INTERIM GUIDANCE

ON IMPLEMENTATION

OF THE

HPSS COMPLAINTS PROCEDURE

DECEMBER 1995

[HPSS ME LOGO]

Contents

Interim Guidance on Implementation of the HPSS Complaints Procedure

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IMPLEMENTATION OF THE NEW HPSS COMPLAINTS PROCEDURE

1 Background

1.1 *Being Heard*, the report on NHS complaints procedures by a Review Committee, chaired by Professor Alan Wilson, Vice Chancellor of Leeds University, was published in May 1994.

1.2 The health services in Northern Ireland were included within the remit of the review. Complaints procedures for community care and child care, which are the responsibility of local authorities in Great Britain, were outside the scope of the review.

1.3 Following formal public consultation on the conclusions and recommendations of the Review Committee, the HPSS Management Executive published *Acting on Complaints*, its revised policy and proposals for a new unified HPSS complaints procedure, in March 1995. Complaints on child care will not be incorporated within the new procedure but will be dealt with under the procedures in the *Children (Northern Ireland) Order 1995*.

1.4 Nationally, the NHS Executive took forward the initial work in developing guidance on implementation of the new procedure. In Northern Ireland, the HPSS ME set up a Steering Group to take account of the decisions which have been emerging nationally and, in turn, to produce guidance and oversee implementation. The Steering Group comprised representatives from the professions, HSS Boards, HSS Trusts, Health and Social Services Councils and other key interests.

2 Interim Guidance

2.1 This Interim Guidance is designed as a working document for those who are involved in taking forward the new procedure and ensuring its smooth implementation. In particular, it is to help:

- staff responsible for responding to complaints, including Chief Executives, Complaints Officers, and front-line staff; and
- those who will take on a role in the new procedure, including non-executives who are appointed as conveners and panel members, independent lay chairmen of potential panels, and those who are appointed to act as independent assessors.

2.2 The Interim Guidance aims to provide advice for those tackling the practical details of how the policy objectives of *Acting on Complaints* are to be achieved. It sets out initial guidance for HSS Boards, HSS Trusts, and to some extent, the family health services, including GP Fundholders, to help them develop their local plans for implementing the new complaints procedure through their front-line staff.

2.3 Information will be provided separately for family health services practitioners on setting up and operating practice-based arrangements for Local Resolution. This is still subject to negotiation with the professions.

2.4 Where some issues are identified in the document as remaining open, resolution will be sought as soon as possible, so that further specific guidance can be issued.

2.5 The intention is to publish the updated and final Guidance in February 1996.

3 Policy Objectives

3.1 The outcome of the formal consultation on *Being Heard* revealed broad agreement on the objectives for change that had been outlined by the Review Committee. The key objectives for introducing the new procedure remain:

- ease of access for patients and clients;
- a simplified procedure, with common features, aimed at satisfying complainants concerns;
- more rapid, open responses, with an emphasis on early resolution;
- fairness for staff and complainants alike;
- making it easier to learn from complaints, in order to improve services and standards.

3.2 The Department is committed to achieving all these objectives. They are a key part of the programme of action flowing from the Charter for Patients and Clients. The new procedure aims at satisfying complainants by resolving complaints as quickly as possible. This may be through an immediate informal response by a front-line member of staff or practitioner, or by subsequent investigation and conciliation by staff who are empowered to deal with complaints in an open and non-defensive way.

3.3 In developing the processes needed to implement the new complaints procedure, it became apparent that use of the terms Stage 1 and Stage 2 in *Acting on Complaints* implied a progression through the stages of the procedure and gave the wrong message about the objective of early resolution. The Guidance therefore refers to **Local Resolution** instead of Stage 1, and **Independent Review** instead of Stage 2.

4 Framework

Legal Framework

4.1 HSS Boards and GP Fundholders will be required (through directions and regulations as appropriate) to set up complaints procedures in their contracts with providers. Regulations will require family health services practitioners and GP Fundholders to set up and run practice-based complaints procedures and to comply with the complaints review procedures organised by HSS Boards.

4.2 This will have the following statutory basis:

- under Article 17 of the *Health and Personal Social Services (Northern Ireland) Order 1972* the Department has powers to delegate to HSS Boards such functions as it may direct, and require HSS Boards to exercise them on its behalf;
- under Article 10 of the *Health and Personal Social Services (Northern Ireland) Order 1991* the Department has powers to delegate to HSS Trusts such functions as it may direct, and require HSS Trusts to exercise them on its behalf;
- under Article 17 of the *Health and Personal Social Services (Northern Ireland) Order 1991* the Department has powers to make regulations for recognition of GP Fundholders with respect to the conditions to be fulfilled for obtaining and continuing to be entitled to such recognition;
- under Article 27 of the *Health and Personal Social Services (Northern Ireland) Order 1972* the Central Services Agency shall carry out such functions as the Department may direct;
- under Article 4 of the *Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990* a special agency shall carry out such functions as the Department may direct.

