with the process of raising a concern are also vital components of any system.

On the positive side, both the HSC and RQIA surveys indicated that a large percentage of staff knew their organisation had a whistleblowing policy in place. The HSC survey also reported that the majority of staff (80%) would be confident to speak up and raise a concern. The majority of staff responding to the RQIA survey would feel comfortable in approaching their line manager to raise a concern (80.9%).

However, a lesser percentage (65%) of respondents to the HSC survey indicated that they felt their organisation would handle their concern appropriately. 55.4% of staff who responded to the RQIA survey had confidence that their organisation would carry out a robust investigation of any concern they might raise and only 52.5% would feel comfortable reporting a concern to a senior member of their organisation. This identifies that approximately one third of staff responding to the HSC survey feel their organisation would not handle their concern appropriately.

841 members of staff who had raised a concern within their organisation responded to the RQIA survey. 477 (56%) of these respondents considered that their concern had not been dealt with appropriately and 572 (68%) had not referred to the organisation's whistleblowing policy. 372 (44.2%) considered that they had suffered detriment as a result of raising that concern.

While the survey numbers are small, the results indicate that although staff are aware of whistleblowing policy and procedure, a number are not confident that if they raised a concern it would be dealt with appropriately. Of those who had raised a concern, over half felt their concern had not been dealt with appropriately.

The majority of staff attending focus groups were also aware of the existence of a whistleblowing policy but few were aware of what it contained. However, once again staff felt confident about approaching their line manager.

It was noted that several non-senior auxiliary staff expressed doubt as to whether they would be listened to if they raised concerns.

It was identified that many staff had a limited understanding of whistleblowing and the associated process for raising a concern. If advice and support was readily available to them, this may have increased the number of concerns raised.

A whistleblowing helpline has been established by the Department of Health in England. The helpline is provided free of charge, staffed by specially trained advisors and provides advice to individuals at all stages of the spectrum of raising concerns, from those thinking about speaking up to those who have suffered as a result.

On 2 April 2013, The Scottish Government, in its response to the Francis Report, launched The National Confidential Alert Line for NHS Scotland. This helpline was managed by PCaW, and was designed to provide a safe space where staff could raise concerns about patient safety and malpractice. Staff could also obtain advice and support if they felt they had been victimised as a result of whistleblowing. Following what was considered to be a successful pilot, the Confidential Alert Line was continued after receiving further funding.

To demonstrate a commitment in relation to raising concerns within Northern Ireland, the review team considered that DoH should establish a pilot confidential helpline. The helpline should provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland.

In line with the Scottish approach, the helpline could be run as a pilot for a period of at least one year, with an evaluation prior to the pilot finishing to decide whether or not to continue with it. Data from the calls should be used in the evaluation and also to support learning.

Recommendation 4	**Priority 1**
The Department of Health should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	

All senior staff reported that the whistleblowing policy formed part of a staff induction process. The policy was then made available on organisational intranets. Other methods of raising staff awareness included a Raising Concerns Booklet, staff notice boards, posters and screensavers on employee computers.

One organisation is currently developing an e-learning package for staff, and another had developed a training package to be delivered across middle management which will place an emphasis on “ringing bells” rather than “blowing whistles”, in order to decrease the negativity around being seen as a whistleblower. These were seen by the review team as positive developments.

However, beyond this no further training or awareness sessions were carried out and no organisation tested staff awareness on an ongoing basis. It was also unclear as to the level of training provided for line managers and all other managers with responsibilities outlined in whistleblowing policies.

The review team considered that for a system of raising concerns to work effectively, awareness training needed to be available for staff in how to raise concerns but also in relation as to how raising a concern fits in the overall governance process, including incident reporting complaints etc. For operational staff, this could indeed be part of induction but needed to go further than just being made aware of the existence of a policy. Managers need to be provided with the competence and confidence to enable them to respond to and address concerns raised with them.

Specific training also needs to be available for all staff involved, including managers, in the operation of the process for raising concerns. The review team considered that following development of any new policy, awareness training and bespoke training in relation to raising concerns should be developed for staff. This work may involve utilising existing training resources or the development of new e-learning packages.

Recommendation 5	**Priority 2**
Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	

Recommendation 6	**Priority 2**
All managers should receive bespoke training in the operation of their policy for raising concerns.	

As well as the provision of training, assessing the effectiveness of any training provided is also important. One method of assessing staff awareness of raising concerns and the effectiveness of any training provided is through staff appraisal. Appraisal also provides an opportunity to emphasise to staff, the importance to the organisation of raising concerns. The review team discussed appraisal rates during meetings with senior teams.

Appraisal rates in the small organisations were mainly good; however, appraisal rates in the larger organisations varied between 42% and 80%. It is not uncommon for smaller organisations to have a higher appraisal rate than in the larger organisations; however, the review team considered that appraisal rates in some organisations were very low and efforts should be made to increase the uptake of staff appraisal.

Recommendation 7	**Priority 1**
All organisations, particularly where appraisal rates are low, should work towards raising the uptake of staff appraisal.	

Organisational Oversight

One of the recommendations of the Freedom to Speak Up review was in relation to where responsibility for the daily oversight of the process for raising concerns should be situated. In the majority of organisations in the United Kingdom, responsibility lies with the HR department. However, the Francis review questioned as to whether this was appropriate. HR may be seen as threatening, as it is the department that will take the lead in grievance processes and processes to deal with poor performance. The Francis report made the recommendation that:

“To reinforce the concept of raising concerns as a safety issue, responsibility for policy and practice should rest with the executive board member who has responsibility for safety and quality, rather than human resources”.

A number of organisations reported that having whistleblowing under the responsibility of HR worked well for them, and saw no reason to change. Some of the smaller organisations may also see any change being difficult as a result of their size. There is logic, however, that if the raising and reporting of concerns becomes part of everyday culture, responsibility may best sit elsewhere within governance reporting structures. This would then allow HR departments to become more independent when it comes to any concern that required further investigation.

The review team does not feel that it can be prescriptive as to where responsibility is best placed, but would recommend that when a new policy is developed, consideration should be given as to where best responsibility for oversight sits.

Recommendation 8	**Priority 1**
All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	

Effective Feedback

One of the principles contained in the Whistleblowing Code of Practice is that a member of staff who has raised a concern should be told, where appropriate, the outcome of any investigation. The Freedom to Speak Up report also considered that feedback was an important part of the process.

The review team considered that any change in practice/procedure should take place at both an operational and an organisational level. The review team was told that organisations mostly did not record concerns and also did not feedback what action was taken as a result of raising a concern. That is not to say that there was no feedback at all, and several organisations described multiple feedback methods including newsletters, staff briefings and learning reports. One organisation, perhaps as a result of previous incidents, had a more developed culture of raising concerns, was reflecting these on risk registers and when resolved, feeding back to those involved in raising the concern.

Any method of feedback is to be supported, but feedback to individuals is essential. Using the mediums described did not emphasise that learning and any change in practice, was as a result of reporting a concern. The review team also considered this would be an important step towards normalising the raising of concerns.

Recommendation 9	**Priority 1**
All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	

Local Advocates

The Freedom to Speak Up report suggested that organisations develop local champions in relation to raising concerns. The functions of a local champion included:

- ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels
- intervene if there are any indications that the person who raised a concern is suffering any recriminations
- work with HR to address the culture in an organisation and tackle the obstacles to raising concerns

An example of the development of local champions is the appointment of advocates in relation to raising concerns in Guys & St Thomas' NHS Foundation Trust.

The role of an advocate in the trust is one of support for members of staff who wish to raise concerns and to help them to determine the most appropriate way for their concern to be dealt with. In their role profile, advocates "provide immediate support and signposting for staff members raising concerns, determining the best course of action and advising the staff member of their options. It is not envisaged that the Advocate would take on the concern but rather support the staff member to effectively raise their concern, where appropriate, or seek an alternative course of action."

The review team considered that the development of advocates at a number of levels, especially in larger organisations, may contribute to development of a more open culture in relation to raising concerns.

Recommendation 10	**Priority 2**
All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	

Independent Oversight

The Freedom to Speak Up review recommended that an Independent National Officer be appointed, with functions that include:

- reviewing the handling of concerns raised by NHS workers where there is cause for concern in order to identify failures to follow good practice
- advising the relevant NHS organisation, where any failure to follow good practice has been found, to take appropriate and proportionate action, or to recommend to the relevant systems regulator or oversight body that it makes a direction requiring such action
- acting as a support for Freedom to Speak Up Guardians
- offering good practice advice about handling concerns
- publishing reports on the activities of the office

The Scottish government has also committed to the development and establishment of an Independent National (Whistleblowing) Officer, to provide an independent and external review on the handling of whistleblowing cases.

The topic of whether or not Northern Ireland should have such an oversight body was discussed during a number of organisational meetings and also at the stakeholder event. The consensus of opinion seemed to be that due to the scale of the system in Northern Ireland, there was no need for such an appointment and the review team agreed with this point of view. However, the review team considered that there should be some ongoing oversight at an operational level as to whether processes for raising concerns were effective.

RQIA carries out reviews and inspections in acute hospitals, assessing them against the domains of safe, effective, compassionate care and well-led. The review team considered that progress in relation to normalisation of raising concerns may be included as part of the well-led domain of the RQIA regulatory process. This would provide assurance in the larger trusts, and DoH should consider how this could be taken forward in the smaller Arm's Length Bodies.

Recommendation 11	**Priority 1**
RQIA should include progress in relation to normalisation of raising concerns in the well-led domain of its regulatory programme.	

All organisations recognise that raising concerns is one essential element of an open and transparent culture. All organisations felt that they had an open and transparent culture but were unclear as to what evidence could be produced to substantiate this claim. All organisations quoted the results of the HSC survey and a number quoted having gained Investors in People as measures that all was well with the culture in their organisation. These are positive developments and not to be underestimated, but are quite high level measurements.

Evidence from this review suggests that while many staff do raise concerns, a significant minority do not, for a variety of reasons, including feeling that nothing will be done and fear of reprisal. The review team considered that most organisations had not effectively promoted raising concerns or looked for evidence of the effectiveness of their strategies.

Northern Ireland has a very low level of whistleblowing, and again, organisations used this as another measure of demonstrating that all is well. The lack of whistleblowing cases may indeed reflect that systems are working effectively; however, it may also be evidence that the system is not working at all. The reason for a very small number of cases may be that staff do not have confidence that there will be positive outcomes for them or their organisation, as a result of raising a concern.

What should be reported and recorded in terms of raising concerns was also the subject for much discussion during organisational visits and also during the stakeholder event. It is accepted that not every conversation that takes place between a line manager and a member of staff needs to be recorded; however, there must be a threshold beyond which a concern should at least be recorded in the system.

Identifying a threshold for recording concerns will enable better monitoring of trends and will help to normalise the raising of concerns, which could contribute to a more open and honest culture.

It would also:

- facilitate the process of feedback to staff who have raised a concern
- enable outcomes, in terms of change in practice, to be demonstrated

Such feedback has the added advantage of making staff feel valued and helps them to understand what they do actually matters. It again has to be emphasised that it is not the intention of this review to create yet another industry around reporting and recording of concerns.

Organisations already have strong governance processes in place and raising concerns should become part of normal day to day governance. Awareness raising for all staff and training for managers should provide them with the skills to assist with the process.

Due to the diverse nature of the organisations, it is very difficult to make specific recommendations aimed at developing an open and honest culture. This is something that organisations must develop themselves. Organisations must also identify ways of demonstrating that they are working towards developing such a culture that fits their particular circumstance. All organisations must also decide what level of recording and reporting they feel is appropriate for them. The review team considers that it is not acceptable for organisations to assume that a low level of raising concerns is positive. They must each 'test the silence' using a range of metrics and indicators to build a picture of the 'health' of individual directorates/divisions/departments. This will provide assurance as to whether the process of raising concerns is working well in their organisation.

The review team understands the difficulty in prioritising raising a concern/ whistleblowing when it is competing against a wide range of other priorities. It may be that there are low levels of concerns in Northern Ireland. However, if these small numbers are not treated appropriately, then many more staff will learn from this negative experience that it is better not to speak up.

Culture change will not occur overnight and striving for a true open and honest culture is an ongoing and perhaps never ending process. Normalising the reporting of concerns is only one building block of an open and honest culture; however, it can be an important issue in terms of patient safety.

This report and the recommendations contained within it are designed to create a framework where all staff understand the need to report appropriate concerns and feel totally comfortable raising those concerns.

RQIA wishes to thank the management and staff from the HSC organisations for their cooperation in taking forward this review, and the contributions from the other stakeholders for their input.

3.2 Summary of Recommendations

The recommendations identified during the review have been prioritised in relation to the timescales in which they should be implemented.

Priority 1 - completed within 6 months of publication of report
Priority 2 - completed within 12 months of publication of report
Priority 3 - completed within 18 months of publication of report

Implementation of the recommendations will improve the arrangements for raising concerns.

Number	Recommendation	Priority
1	The Department of Health should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary.	Priority 1
2	All organisations should develop or continue to develop and support behaviours which promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	Priority 1
3	Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.	Priority 1
4	The Department of Health should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	Priority 1
5	Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	Priority 2
6	All managers should receive bespoke training in the operation of their policy for raising concerns.	Priority 2
7	All organisations, particularly where appraisal rates are low, should work towards raising the uptake of staff appraisal.	Priority 1
8	All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	Priority 1

9	All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	Priority 1
10	All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	Priority 2
11	RQIA should include progress in relation to normalisation of raising concerns in the well-led domain of its regulatory programme.	Priority 1

Appendix 1 - Abbreviations

CQC	- Care Quality Commission
DHSSPS	- Department of Health, Social Services and Public Safety
DoH	- Department of Health
HR	- Human Resources
HSC	- Health and Social Care
INO	- Independent National (Whistleblowing) Officer
NAO	- National Audit Office
NHS	- National Health Service
NISCC	- Northern Ireland Social Care Council
PCaW	- Public Concern at Work
RQIA	- Regulation and Quality Improvement Authority
Southern Trust	- Southern Health and Social Care Trust

Appendix 2 – Staff Suggestions from Focus Groups

At the end of each focus group, participants were asked to propose some suggestions as to how their organisation could improve its whistleblowing arrangements. Those suggestions that were in effect a differently worded version of the same idea were grouped under a common heading. Furthermore, in processing the data captured, suggestions were grouped together in certain themes.

What follows is a summary of the findings.

Top Suggestions	
Training (no further specification)	33
Training for management	12
Mandatory training	11
Awareness, improvement through posters etc.	11
Assurances for confidentiality	9
Use different term	7
E-learning	6
Interactive awareness/workshop sessions	6
Independent whistleblowing contact in the trust	5
Talk about whistleblowing in team meetings	5
Flowchart/poster to show channels in raising concerns	4
Publication of positive outcome whistleblowing/reporting of number of cases	4
Feedback for whistleblower	4
Better support for whistleblower	4
Shortening investigations/clear-cut timeframes	4
Increase awareness of policy	4

Over 40% of all suggestions related to the need for training around whistleblowing.

While this was a huge finding, when considered alongside the findings of the main staff engagement report, it is perhaps not that surprising. It was clear that throughout the sector there was a lack of knowledge and understanding around the core principles of whistleblowing, right down to what the term even refers to. As a means of educating staff, training is the obvious solution to this problem.

Of those suggestions captured under the theme of training, there were some consistent more specific suggestions. The most common of the specific ideas (29%), was that there should be specific training for management around whistleblowing. This suggestion seemed largely borne out of the gross negative effect that management can have on the system if they don't handle instances appropriately. Many participants suggested that training should be mandatory, although many people felt that this would be unworkable, given the already large amount of training that needed to be undertaken.

One proposal that made up 15% of the training suggestions was to have compulsory e-learning. Several participants spoke of how this was a manageable and often quite effective way of conducting training.

The second most common grouping of suggestions related to ways in which management communicated to the staff body – i.e. management messaging.

Interestingly, similar to training detailed above, these sorts of suggestions also related to the way in which staff could be educated about whistleblowing. The most common suggestion (42%) in this category was a poster campaign designed to improve awareness around whistleblowing. Another popular idea as to how information on whistleblowing could be communicated was via a regular slot in team meetings. Many participants felt that this may normalise the process.

Another idea that was repeated on several occasions was to have flowcharts posted in wards detailing options for raising concerns, and in what order they should be attempted. Not all suggestions in this grouping related to informing staff of the arrangements for whistleblowing. It was also considered by some participants that management messaging could be used as a way to improve trust and confidence in the organisations whistleblowing arrangements. The most popular of these suggestions was for the organisation to publicise successful instances of whistleblowing where the problem was solved and the whistleblower unaffected. Many participants questioned the feasibility of this given various duties of confidentiality; however, the benefits of countering the media's overwhelming negative portrayal were seen to be a very worthwhile goal.

How concerns are handled (15%), points of contact for raising concerns (8%) and the term *whistleblowing* itself (6%), were all also popular topics.

Approaches to improving handling were mainly directed at improving things for the whistleblower. This made up 88% of the suggestions in this group, and this aim was evenly split between better protection of the whistleblower's identity (to avoid victimisation) and better support for the whistleblower. In the former category the prevalent view was for greater assurances around confidentiality, whereas in the latter sub-group, views were spread across better support, feedback for the whistleblower and shorter, or better time framed, investigations. Generally, this was slightly out of step with the views expressed in the sessions themselves, where protection of identity was often seen as the only way of making things better for whistleblowers. This might reflect the fact that participants had just not thought of other ways the organisation could improve measures, and that once this was put to them they saw the value in it.

Very often in the focus groups, there were discussions about what, if anything, to do with the term whistleblowing, given the negativity that surrounded it.

This unsurprisingly manifested itself in a significant proportion of participants putting forward suggestions related to this. The vast majority of suggestions were to change the name as means of escaping the stigma, although some participants suggested that a better route was to try and normalise it.

The majority of suggestions (71%) related to points of contact were for more internal options. The most common of these was for an independent whistleblowing contact within the organisation who sat outside of the line management chain.

Although a much smaller share of the total suggestions, many participants also put forward suggestions relating to the organisation's policy (5%) and the advice available to whistleblowers (3%).