4.3 The following Regulations will be amended to require family health services practitioners and GP fundholders to operate the Local Resolution process and to comply with the Independent Review process:

- *The General Medical and Pharmaceutical Services Regulations (NI) 1973*;
- *The General Dental Services Regulations (NI) 1993*;
- *The General Ophthalmic Services Regulations (NI) 1986*;
- *The Health and Personal Social Services (Fundholding Practice) Regulations (NI) 1993*.

Access to Health and Social Services Records

4.4 The new complaints procedure will subsume the complaints procedure for access to health records under the *Access to Health Records (Northern Ireland) Order 1993*. The new complaints procedure will also subsume the complaints procedure for access to social services records. Access to social services records is currently provided for under Departmental circular *Client's Access to Non-computerised Personal Social Services Records About Themselves (HSS SP1/87)*, and *The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991*. Legislation to give clients access to social services records similar to that given to patients under the Access to Health Records Order has been enacted but is awaiting implementation of a corresponding GB Bill.

Confidentiality

4.5 Investigation of a complaint does not remove the need to respect the right of a patient/client to confidentiality. New guidance on the use and protection of patient/client information is currently under consideration and this interim guidance takes into account what is likely to be proposed.

Code of Practice on Openness in the HPSS

4.6 There will be an entirely different non-statutory procedure for obtaining access to HPSS information under the Government's policy for extending access to official information. Draft guidance on implementation of the Code of Practice on Openness in the HPSS will be issued for consultation by the HPSS Management Executive early in the new year.

4.7 Where part of a complaint about services is that information has been refused, maybe in pursuit of the original complaint - and provided the Chief Executive has been given the opportunity first to review the circumstances - complainants should be advised of their right to pursue this aspect separately with the NI Commissioner for Complaints (the Commissioner). They should not have to wait for the outcome of investigations into the rest of the complaint.

Complaints about Purchasing

4.8 HSS Boards will **not** be involved in resolving complaints about services provided by HSS Trusts. There will need to be both Local Resolution and Independent Review arrangements for dealing with complaints about purchasing decisions by HSS Boards or GP Fundholders, and services for HPSS patients/clients purchased from the independent sector by HSS Trusts, HSS Boards or GP Fundholders. While most of this guidance is focused on complaints against HSS Trusts and family health services practitioners, as these constitute the vast majority of complaints, similar mandatory provisions and guidance will apply to complaints about purchasing decisions and about services purchased from the independent sector. (See Section 9 - Complaints about Purchasing.)

Mixed Sector Complaints

4.9 Where a complaint involves more than one HPSS provider or one or more other body, such as a purchaser, there should be full cooperation in seeking to resolve the complaint through each body's local complaints procedure. Where a complaint is solely concerned with services provided by another provider or a body outside the HPSS, the complaint should be referred to the Complaints Officer. The officer should ensure that it is passed immediately to the correct body, after consulting with the complainant and provided that the complainant wishes this to be done. The complainant and the body concerned should both then be formally advised in writing.

4.10 It is possible at present to pursue the following types of complaints in parallel through the Independent Review process:

- a complaint about a family health services practitioner and a related complaint about the Board in its family health services capacity;
- a complaint against a GP Fundholder for actions connected with their responsibilities to provide family health services and a complaint about their purchasing decisions;
- a complaint about services provided by an independent sector body for an HPSS patient and the purchasing decision associated with this.

In such cases, if clinical assessors need to be appointed, the HSS Board will need to nominate at least one assessor to deal with each of the clinical aspects of the complaint.

4.11 Unfortunately, it is not possible to pursue through a single Independent Review a mixed complaint relating to the actions of two HPSS providers/purchasers, for example, two HSS Trusts, or a family health services practitioner and a HSS Trust, or a HSS Trust and a purchaser. Where a complainant wishes to pursue such related complaints to Independent Review, the complaint should be copied to the other provider/purchaser concerned and the conveners should liaise with each other to ensure that each aspect of the complaint is fully considered.

5 Preparatory Action

Note: Some sections of the Interim Guidance are reproduced in ***bold/italics*** indicating ***mandatory requirements*** of the new procedure, which will be established in ***Directions and Regulations***, to be published in February 1996.