Training		Points of contact		Messaging		Handling		The term		Advice		Policy		Other		
Mandatory training	11	Independent whistleblowing contact in the trust	5	Awareness improvement through posters etc	11	Joined up policy for incident reporting	1	Use different term	7	Independent source of advice	3	More accesible policy	3	Online system for raising concerns	2	
E-learning	6	Independent reporting contact outside of the trust	2	Flowchart/poster to show channels in raising concerns	4	Gateway teams' for handling whistleblowing concerns	1	Increase use of the term to familiarise/normalise it	3	Better awareness of advice available	1	Forced reading of policy	1	Cross-trust investigations	1	
Training for management	12	Senior management more visible / drop-in	2	Encourage staff to raise concerns	2	Improving audit of existing reporting arrangements	1	Better understanding	1	For managers	1	Simplified policy	1	"Have no fear of repurcussions for whistleblowing"	1	
Interactive awareness/worksh op sessions	6	Make reporting to senior management more straight forward	3	Talk about whistleblowing in team meetings	5	Assurances of confidentiality	10			On site advice	1	Increase awareness for policy	4	Responsibility for whistleblowing devolved to invidividual departments	1	
Training on policy	2	Independent external body that can mediate	1	Publicisation of positive outcome whistleblowing / reporting of number of cases	4	Feedback for whistleblower	4							Independent panel within trust to investigate whistleblowing concerns	2	
Training to complete at home	1	Making contacting RQIA easier	1			Better support for whistleblower	4							Code of practice for management in dealing with concerns	1	
Training on distinguishing from other reporting lines	1					Shortening investigations / clear-cut time frames	4							Discipline managers who breach confidence	2	
Training for investigators	1					Guaranteed anonymous way of raising concerns	2							Improve confidence in reporting	1	
Induction training	1															
Training (no further specification)	33															
	74		14		26		27		11		6		9		11	178
	41.57%		7.87%		14.61%		15.17%		6.18%		3.37%		5.06%		6.18%	100.00%

Appendix 3 – Case Studies

During each day of focus groups, an opportunity was provided for those with first-hand involvement of whistleblowing to talk with PCaW directly, so that their experiences could be included within the report.

There were several stories which PCaW felt, given the sensitivity of the case, would not be appropriate to include. This was due to a risk that the individual would be identified by the nature of the facts and their situation could potentially be made worse.

Of those stories that PCaW felt could be anonymised, a selection of these case studies have been detailed below. In addition to telling the individual's unique story, while still retaining the spirit of the experience, the case studies demonstrate some of the more general challenges faced in getting whistleblowing arrangements right.

Potential Consequences

Several participants spoke about the potentially damaging, and unnecessary effects that whistleblowing can have on their own personal circumstances. One of these stories highlighted the stark contrast between the positive change that the person was trying to make and the eventual personal cost that they had to endure.

An individual advised of raising serious concerns about another colleague, who apparently in a fit of temper, had shouted, man-handled and took away the belongings of a patient who had severe pre-existing anxiety issues. The whistleblower took the concerns to their manager, but fearing a reaction from the staff member implicated, had requested that their identity be kept confidential.

Confidentiality was not maintained and the disclosure eventually made its way back to the guilty party, who apparently then proceeded to manipulate the team against the individual who raised the concern. The individual advised that trusted colleagues turned against them, resulting in the individual suffering stress and distress, and subsequently having to take time off work. The individual described in vivid terms how their health, both physical and mental, deteriorated as they tried to cope with the circumstances.

Although the individual was back in employment and generally recovered, they described the intense anger they had towards the way that their manager had handled the incident. The lack of confidentiality resulted in challenging times for the whistleblower, and a presumed knock-on effect of fear, for anyone who might think of raising a concern in the future.

Anonymous Concerns

During a one-to-one session, a participant described their experiences of the effects that anonymous concerns can have on staff, and the delivery of service. The individual worked in a clinical environment which had, over the course of a short period of time, been the subject of several anonymous letters written to senior management. The participant explained that the consequent long investigation times and lack of knowledge surrounding the issues permeated a culture of fear, distrust and uncertainty throughout the team. They advised that there was a clear loss of morale and suggested that the service provided was less effective, as staff no longer trusted their instincts and were constantly checking every decision with management.

Of the concerns where investigations had concluded, the participant advised that no action had been taken. The participant acknowledged the need for workers to be able to raise their concerns in any way possible, but stated that these incidents had come at a high cost for their team. They advised that the team was also no clearer as to the specific circumstances surrounding the concerns, and rumours had spread that the concerns raised were vexatious. The participant questioned what action their team or the trust could do to protect themselves in this instance.

Challenges for Trade Unions

On many different occasions there were discussions about the role that the trade unions played with respect to whistleblowing. Many participants advised that if they were unsure how to raise concerns, or needed support in doing so, they would approach their trade union.

A core function of the Union is their duty towards their members. This however, became a particular challenge in cases where they had to support staff on both sides of a concern.

Handling of Concerns by Management

During the course of the staff engagement exercise, PCaW met with a clinician in one of the trusts, who described how multiple members of the staff had separately raised concerns about a particular site. The individual explained how staff not only had identified problems, but also suggested practical and attainable solutions.

The clinician advised that staff felt they were unable to escalate their concerns beyond a particular level of management, the positions became entrenched, relationships broke down, and ultimately the concerns remained. The situation has since improved; however, according to the individual, many of those involved in raising the concerns left the organisation, as a result of how this was handled.

Lack of Feedback – a Missed Opportunity for a more Positive Outcome

For many whistleblowers, the potential victimisation from colleagues can be a major concern. This was a particular concern for one individual who spoke with PCaW.

An individual advised of being concerned about the level of professionalism by some managers within the team, and the knock-on effect that this was having on the service users.

They advised of following the whistleblowing policy, and stated that initially it worked well for them, as it provided an avenue for the concerns to be raised outside of line management. However, once the concerns had been detailed to senior management, the individual stated that they were considered no longer involved in the process. They stated that HR sometimes contacted them, but not with any updates in relation to the concerns.

Due to the lack of feedback, the individual stated that they could only speculate on what was happening. They did not know, and were concerned about, whether others knew that they raised the concern. The individual advised of becoming somewhat paranoid about any potential consequences. As a result, they advised of becoming stressed, which was starting to impact on their health. They found it hard to cope and subsequently had to take time off work. After an extended period of absence, they advised that they are only now starting to get back to normal.

The participant described how whistleblowing, even when they are not directly involved, can be an extremely stressful experience, and especially when there is no support during the process.

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
Review of General Practitioner Out-of-Hours Services	September 2010

Review	Published
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams	August 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013

Review	Published
Review of Specialist Sexual Health Services in Northern Ireland	October 2013
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015

Review	Published
Review of Eating Disorder Services in Northern Ireland	December 2015
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	January 2016
Review of Community Respiratory Services in Northern Ireland	February 2016
Review of the Northern Ireland Ambulance Service	March 2016
Review of HSC Trusts' Readiness to Comply with Allied Health Professions Professional Assurance Framework	June 2016
RQIA Publishes Overview of Quality Improvement Systems and Processes in Health and Social Care	June 2016
RQIA Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland	July 2016

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FEBRUARY 18

HSC WHISTLEBLOWING TASK AND FINISH GROUP - SIGN OFF REPORT

BACKGROUND

- A Regional Task and Finish Group was established in August 2016 to take forward the recommendations made by RQIA as part of their Sept 16 Whistleblowing Report

- The Task and Finish Group was chaired by Jacqui Reid, Assistant Director NHSCT, and contained representation from each of the five Trusts and the Department of Health. Papers from each meeting were also shared with Trade Union representatives across the duration of the group's tenure.

- From August 16 until January 2018 the group met regularly to agree and take forward a consistent implementation plan for each of the eleven RQIA recommendations.

The last discussion took place by teleconference in January 18 with the group's membership accepting that each of the recommendations had now reached completion.

RECOMMENDATION SYNOPSIS

Rec. No.	Priority *	RQIA Recommendation (Synopsis)
1	1	DOH production of a model policy for raising concerns
2	1	Organisations to develop or continue to develop and support behaviours that promote and encourage staff to speak out
3	1	HSC organisations to appoint a non- executive board member to have responsibility for oversight of the culture of raising concern
4	1	DHSSPS to establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns
5	2	Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available…
6	2	Managers to receive bespoke training in the operation of their policy…
7	1	Organisations, where appraisal rates are low, to work towards raising the uptake of staff appraisal
8	1	Organisations to consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed to sit
9	1	Organisations to routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved
10	2	Organisations to consider appointing an appropriate number of advisers/advocates to signpost and provide support to concern raisers
11	1	RQIA should include progress in relation to normalisation of raising concerns in the well led domain of its regulatory programme

*Priority 1 - completed within 6 months of publication of RQIA report, Priority 2 - completed within 12 months of publication of RQIA report, Priority 3 - completed within 18 months of publication of RQIA report

FEBRUARY 18

HSC WHISTLEBLOWING TASK AND FINISH GROUP – SIGN OFF REPORT

Rec. No.	Prior -ity*	RQIA Recommendation (Full Text)	Status	Feb 18 Update
1	1	DHSSPS should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary	Complete	- DoH Whistleblowing Framework and Model Policy issued for adoption via a letter received from Andrew Dawson, Director of Workforce Policy, on 3rd November 2017. - Each Trust has now made a commitment that they shall have adopted the Model Policy by no later than 31st March 2018.
2	1	All organisations should develop or continue to develop and support behaviours that promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	Complete	- Each Trust has now committed themselves to hosting a 'Raising Concerns Awareness Week' commencing Monday 9th April. The event will take place on an annual basis and will be used as a vehicle to promote the importance of Raising Concerns within each organisation. Practically the week will revolve around the delivery of pop-up and open access training sessions and localised Trust publicity - corporate broadcasts, staff news etc.
3	1	Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation	Complete	- Each organisation has now appointed a NED to have responsibility for raising concerns agenda within their respective organisation.
4	1	DHSSPS should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	Complete	- Upon the conclusion of a scoping exercise to determine the merits and extent to which a dedicated phone line would be used the DOH decided not to establish a confidential helpline pilot.