Written Procedure

5.1 ***HSS Trusts/Boards must establish a written complaints procedure and take steps to publicise the arrangements.***

5.2 It will be a requirement for all HSS Trusts/Boards to have a formally adopted written complaints procedure for complaints against themselves. Family health services practitioners will be required to establish and operate a Board approved complaints procedure within their practices. This applies to all practitioners who appear on the HSS Board's list of persons undertaking to provide relevant services, whether they are individuals, or public or private companies.

Publicity

5.3 ***HSS Trusts, HSS Boards, and family health services practices must ensure well publicised advice is available to all users of their services, visitors, staff, and their local HSS Council, about:***

- ***the arrangements for dealing with Local Resolution and the Independent Review of complaints;***
- ***how to refer a complaint to the Complaints Officer or the Chief Executive;***
- ***how to approach the convener with a request for an Independent Review panel to be set up;***
- ***the role of the HSS Council in giving individuals advice and support on making complaints***
- ***the right to complain, and the means of making a complaint to the Commissioner.***

Who may complain

5.4 Directions will specify who may have a complaint dealt with through the new complaints procedure.

HSS Trusts

5.5 ***Complainants will be existing or former users of the HSS Trust's services. People may complain on behalf of existing or former users where the Trust - usually through its Complaints Officer, or the convener at the Independent Review stage - accepts them as a suitable representative, who has been authorised to act on the patient's/client's behalf.***

5.6 The question of suitability to represent a patient normally depends on the patient's/client's explicit knowledge and consent that a specific person may act on their behalf. Where the patient/client has died, or is not competent to give consent - for example, due to mental illness or disability, or because they are too ill at the time - it will be necessary to establish in these circumstances that the complainant is suitable to represent the patient/client, paying particular attention to the need to respect the confidentiality of the patient, and to any known wishes expressed by the patient/client that information should not be disclosed to third parties.

Family Health Services

5.7 ***Complainants will be existing or former patients of a practitioner who has arrangements with a Board to provide family health services - or people who have received family health services, or any person who is accepted as suitable to act on behalf of such a patient. Complaints must be related to services provided by the individual practitioner or the family health service practitioner concerned. Or any person providing such services on their behalf.***

Time Limits on Initiating Complaints

5.8 ***A complaint should be made as soon as possible after the action giving rise to it. The time limit for making a complaint will be within six months of the event giving rise to it, except that if a complainant was not aware that there was cause for complaint, the complaint must be made within six months of becoming aware of the cause for complaint, or twelve months from the date of the event, whichever is the earlier. There is discretion to extend these time limits where it would be clearly unreasonable for the complaint to have been made earlier; and where it is still possible to investigate the facts of the case.***

5.9 The discretion to vary the time limit should be used with flexibility and sensitivity, Wherever possible the complainant's concerns should be addressed, while remaining scrupulously fair to staff. An example of where discretion should be exercised in favour of extending the time limit would be where the complainant has suffered particular distress or trauma which prevented them from making their complaint at an earlier stage.

Complaints Officer

5.10 ***The HSS Trust/Board must have a designated Complaints Officer, who is readily accessible to the public.***

5.11 Where the Complaints Officer is not the Chief Executive, he/she should be directly accountable to the Chief Executive. The Complaints Officer should have access to all the relevant records which are essential for the investigation of any complaint referred to him/her.

5.12 The Complaints Officer's role is mainly to deal with written complaints on behalf of the Chief Executive. He/she should also investigate and resolve other complaints under the Local Resolution process where the complainant does not wish to raise their concerns with the people directly involved with their care, or where front-line staff are unable to deal with the complaint. The Complaints Officer should support and help staff who respond to complaints.

5.13 It will be for family health services practices to decide who is most appropriate in the practice to be responsible for the practice complaints procedure. In the case of general medical practices it may, for example, be the senior partner, or possibly the practice manager. General dental practitioners, pharmacists, ophthalmic medical practitioners, and optometrists, must make similar appropriate arrangements.

Role of Health and Social Services Councils

5.14 The staff of Health and Social Services Councils have a very important role in assisting complainants at each stage of the process in both the hospital and community services, and family health services. HSS Trust and HSS Board Chief Executives should ensure that advice on how to contact the local HSS Council for assistance in making a complaint is well publicised, and that HSS Councils are fully aware of the complaints procedures in operation.

Appointment of Convener

5.15 ***The Board must appoint one or more of its non-executive directors to act as convener.***

5.16 The convener will consider requests by complainants for Independent Review panels to be set up. The discretion to appoint more than one non-executive to this function allows the role to be shared, and a successor or understudy to be trained. It also provides for the possibility of an alternate convener to represent the Board on the panel, if it is established. This will also relieve pressure on the original convener who may be involved in more than one convening request. The concept of a 'lead' convener, or 'convener's office', may be useful.