Rec. No.	Prior -ity*	RQIA Recommendation (Full Text)	Status	Feb 18 Update
5	2	Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	Complete	- A Raising Concerns training tool has now been developed for both Managerial and Non-Managerial staff via PageTiger. - Each Trust now has access to the training and has provided a commitment to formally commence roll out.
6	2	All managers should receive bespoke training in the operation of their policy for raising concerns.	Complete	- The operation of the raising concerns policy is addressed within the Managerial Raising Concerns training which is to be rolled out to managers within each organisation.
7	1	All organisations, where appraisal rates are low, should work towards raising the uptake of staff appraisal.	Complete	- Agreement that no additional work needed to take place against this recommendation as each Trust was already working to their annual DOH appraisal target.
8	1	All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	Complete	- Agreement that in the absence of a prescriptive or legal requirement stipulating where raising concerns should be placed, each organisation was content with the location of raising concerns within their structures.
9	1	All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	Complete	- Assurance provided from each organisation that they had mechanisms in place to ensure that any shared learning from a raising concern issue would be cascaded down through their organisational levels.

10	2	All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	Complete	- Each organisation has appointed advisors/advocates to support staff wishing to raise a concern. These members of staff have all been privy to specialist Raising Concerns training as provided by Public Concern at Work.
11	1	RQIA should include progress in relation to normalisation of raising concerns in the well led domain of its regulatory programme.	N/A	- RQIA led recommendation which was not applicable for Regional Task and Finish Group.

CONCLUSION

The regional task and finish group are content that collectively no further work needs to take place to take forward the RQIA recommendations and as such they seek agreement that the group be formally closed.

The group acknowledges the fact that work does need to take place within individual Trusts to close off some of the organisational commitments made. These updates shall be provided to RQIA through the bi-annual returns that each organisation traditionally makes.

2015-16 CHECKLIST FOR ARM'S LENGTH BODY (ALB) SPONSOR BRANCHES

Name of ALB:	
Name of sponsor branch:	
Checklist completed by:	**Date:**

1. Roles and Responsibilities

1.1	**Yes**	**No**	**Partly**
Can you confirm that: (a) an approved Management Statement / Financial Memorandum (MSFM) between Department and ALB is in place (b) The MS/FM has (if in place for more than a year) been reviewed/updated within the last 5 years; and (c) the MSFM is available to the public through the ALB (e.g. on the ALB website)?			
Suggested Evidence of Compliance: (i) MS/FM agreed by DFP (date) (ii) Signed by ALB Accounting Officer (date) Department A/c Officer (date) (iii) Approved copy held on file and reviewed (date) (iv) Confirmed copy of MSFM on ALB website (date)			
Comments: •			

1.2	**Yes**	**No**	**Partly**
Can you confirm that: (a) all operational staff in the sponsor branch have attended a training course in relation to sponsored bodies, to aid their full understanding of roles and responsibilities; and (b) sponsor branch staff attend sponsor branch meetings with CAGU?			
Suggested Evidence of Compliance: (i) Date of attendance at training by all sponsor branch staff			
Comments: •			

1.3	**Yes**	**No**	**Partly**

Can you confirm that: (a) the ALB Chief Executive has acknowledged in writing receipt of a formal letter of designation as Accounting Officer defining the role and responsibilities of this position; (b) the clerk to PAC has been informed of the appointment; and *(c)* the ALB Chief Executive has, within three months of appointment, attended the training course *An Introduction to Public Accountability for Accounting Officers?*			
Suggested Evidence of Compliance: (i) Copy of Accounting Officer letter and acknowledgement; (ii) cc'd to PAC Clerk/ (iii) Confirmation of attendance at training course from Accounting Officer (Letter/ e-mail/ from minutes of Accountability meeting)			
Comments: •			

1.4	**Yes**	**No**	**Partly**
Can you confirm that the ALB; (a) holds open board meetings; (b) advises the public of board meetings through the press; and (c) makes minutes publicly available?			
Suggested Evidence of Compliance : (i) Confirmation from ALB (ii) Minutes on ALB website			
Comments: •			

2. Business Planning and Risk Management

2.1	Yes	No	Partly
Can you confirm that : (a) the ALB has a three-year Corporate plan in place which identifies strategic aims and objectives; (b) the Corporate plan includes an annual operating Business Plan which contains objectives specifying the key outcomes to be achieved in the focal year, linked to the ALB's strategic aims and objectives; (c) the ALB's objectives in the Corporate/Business Plan are consistent with the Department's and that common/shared objectives are accurately reflected in both Departmental and ALB plans; and (d) ALB Plans are reviewed and approved by the Department before the start of the reporting year?			
Suggested Evidence of Compliance: (i) Copy of Corporate/Business Plan submitted (ii) Copies of Departmental correspondence seeking amendment to objectives/ confirming content with proposed objectives (iii) Confirmation of ALB board approval of plans			
Comments: •			

2.2	Yes	No	Partly
Can you confirm that: (a) annual Commissioning Plan and Trust Delivery Plans to meet PfG and PfA commitments are submitted to the Department within the timescale specified; (b) the Plans are reviewed to confirm that the HSC can deliver on standards/targets set within the resources allocated; (c) the Plans are consistent with the Departments and that common/shared objectives are accurately reflected in both Departmental and ALB plans; and (d) Ministerial approval of Commissioning Plan/ Trust Delivery Plans is obtained within two months of the start of the reporting year?			

Suggested Evidence of Compliance: (i) Copies of plans submitted (ii) Submission to Minister seeking approval (iii) Approval letters issued to HSCB, PHA and Trusts
Comments:

2.3	**Yes**	**No**	**Partly**
Can you confirm that (a) an accountability meeting at Ministerial or senior Departmental level is held with the ALB at least biannually; (b) governance, resources, quality and service delivery are fixed items on the agenda; and (c) outside the formal accountability meetings, the sponsor branch meets the ALB regularly to monitor progress on achievement of key objectives?			
Suggested Evidence of Compliance: (i) Accountability review agenda and minutes (ii) Evidence of performance meetings between Sponsor branch and ALB outside mid and end year formal assurance meetings (iii) Evidence of Sponsor branch follow-up of any concerns raised or action points from accountability and performance meetings			
Comments: •			

2.4	**Yes**	**No**	**Partly**
Can you confirm that the ALB's Assurance Framework is: (a) in line with Departmental guidance '*An Assurance Framework: a Practical Guide for Boards of DHSSPS Arm's Length Bodies'*, as regards e.g. appropriate strategic objectives, key strategic risks, coherence with the risk register, sources of internal and external assurance; (b) approved by the ALB board; and (c) subject to regular board review.			
Suggested Evidence of Compliance: (i) copy of the Assurance Framework (ii) board minutes			
Comments: •			

2.5	Yes	No	Partly
Can you confirm that the ALB disseminates good practice on risk management across the organisation by: (a) having clear risk management policies and procedures in place and communicating these to staff; (b) providing appropriate training on risk management to staff; (c) having a board member allocated with specific responsibility for risk management; (d) ensuring ALB board members on Audit or Governance Committees have within three months of appointment, attended appropriate training course; (e) achieving substantive levels of compliance with control assurance standard on risk management; and (f) ensuring compliance with risk management policies and procedures is subject to regular internal audit review?			
Comments: •			

2.6	Yes	No	Partly
Can you confirm that the ALB Risk Register: (a) is linked to key strategic/ annual objectives to ensure that risks to their achievement have been identified and are being actively managed; (b) contains the required information – the ALB's assessment of the level of risk (likelihood/impact), key controls and any action required; (c) is sufficiently consistent in its coverage with that of comparable organisations; and (d) is approved by the Audit/Governance Committee and/or ALB board?			
Suggested Evidence of Compliance: (i) Copy of the ALB Risk Register forwarded to the sponsor branch biannually (ii) Minutes from Audit/Governance committee and ALB board meetings			
Comments: •			

2.7	Yes	No	Partly
Can you confirm that the ALB's Risk Register is a 'live' document i.e. is there evidence of: (a) text being updated, risks moving on and off register over time, rating of risks changing, action points being added and removed as addressed; (b) regular reports to the Audit/Governance Committee and ALB board on risks; and (c) it being reviewed by ALB Internal Audit? In addition, are significant ALB risks being considered by the sponsor branch for possible escalation to the Department's Risk Register?			
Suggested Evidence of Compliance: (i) Copy of the ALB Risk Register forwarded and reviewed by the sponsor branch biannually (ii) Minutes from Audit/Governance committee and ALB Board meetings received and reviewed on a timely basis (iii) Internal Audit reports on risk management reviewed by sponsor branch (iv) ALB risks are considered by the Sponsor Branch for incorporation/escalation in the branch, directorate and Departmental risk registers, as appropriate to the level of risk			
Comments: •			

2.8	Yes	No	Partly
Can you confirm that the ALB's mid-year assurance statement and Governance Statement each: (i) contains all the information required; (ii) details significant internal control problems; (iii) reflects the outcomes of any adverse Internal Audit reports; (iv) provides the necessary assurance that appropriate action is being taken to address the control/ risk issues identified; and (v) provides, for the mid-year and end-year accountability reviews, due assurance that all significant control issues are identified and that there is effective management of risk? In addition, the Sponsor Branch liaises with Finance Directorate as appropriate, in relation to			

any impact on (and disclosure in) the Department's Governance Statement?			