5.17 Conveners may be any of the non-executives, but the appointments should not be of practising or recently retired clinical professionals and former HPSS staff, where this might give rise to criticism of bias by either the complainant or the complained against. HSS Boards should be sensitive to these concerns.

5.18 It is suggested that these appointments be for an initial period of at least two years, but where more than one is designated, the appointments might be staggered.

Separation of Complaints and Disciplinary Procedures

5.19 ***The complaints procedure must be kept separate from disciplinary procedures.***

5.20 Policy is firm on the need for the new complaints procedure to be concerned only with resolving complaints and not with investigating disciplinary matters. The purpose of the complaints procedure is not to apportion blame amongst staff. It is to investigate complaints to the satisfaction of complainants (while being scrupulously fair to staff) and to learn any lessons for improvements in service delivery. Inevitably some complaints will throw up information about serious matters which indicate a need for disciplinary investigation.

5.21 In hospital and community/ambulance services, a case for considering disciplinary action can be suggested at any point during the complaints procedure. Consideration on whether or not disciplinary action is warranted is, however, a separate matter for management outside the complaints procedure and must be subject to a separate process of investigation.

5.22 Relevant papers that have been accumulated during the investigation of the complaint may be passed to the appropriate person in the HSS Trust/Board who will be considering the need for a disciplinary or other form of investigation (see paragraph 5.24). The papers should not be treated as privileged information as they may need to be considered in any such disciplinary or other investigation.

5.23 In the case of family health services, the Service Committee procedure will cease for complaints made on or after 1 April 1996. After that date, disciplinary action will only be considered after the handling of a complaint had been concluded and will not therefore proceed in parallel. Only if action was necessary to protect patients, for example, involving the police, professional registration body, or the HPSS Tribunal, will disciplinary action interrupt the handling of a family health services complaint.

5.24 *If any complaint received by a member or employee of a HSS Trust/Board indicates a possible need for referral to:*

i an investigation under the disciplinary procedure;

ii one of the professional regulatory bodies; or

iii an investigation of a criminal offence;

the person in receipt of the complaint should immediately pass the relevant information to the Complaints Officer. The officer will pass it on to a suitable person who can make a decision on whether or not to initiate such action. This referral may be made at any point during any stage of the complaints procedure.

Neither the Complaints Officer nor the convener shall be responsible for deciding whether or not to initiate any of the action referred to in the above paragraph and they should refer such circumstances to the person designated in the HSS Trust/Board for dealing with such matters.

Whenever these circumstances arise, a full report of the investigation thus far should be produced and made available to the complainant.

The complaints procedure will not deal with matters which are currently the subject of disciplinary investigation. If action is initiated under i or ii above, the complainant should be advised accordingly. Where there are other matters raised in the complaint which do not relate to disciplinary investigation appropriate action should then be pursued under the complaints procedure.

If any action is initiated under iii above, the complaints procedure should be similarly modified until such action is concluded.

When any action as set out above has been concluded, the complaints procedure should only recommence where there are matters in the complaint which have not been dealt with through that action.

5.25 When a decision is made to embark upon a disciplinary investigation, the processing of the complaints procedure does not automatically cease. Those aspects of the original complaint not covered by the disciplinary inquiry will continue to be investigated. It is essential for the person handling the complaint to make clear to the complainant that a disciplinary inquiry is now under way, particularly if the complainant is likely to be asked to take part in this process.

5.26 If there are no outstanding issues from the original complaint to be investigated the complainant should be advised that no further action will be taken, other than that through the disciplinary procedure.

5.27 The complainant may well ask at this point to be informed of the outcome of the disciplinary inquiry. It is recognised that HSS Trusts/Boards may be reluctant to provide this information, recognising their obligations to retain the confidentiality of employment arrangements with individual members of their staff. A judgement will need to be made on how to reassure the complainant that the matter complained about has been dealt with seriously and satisfactorily, while protecting the confidentiality of the member of staff.

5.28 The guiding principle should be that, when the disciplinary procedure is invoked, the complainant receives the same consideration and level of information as if the matter had been dealt with through the complaints procedure. The complainant should be able to understand what happened, why it happened, and what action has been taken as a consequence to ensure that it does not happen again. The complainant should be informed in general terms of any disciplinary sanction imposed on any staff member.