Suggested Evidence of Compliance:

(i) Copy of the Mid Year Assurance Statement
(ii) Copy of Governance Statement
(iii) All Internal Audit reports with less than satisfactory assurance forwarded to sponsor branch
(iv) Copies of mid-year and end-year accountability review meetings
(v) Evidence of Sponsor branch follow-up of concerns from the ALB's Governance Statement/mid-year assurance statement and of communication with Finance Directorate as appropriate in relation to any impact on (and disclosure in) the Department's Governance Statement

Comments:

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2.9	Yes	No	Partly
Can you confirm that, where governance arrangements of an ALB have been subject to PAC criticism: (a) this is automatically recorded as high risk on the ALB risk register; (b) it is considered for escalation to the Department's risk register (if risk adversely impacts on the delivery of Departmental objectives); and (c) is subject to periodic review by the sponsor branch until completely resolved?			

Suggested Evidence of Compliance:

(i) PAC reports
(ii) Risk registers
(iii) Minutes of accountability meetings

Comments:

2.10	Yes	No	Partly
Can you confirm that: (a) the ALB has a Business Continuity Plan in place; (b) the Business Continuity Plan is tested regularly; and (c) the ALB has achieved substantive levels of compliance with controls assurance standard on Emergency Planning?			

Suggested Evidence of Compliance: (i) ALB Business Continuity plan (ii) Copy of ALB's Controls Assurance report to the Department
Comments: •

2.11	**Yes**	**No**	**Partly**
If the ALB is subject to regular inspection by an external body (eg MHRA), can you confirm that: (a) the sponsor branch receives copies of the inspection reports; (b) the ALB has an action plan in place to address the recommendations therein; (c) satisfactory progress is being made in implementing them; and (d) the ALB is compliant with any legislative, licensing etc requirements?			
Suggested Evidence of Compliance: (i) Copies of the reports and ALB action plans			
Comments:			

2.12	**Yes**	**No**	**Partly**
Can you confirm that the ALB has in place robust anti-fraud measures, as set out in Appendix A.4.7 of MPMNI, and that these are formally considered by the ALB Audit Committee?			
Suggested Evidence of Compliance: (i) Copy of Anti fraud policy (ii) Fraud Policy Statement (iii) Fraud response plan (iv) Evidence of training			
Comments: •			

2.13	**Yes**	**No**	**Partly**
Has the sponsor branch carried out a risk assessment of the ALB to determine the appropriate level of oversight/control required for the individual ALB and is this reflected in a branch risk register? Have reported whistle-blowing, fraud/irregularity events or adverse media interest been reflected in the assessment of risk and control?			

Suggested Evidence of Compliance: (i) Sponsor Branch/ Directorate risk register
Comments: •

3. Governance

3.1	Yes	No	Partly
Can you confirm that, within three months of appointment, all ALB Board members have attended appropriate training courses (e.g. CIPFA *On Board*) to provide them with a clear understanding of their role and responsibilities?			
Suggested Evidence of Compliance : (i) ALB confirmation			
Comments: •			

3.2	Yes	No	Partly
Can you confirm that: (a) a senior Departmental representative conducts an annual appraisal of the ALB board Chair; and (b) the board Chair conducts annual appraisals of all Non-Executive Directors?			
Suggested Evidence of Compliance: (i) minutes from chair appraisals (ii) ALB board chair confirms, in his annual self-assessment return, that annual appraisals of all Non-executive Directors were conducted			
Comments: •			

Can you confirm that the ALB has in place a Remuneration Committee which: a) is chaired by a non-executive; b) has a wholly non-executive membership with a minimum of three members c) has a TOR approved by Board and publicly available; d) provides recommendations to the board on remuneration and terms and conditions of employment for the Chief Executive and other executive directors; e) has a membership which, within three months of appointment, attended appropriate training courses on their respective roles and responsibilities; and f) has a chair who is (i) annually appraised for his/her work, and (ii) annually appraises the other committee members g) none of the members are members of the			

Audit Committee?			
Comments: •			

3.3	**Yes**	**No**	**Partly**
Can you confirm that the ALB has in place an Audit Committee which complies with the requirements of DAO 07/07 eg that it : a) is chaired by a non-executive; b) has a wholly non-executive membership with a minimum of three members; c) has at least one member with recent financial experience; d) has a TOR approved by Board and publicly available; e) provides a report to the board after each meeting and produces an annual report to support the SIC; f) has a membership which, within three months of appointment, attended appropriate training courses on their respective roles and responsibilities; and g) has a chair who is (i) annually appraised for his/her work, and (ii) annually appraises the other committee members? In addition none of its members are members of the remuneration committee.			
Suggested Evidence of Compliance: (i) confirmed from minutes of Audit Committee meetings (ii) confirmed by Public Appointments Unit (iii) confirmed by ALB (specified in Management Statement) (iv) confirmed from Board minutes (v) Sponsor Branch to receive Audit Committee TOR			
Comments: •			

3.4	**Yes**	**No**	**Partly**
Can you confirm that a Departmental representative has attended one audit committee meeting in the course of the financial year?			

Suggested Evidence of Compliance: **(i)** confirmed by Brief supplied by the Departmental representative
Comments: •

3.5	**Yes**	**No**	**Partly**
Can you confirm that there are annual bilateral meetings between the ALB Audit Committee chair and each of the following parties the ALB Chair of the Board, ALB Accounting Officer, ALB Head of Internal Audit and External Audit?			
Suggested Evidence of Compliance: **(i)** Copies of minutes from these meetings			
Comments:			

3.6	**Yes**	**No**	**Partly**
(a)			
Suggested Evidence of Compliance: (i) Copy of Governance/Assurance Committee TOR, work-plan and meeting schedule (ii) Confirmed by ALB			
Comments: •			

3.7	**Yes**	**No**	**Partly**
Can you confirm that the sponsor branch receives copies of the minutes of ALB board meetings on a timely basis that these are reviewed and that appropriate action is taken in areas of concern?			
Suggested Evidence of Compliance: (i) Copies of Board minutes **(ii)** Copies of correspondence with ALB in relation to any areas of concern			

Comments:
•

3.8	Yes	No	Partly
Can you confirm that the ALB has in place: (a) an approved, publicly available, Code of Practice for ALB board members setting out the standard of conduct to which they are expected to adhere; and (b) a Code of Conduct for staff (in line with the Model Code for staff of Executive Non Departmental Public Bodies)?			
Suggested Evidence of Compliance: (i) Code of Practice for ALB board members (ii) Code of Conduct for staff			
Comments: •			

3.9	Yes	No	Partly
Can you confirm that the ALB has in place an up-to-date register of members' interests and that this is available for public inspection?			
Suggested Evidence of Compliance: (i) Register of members' interests			
Comments: •			

4. *Internal Audit*

4.1	Yes	No	Partly
Can you confirm that the sponsor branch (a) have an annual meeting with the ALB's internal audit to ensure that shared assurance requirements (in relation to risk areas/topics) are built into the ALBs audit plan and audit strategy; and (b) ensure that all significant control issues identified by the ALB's internal auditors are fast tracked to the branch?			
Suggested evidence of Compliance: (i) ALB Internal Audit workplan (ii) ALB Governance Statement (iii) ALB Risk Register			
Comments: •			

4.2	Yes	No	Partly
Can you confirm that the sponsor branch receives and reviews on a timely basis: (a) the Internal Audit workplan; (b) HIA annual and mid year assurance statements); (c) IA progress report; (d) Internal audit assignment reports where satisfactory assurance is not received; (e) the output of internal and external assessments of the internal audit function; (f) all Audit Committee minutes; (g) copies of NIAO management letters sent to the ALB; and (h) the number of outstanding internal audit recommendations (bi-annually)			
Suggested Evidence of Compliance: (i) Internal Audit reports (ii) Audit Committee meeting minutes (iii) NIAO management letters (iv) Evidence of Sponsor branch follow-up of concerns			
Comments: •			

4.3	Yes	No	Partly

Can you confirm that the sponsor branch has effective arrangements in place to ensure that Departmental HIA is provided with: (a) the ALB audit plan; (b) ALB internal audit assignment reports where satisfactory assurance is not achieved; and (c) the HIA's mid year and annual reports?			
Suggested Evidence of Compliance: (i) Dates these documents are sent to Departmental HIA			
Comments: •			

I confirm that the sponsor branch continues to monitor the ALB in respect of the requirements of good governance as set out in the checklist.

Name: Date:

Signature: Branch

Authorised: Directorate:
[responsible Grade 5]

CHECKLIST FOR ARM'S LENGTH BODY (ALB) SPONSOR BRANCHES

Version control: 1.5

Name of ALB:

Name of Sponsorship branch:

Checklist completed by:

Checked by G7:

Cleared by EBM Sponsor:

Statement of Purpose

- The purpose of this checklist is to provide a guide for Sponsor Branches in terms of assessing the extent to which they are operating within departmental guidelines and good practice.
- Completion of the checklist will assist the Executive Board Member Sponsor in providing assurance to the Accounting Officer on the adequacy of existing accountability arrangements.
- This is an internal tool to assist sponsor branches. In line with good practice, sponsor branches should ensure that accurate and timely records are maintained that support the completion of the checklist.

1. Roles and Responsibilities

1.1	Yes	No	Partly
Can you confirm that: a) as part of the induction process, new sponsor branch staff familiarise themselves with the ALB's founding legislation. b) an approved Management Statement/Financial Memorandum (MS/FM) between Department and ALB is in place c) the MS/FM is reviewed and updated at least every 5 years; and d) the MS/FM is available to the public through the ALB (e.g. on the ALB website)? e) Documentation is provided to the Department by the ALB as set out in the Appendix of the Management Statement.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

1.2	Yes	No	Partly
Can you confirm that: a) all operational staff in the sponsor branch have attended a training course in relation to sponsored bodies, to aid their full understanding of roles and responsibilities; and b) A representative from sponsor branch attends the majority of Sponsor Branch Forums			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

1.3 only required if new Chief Executive	Yes	No	Partly
Can you confirm: a) The ALB Chief Executive has acknowledged in writing receipt of a formal letter of designation as Accounting Officer defining the role and responsibilities of this position; b) The clerk to PAC has been informed of the appointment; and c) The ALB Chief Executive has, preferably within three months of appointment, attended the training course ***An introduction for Accounting Officers?***			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

2.0 ALB Board Governance

2.1 To be completed by Public Appointments Unit	Yes	No	Partly
Can you confirm that: a) Appointments to the Board of the ALB are in line with the 'Code of the Commissioner for Public Appointments NI' b) Appointments and tenure periods of Board members are monitored to ensure that appointment competitions are run on a timely bases c) Board appointments are sufficiently staggered to ensure that there is appropriate retention of experienced Board members balanced by the influx of new members bringing fresh challenges			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

2.2 To be completed with input from Public Appointments Unit	Yes	No	Partly
Can you confirm that a) All newly appointed ALB Board Members have attended an appropriate training course preferably within 6 months of appointment. This training course (which is provided by either CIPFA or ON BOARD TRAINING) is in addition to any Induction training provided by the Chair and the ALB and increases their effectiveness in discharging their roles and responsibilities b) an approved, publicly available, Code of Practice for ALB board members setting out the standard of conduct to which they are expected to adhere is available; c) a senior Departmental representative conducts an annual appraisal of the ALB board Chair; and d) the ALB board Chair conducts annual appraisals of all Non-Executive Directors. This appraisal includes consideration of performance as a committee member (as appropriate)?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

2.3 Board Meetings	Yes	No	Partly
Can you confirm that the ALB; a) holds open board meetings; b) advises the public of board meetings; c) makes minutes publicly available and d) has a register of members' interests that is available publicly.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

2.4 Board Agenda	Yes	No	Partly
Can you confirm that the Board of the ALB a) receives and reviews regular updates on the ALBs performance (both non-financial and financial performance); b) considers the risks facing the organisation including reviewing the Body's corporate risk register; and c) receives reports from the Board's committees on the work they are undertaking.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

2.5 Board Minutes	Yes	No	Partly
Can you confirm that: a) the sponsor branch receives copies of the minutes of ALB board meetings as soon as these are available and that these are reviewed in a timely manner? b) If concerns are identified, assurance is sought from the ALB that appropriate action is being taken to address issues? c) any unresolved issues arising from the areas covered by Section 2 of this template are escalated in the Department as appropriate?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

3. Business Planning and Risk Management

3.1	Yes	No	Partly
Can you confirm that: a) in line with the MS/FM, direction is provided to the ALB on development of corporate and business plans b) the ALB has a corporate plan in place in line with the Assembly budget process c) the ALB has a more detailed business plan for the year developed by the ALB on an annual basis; d) ALB plans are reviewed and approved by the Department before the start of the reporting year; and e) appropriate processes are in place in the Department to monitor the performance against approved business plans. DN: specific references to Trust plans to be added when clarity received.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

3.2	Yes	No	Partly
Can you confirm that: a) the ALB has a Board approved Assurance Framework in place; b) the ALB has a clear risk management strategy in place that is kept up to date; and c) compliance with risk management policies and procedures is subject to regular internal audit review.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

3.3	Yes	No	Partly
Can you confirm that the ALB Risk Register: a) is linked to key strategic/annual objectives to ensure that risks to their achievement have been identified and are being actively managed; b) contains the required information i.e. the ALB's assessment of the level of risk (likelihood/impact), key controls and any action required; c) is approved by the Audit/Governance Committee and/or ALB board; and d) is a 'live' document i.e. is there evidence of: • text being updated, risks moving on and off register over time, rating of risks changing, action points being added and removed as addressed; • regular reports to the Audit/Governance Committee and ALB board on risks; and • it being reviewed by ALB internal Audit?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

3.4	Yes	No	Partly
Can you confirm that: a) the ALB's risk registers are provided at least biannually to the Department; b) the risk registers are considered by sponsor branch to ensure that they include mitigating measures and actions to address identified risks; and c) significant ALB risks are considered by the sponsor branch (with input from policy leads as required) for possible escalation within the department.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

4. Governance arrangements

4.1	Yes	No	Partly
Can you confirm that the ALB's mid-year assurance statement and Governance Statement each: a) details significant internal control divergences; b) details level of compliance with controls assurance standards; c) reflects the outcomes of any adverse Internal Audit reports; d) provides the necessary assurance that appropriate action is being taken to address the control/risk issues identified; and e) provides for the mid-year and end-year accountability reviews, due assurance that all significant control issues are identified and that there is effective management of risk? Does Sponsor Branch escalate through Finance significant control divergences for consideration for inclusion in Department's Governance Statement?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

4.2	Yes	No	Partly
Can you confirm that a) a ground clearing meeting at senior departmental level is held with the ALB at least biannually; b) an accountability meeting chaired by the Permanent Secretary (or appropriate deputy by exception) is held with the ALB at least annually; c) governance, resources, quality and service delivery issues are considered as agenda items as appropriate; d) Minutes for both meetings should be drafted and circulated as promptly as possible after the meeting, ideally within 2 weeks; e) outside the formal accountability process, the sponsor branch engages with the ALB as regularly as appropriate; f) the EBM provides assurance to the AO that the level of sponsorship for the ALB is proportionate.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

4.3	Yes	No	Partly
Can you confirm that the ALB has in place an Audit Committee which complies with the requirements of DAO 05/14 e.g. that it: a) is chaired by a non-executive; b) has a wholly non-executive membership with a minimum of three members; c) has a least one member with recent financial experience; d) has a TOR approved by Board and publicly available; e) provides a report to the Board after each meeting and produces an annual report to support the Governance Statement; f) has a membership which, preferably within six months of appointment, attended appropriate training courses on their respective roles and responsibilities; Can you confirm that a departmental representative has			

attended at least one audit committee meeting in the course of the financial year?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

4.4	Yes	No	Partly
Can you confirm that: a) The ALB has a Business Continuity Plan in place; and b) The Business Continuity Plan is reviewed annually.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

4.5	Yes	No	Partly
If the ALB is subject to regular inspection* by an external body (e.g. MHRA), can you confirm that: a) the sponsor branch receives copies of any adverse inspection reports; b) the ALB has an action plan in place to address the recommendations therein; and c) satisfactory progress is being made in implementing the recommendations (*this excludes RQIA inspection reports)			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

4.6	Yes	No	Partly
Can you confirm that the ALB has in place a) robust anti-fraud measures, as set out in Appendix A.4.7 of MPMNI, and that these are formally considered by the ALB Audit committee; b) A whistle blowing policy; and c) A gifts and hospitality policy.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

5. Internal audit

5.1	Yes	No	Partly
Can you confirm that the sponsor branch has an annual meeting with the ALB's internal audit to discuss issues and topics for consideration for inclusion in ALBs audit plan and audit strategy?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

5.2	Yes	No	Partly
Can you confirm that the sponsor branch receives and reviews on a timely basis; a) the Internal Audit workplan; b) HIA annual and mid-year assurance statements; c) Internal audit assignment reports where satisfactory assurance is not received d) all Audit Committee minutes; and e) copies of Reports To Those Charged With Governance sent to the ALB Can you confirm that the sponsor branch provides copies of these documents to departmental HIA?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

Summary of any issues identified during completion for checklist that require follow-up action or consideration for escalation.

MAHI - STM - 118 - 3222

BELFAST HSC TRUST PERFORMANCE AND YEAR-END ACCOUNTABILITY MEETING 2008/09 – MINUTES

18 June 2009 at 2.00pm, Castle Buildings

ATTENDEES:

DHSSPS	Michael McBride
	Sean Donaghy
	Julie Thompson
	Dean Sullivan
	Noel Irwin
HSC Board	John Compton
	Michael Bloomfield
Public Health Agency	Janet Little
Belfast HSC Trust	William McKee
	Wendy Galbraith
	Valerie Jackson
	Tony Stevens
	Catherine McNicholl
	Jennifer Welsh
	Jennifer Thompson

Introductions and Welcome

1. Dr McBride welcomed the Trust, HSC Board and Public Health Agency to the meeting. He acknowledged the new role of the Board and Agency in the accountability review process and outlined the format of the meeting.

Performance against the PfA targets in 2008/09

2. By way of introduction, Dr McBride referred to the letter issued by the Department to the Belfast Trust on the 20 March 2009 which highlighted the Department's concerns about the Trust's unsatisfactory performance in a number of priority areas.

3. Mr Compton advised that a process was in place between the Board and the Trust to take forward the implementation of an agreed action plan to bring the Trust's performance into line with the Minster's minimum performance standards. He confirmed discussions against the action plan formed part of the monthly performance meetings and an improvement in performance was expected by October 2009.

4. Mr McKee expressed the Trust's disappointment with the conclusions reached regarding the Trust's performance in the letter from the Department. However, he welcomed the inclusive and supportive approach adopted by the Board to working with the Trust in securing the necessary improvements in performance in 2009/10.

Principal PfA Targets

5. Mr Bloomfield confirmed that while the Trust had made progress across a range of areas, a number of targets had not been achieved and a number of challenges remained in respect of others.

6. He advised that across the relevant 21 principal PfA targets in 2008/09 the Trust fully achieved seven targets, substantially achieved five (Quality improvement Plans, Diagnostics, AHP Services, Older People (12 weeks) and Mental Health Assessment), partially achieved two further targets (Cancer – 31 and 62 days) and six targets were not achieved (Healthcare Associated Infection (MSSA and C.diff), Outpatients, Inpatient/Daycase, Fractures and A&E). In relation to the

remaining target – delayed discharge – an assessment of the Trust's performance had been deferred as there are definitional issues to be resolved, monitoring of performance will commence in June 2009.

A&E

7. In 2008/2009 there were 857 breaches of the 12 hour maximum standard. Mr Bloomfield confirmed that Trust performance against the 12 hour maximum had improved in 2009/10, with 13 breaches of the target in May 2009 and eight in June 2009 to date. Mr Compton noted the challenges in the medium term of maintaining the Trust's current profile of A&E services in Belfast.

HCAI

8. While the target for the reduction in C Diff infections had not been met in 2008/09, Mr Bloomfield confirmed that the levels of C Diff infections had improved in April and May 2009 to within the required profile for 2009/10 with 37 infections occurring against a profile of 40.

Outpatients, Inpatient / Daycase

9. Mr Compton noted the challenges faced by the Trust in some regional specialities. He commented that the planned investment in elective care in 2009/10 would have a positive impact on performance.

10. Dr McBride welcomed the recent improvement in Trust A&E and HCAI performance and invited comments from the Trust. Mr McKee noted the Trust had much to improve against certain priorities. He also highlighted the challenge in delivering the required A&E performance in Northern Ireland in the context of patient needs and available funding.

Supplementary PfA Targets

11. Across the 32 supplementary PfA targets relevant to the Trust in 2008/09, Mr Bloomfield confirmed 27 targets were assessed as achieved. Five targets were assessed as not being achieved: diagnostic

reporting, paediatric and neo natal intensive care transport service, family support packages–dedicated outreach programme, family group conferencing, and support to young people aged 16-17 in care to engage in part-time and full-time employment.

Diagnostic reporting

12. Mr Bloomfield noted that 90% of all urgent diagnostic tests in March 2009 were reported on within the two days timescale set (against a target of 100%). He also noted that 90% of routine tests were reported on within two weeks (against a target of 75%), although 127 tests (2.1%) took longer than the target backstop of four weeks to report.

13. In response, Dr Stevens confirmed steps were being taken to further improve Trust diagnostic reporting performance during 2009/10.

Dedicated paediatric and neo-natal intensive care transport service

14. It was noted that the transport service is currently operating on a limited time basis and the Trust is in discussions with the Regional Medical Service Group about the most appropriate arrangements for delivering this regional service in the future.

Family Support Packages – dedicated outreach programme

15. Mr Bloomfield confirmed the Trust had exceeded the first part of this target in providing family support packages to 1,080 young people against a Trust target of 215 (and a regional target of 1,000). However, the Trust did not meet the second part of this target as it did not have a dedicated outreach programme in place by 31 March 2009. The Trust confirmed recruitment is on going to fill relevant vacancies to ensure the provision of this service in 2009/10.

Family Group Conferencing

16. Mr Bloomfield advised that, by 31 March 2009, 74 people against a target of 108 had participated in family group conferences. The Trust advised, with the service only starting part way through the 2008/09

year, it was confident the required level of performance would be achieved during 2009/10.

Support to young people aged 16-17 in care to engage in employment

17. Mr Bloomfield confirmed that guidance agreed regionally had been put in place by the Trust however no dedicated development workers had been appointed by 31 March 2009. The Trust confirmed it was their intention to have these staff in place by the end of the summer.

Governance and Statement on Internal Control

18. Dr McBride reminded Trust representatives of Dr McCormick's previous correspondence on the importance of organisations' SICs being open about any significant internal control issues encountered. This still applied and the validity of the Department's own SIC was dependent on this.

19. Dr McBride asked if the Trust was content that action plans being implemented to address control weaknesses identified by their Internal Audit Service were adequate to address issues, especially Records Management and Agenda for Change. Mrs Galbraith confirmed robust action plans were in place for each of these areas and there were no further issues to be included in the Trust's 2008/09 SIC.

20. Mr McKee noted again the issues raised previously by the Trust in relation to the Controls Assurance Standards.

21. Whilst noting Mr McKee's comments, Dr McBride asked if action plans were in place to address the non–compliance of three control assurance standards with the requirement to reach substantive compliance. Dr Stevens confirmed the Trust's expectation that each standard would reach the required substantive level of assurance in 2009/10. In respect of the ICT standard, he advised that the score had fallen from 84 in 2007/08 to 68 in 2008/09 due to issues carried forward from the legacy

Trusts; it had also been subject to validation by internal Audit. In relation to the Records Management standard, it was noted that a Records Manager had now been appointed which should improve Trust performance in this area.

22. In relation to training of Non-Executive Directors in respect of their board role and as members of the audit committee, the Department advised the Trust it would seek the necessary assurances from the Trust following the formal accountability meeting.

Financial position for 2008/09

23. Mr Donaghy welcomed the improvement to the Trust's position to a deficit of deficit of £0.46m but reminded the Trust of the need to recoup this deficit during 2009/10.

Financial position for 2009/10

24. Mr Compton confirmed the Board had met with the Trust to gain a better understanding of its projected deficit position set out in its 2009/10 TDP and further discussions would be held . He acknowledged the challenges facing Trusts to break even during 2009/10 and confirmed he was seeking to reach a shared understanding with all Trusts on their financial positions. Mr Donaghy emphasised the need for all organisations to break even, implementing recovery plans if appropriate.

25. Mr McKee thanked Mr Compton for his comments and acknowledged the requirement for the Belfast Trust to break even in 2009/10.

Other issues and risks for 2009 /10 and beyond

<u>Middle grade staff vacancies in A&E</u>

26. Dr Stevens highlighted difficulties being experienced in filling vacancies across the Trust's three A&E Departments and the resultant impact this

was having on maintaining services and achieving compliance with the Working Time Directive. Dr Stevens also detailed similar staffing issues within a number of the smaller specialities due to the lack of middle grade staff and a shortage of trainees.

27. He advised of the Trust's plans to establish "hospital at night" schemes at the Mater and Belfast City Hospitals but noted that, at best, only one of these schemes would be in place by the 1 August 2009.

28. Mr Compton advised the Board would be meeting with the Trust over the coming days to discuss the issues raised. He noted the substantial additional resources provided to the Trust in the most recent round of ISG bids. He suggested that these resources provided an opportunity to address both service capacity and work force issues.

Capital funding

29. Mr McKee expressed concerns about the adequacy the Trust capital allocation for estate maintenance to meet requirements given the need to meet expected in-year commitments of £6m decontamination costs from the Hind report and £1.3m for fire compliance issues. Ms Jackson highlighted the need for accredited decontamination services to be in place to allow bowel cancer screening to progress.

30. Dr McBride agreed to raise the Trust's concerns re estate maintenance funding with John Cole.

Productivity targets

31. Mr McKee highlighted the challenges facing the Trust in implementing higher hospital productivity targets set out in the Programme for Government to 2010/11 without a diminution in the quality of care and services provided. Dr McBride noted the Trust's comments but advised the requirements was for efficiencies to be realised while maintaining the required quality of care and service for patients.

Fractures

32. Mr McKee noted the challenge to the Trust of achieving the 95% fracture target across all fracture types. He requested that the target be more tightly defined to reflect the practicalities of achieving the target for particular specialist fracture services.

Mental Health and Learning Disability

33. Mr McKee highlighted difficulties in meeting the PfA 2009/10 Mental Health and Learning Disability resettlement and discharge targets in light of dependence on the availability of Supporting People funding. The Department advised that discussions with DSD were ongoing in relation to the support that will be available under this scheme.

Supplement for Undergraduate Medical & Dental Education

34. Mr McKee commented on the potential financial exposure of the Belfast Trust if the current review of SUMDE results in an unfavourable outcome for the Trust.

35. Mr McKee noted that both Queens University and DHSSPS would be giving evidence on this issue to the Health Committee on the 25 June and asked whether it would be possible / appropriate for the Trust to also provide input. Dr McBride encouraged the Trust to contact the Health Committee to explore whether they would be amenable to receiving a health service perspective on the SUMDE issue.

Swine flu

36. Dr McBride referred to correspondence to HSC Chief Executives in respect of the adequacy of their emergency planning arrangements. He thanked the Trust, Agency and Board for their work to date.

37. Mr McKee outlined work undertaken by the Trust to date in developing its emergency plan. He advised of the Trust's intention to run a test of the plan in the near future. He further advised that training and

development issues were critical and cited in particular the issue of staffing of ventilator beds. He noted that 80 of Northern Ireland's 120 ventilator beds are located within the Belfast Trust. He noted the importance of training staff in the care of ventilated patients and the potential need for targets to be relaxed to accommodate this.

Closing

38. Dr McBride thanked those present and closed the meeting.

Performance Management Unit
June 2009

BELFAST HSC TRUST END -YEAR PERFORMANCE AND ACCOUNTABILITY REVIEW MEETING 2009/10 – MINUTES

Tuesday 29 June 2010 at 1.30pm, Castle Buildings

ATTENDEES:

DHSSPS	Michael McBride
	Sean Donaghy
	Linda Devlin
	Alison Jeynes
	Maura McKee
	Noel Irwin
HSC Board	John Compton
	Paul Cummings
	Michael Bloomfield
Belfast HSC Trust	William McKee
	Wendy Galbraith
	Catherine McNicholl
	Jennifer Welsh
	Brenda Creaney
	John Growcott
	Denise Stockman
	June Champion
	Cathy Jack

Introductions and Welcome

1. Mr Donaghy welcomed those present to the meeting. He noted that the timing of the Accountability Review meeting so close to submission of the Trust's Delivery Plan, was not ideal as it gave the Department limited time to consider.

End of Year financial position 2009/10

2. Mr Donaghy outlined the background to the Department under-writing a special subvention of £10.7m to the Trust during 2009/10, to allow it to report a break even position at year end. Against this, the Trust reported had reported a small surplus of £74k. The Trust also achieved in full its efficiency savings for the year.

3. Mrs Galbraith acknowledged the support of the Department and the HSC Board to break even and commended this as a good example of the HSC system working well together.

Performance against the PfA targets in 2009/10

4. Mr Bloomfield acknowledged the performance of the Trust during the year against targets. It was noted that Priorities for Action contained 72 standards and targets applicable to the Belfast Trust of which the Trust had fully achieved 26 targets, substantially achieved two, partially achieved seven and 23 were not achieved. In relation to the remaining 14 standards and targets, no assessment had been made for a range of reasons including ongoing issues regarding the accuracy and consistency of monitoring information.

5. In relation to a further four targets monitored by the Department (covering hospital productivity, absenteeism and two capital projects), all except the absenteeism target are assessed as being on track for achievement.

6. Mr Bloomfield highlighted a number of the standards and targets achieved by the Trust in 2009/10 including 35% reduction in MRSA and C Difficile infections, AHP – 9 weeks including the agreed backstop position for Occupational Therapy, Cancer (14 days), Assessment and treatment of older people – 8 and12 weeks, Direct Payments, Family Support Interventions, Family Group Conferencing, reduction in

admissions to mental health hospitals, Mental Health Resettlement, Mental Health Discharge, Learning Disability Discharge, Specialised Wheelchairs, Autism (13 weeks for commencement of specialised treatment), Acquired Brain Injury and cancelled operations.

7. Mr Bloomfield also highlighted a number of standards and targets not maintained or achieved in 2009/10 including Elective Access – 9/9/13, Fractures, Cancer (62 days), A&E (4-hour and 12-hour standards), Renal Services (Fistula), Renal services (Liver Donor Transplant), Mental Health Assessment and Treatment, Autism assessment, and Pre-Operative Assessment.

8. It was noted at the end of March 2010, the Trust achieved the maximum waiting time standard or agreed backstop position across all outpatient specialties with the exception of Ophthalmology, where four patients breached the agreed 26 week maximum waiting time backstop. In respect of diagnostic tests, the Trust achieved the 9 week maximum waiting time standard, or agreed backstop position. For inpatients/ daycases, with the exception of 56 patients, the Trust achieved the 13 week maximum waiting time standard or agreed backstop positions across all inpatient/daycase specialties.

9. Mrs Galbraith thanked the HSC Board for its balanced assessment of the Trust's performance during 2009/10. Commenting on the Trust's overall performance, she advised that a significant proportion of the elective care breaches were down to regional capacity issues and the decision of the Trust to reduce their use of the Independent Sector in September 2009.

10. Mr McKee advised that against an elective care length of stay indicator, the Trust had seen a reduction of 4.57 days to 3.7 days in the period 2008/09 to the beginning of 2010/11. Similarly, in the same time period, he confirmed the non–elective length of stay indicator showed a fall from 9.6 days to 6.4 days. This had been achieved against a background of

rising demand for services and the decommissioning of 100 beds across the Trust.

11. Mr Donaghy thanked the Trust for their response.

Governance and Statement on Internal Control

12. Mr Donaghy reminded the Trust of the importance of openness in the disclosure of any organisational shortcomings in its Statement on Internal Control as the validity of the Department's own Statement on Internal Control depended to a large extent on the openness and balance of Trusts Statement on Internal Control.

13. In response, Mrs Galbraith requested clarity on the inclusion of issues within the Statement arising from earlier periods as the Trust had been requested to make reference to the O'Neill Report published in 2008, despite all recommendations being actioned by the Trust in 2008/09. Mr Donaghy noted the point and advised he would be happy to clarify the position.

14. Mr Donaghy requested confirmation that action plans in place were adequate to address the weaknesses identified by Internal Audit, specifically in areas of limited assurance such as Mental Health Order (Validity of Detentions) and Review of Patients Private Property in Acute Areas. Mrs Galbraith confirmed such plans were in place.

15. Mr Donaghy enquired if there were any other specific internal control problems that needed to be explicitly mentioned. Mrs Galbraith confirmed there were no further issues.

16. Mr Donaghy noted the required compliance had been achieved by the Trust in all but one of the 22 controls assurance standards and requested confirmation action plans were in place to address all

weaknesses identified in the 2009/10 controls assurance compliance exercise.

17. Mr McKee confirmed action plans were in place but questioned the continued usefulness of the controls assurance compliance exercise. In response, Mr Donaghy advised that Trusts had supported their continued application and it was the Department's view that the standards continue to support the embedding of organisation-wide risk management in HSC Trusts.

CSR 2010/11 and beyond

18. Mr Donaghy set out the background to and latest position on CSR 2010/11 process.

Operational and financial issues and risks for 2010/11 and beyond

19. Mr McKee set out a number of Financial and Operational risks facing the Trust:

20. Mr McKee highlighted a differential workload increase from NHSCT, in respect of increasing A&E attendances between 2007/08 to 2009/10 from patients in the northern area, which had increased further since the closure of Whiteabbey A&E, with no additional funding to match. In addition he advised that in June 2010, there was a 32% increase in non-elective Belfast Trust attendees with a postcode in the Northern area. There were also issues regarding the repatriation of fracture and haematology patients to the Northern Trust.

21. Mr Compton advised the Board were carefully monitoring transfer of non elective activity from the Northern Trust and were meeting with the Trust shortly to discuss the position.

22. The Trust highlighted concerns regarding the increasing number of safety and quality policies issued by the Department for implementation without a supporting funding stream.

23. Mr Donaghy advised these were intended to support the delivery of better, more cost effective care, which should realise savings for the Trust. Dr McBride added that that top quality patient care in a safe environment was a requirement of any service provided by the Health and Social Care sector and these initiatives embedded this principle.

24. Mr McKee welcomed the progress made in reducing the numbers of HCAI infections within the Trust and also regionally. In light of the progress made and likely further improvements from lower occupancy levels, single rooms and screening, he suggested a change in focus to areas such as VTE would be a more effective use for funding.

25. Mr McKee outlined changes to service reconfiguration proposed by the Trust. The Trust was currently determining the revenue consequences and sought confirmation on capital funding.

Closing

26. Mr Donaghy thanked those present for attending and closed the meeting.

Performance Management Unit
November 2010