5.29 It is most important that the complainant is satisfied with the action being taken by the HSS Trust/Board. If a referral for disciplinary investigation has been made during the period of Local Resolution then this part of the complaints procedure should be rounded off with a formal written explanation of the action taken by the HSS Trust/Board. Where the referral is made later during the Independent Review process, then a similar written explanation needs to be given on completion. Within the context of the complaints procedure, the overall consideration must be that, even if the investigation has been moved into the disciplinary procedure, the complainant is not left dissatisfied, and feeling that their grievance has only been partially dealt with.

5.30 A similar approach will need to be adopted in a case which has indicated the need for a referral to one of the professional regulatory bodies. A HSS Trust/Board has no control over what then happens and over what period. The complainant should be informed of this decision and at that point given as full a response as possible to the complaint. It should be made clear that any information obtained during the complaints investigation may need to be passed on to the regulatory body.

[paragraphs 5.24 to 5.30 do not apply to family health service practitioners]

Possible Claims for Negligence

5.31 ***If a complaint reveals a prima facie case of negligence, or if it is thought that there is a likelihood of legal action being taken, the person in receipt of the complaint should inform the employees of the HSS Trust/*Board responsible for dealing with risk management and claims management. The complaints procedure should not cease unless the complainant explicitly indicates an intention to take legal action in respect of the complaint.***

[* this does not apply to family health services]

5.32 Even if a complainant's initial communication is via a solicitor's letter, the inference should not necessarily be that the complainant has decided to take formal legal action. A hostile, or defensive, reaction to the complaint is more likely to encourage the complainant to seek information and a remedy through the courts.

5.33 In the early part of the process it may not be clear whether the complainant simply wants an explanation and apology, with assurances that any failures in service will be rectified for the future, or whether the complainant is in fact seeking information with formal litigation in mind. It may be that an open and sympathetic approach will satisfy the complainant. Where there is a prima-facie case of clinical negligence, the person dealing with the complaint should seek advice appropriately. This should not prevent a full explanation being given and an apology offered to the complainant: an apology is not an admission of liability. If formal legal action has been instigated, the complaints procedure should be brought to an end, with the complainant being appropriately advised in writing.

5.34 In all prima facie cases of negligence, or where the complainant has indicated that they propose to start legal proceedings, the principles of good claims management and risk management should be applied. There should be a full and thorough investigation of the events. In any case where the HSS Trust/Board accepts that there has been negligence, a speedy settlement should be sought.

6 Local Resolution

6.1 *As part of its complaints procedure, the Trust/*Board must establish a clear Local Resolution process.*

[* only relevant to complaints about HSS Boards]

6.2 The primary objective of Local Resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. Complaints procedures of HSS Trusts/Boards must therefore have a well-defined Local Resolution process, which lays emphasis on complaints being dealt with quickly and, wherever possible, by those on the spot. The intention of Local Resolution is that it should be open, fair, flexible, and conciliatory. The complainant should be given the opportunity to understand all possible options for pursuing the complaint, and the consequences of following any of these. This explanation should indicate that it might be necessary to look at the patient's/client's health/social services records.

6.3 The process should encourage communication on all sides. The aim should be to resolve a complaint during this stage to the satisfaction of the complainant while being fair to staff. Local Resolution should not be seen simply as a run-up process to Independent Review: its primary purpose being a comprehensive response that satisfies the complainant. The process of Local Resolution should provide for a range of different options for response to the complainant. Rigid, bureaucratic, and legalistic approaches should be avoided at all stages of the procedure, but particularly during Local Resolution.

Role of Front-Line Staff

6.4 Complaints are most likely to be made to front-line staff on hospital wards, in clinics, at reception desks, or in social services departments. Management need to empower front-line staff to deal with complaints on the spot. Local guidance needs to assist front-line staff in distinguishing serious issues which need reference elsewhere, and when to refer complaints for fuller investigation by the Complaints Officer. Steps need to be taken to ensure effective arrangements are in place for dealing with complaints that are received over the telephone. Steps should also be taken to ensure that complainants are made aware of the role of HSS Councils in assisting them to pursue complaints and how to contact them.

6.5 The first responsibility of a recipient of a complaint is to ensure that the patient's/client's immediate health and social care needs are being met. This may require urgent action before any matters relating to the complaint are tackled. Staff should, where possible, deal with the complaint rapidly and in an informal and sensitive manner. Complaints may also be made to clinical staff or even to a member of the HSS Trust/Board. Whoever the complaint is referred to should seek to understand the nature of the complaint and any nuances that are not immediately obvious.

6.6 If the recipient is unable to investigate the complaint adequately, or feels unable to give the assurances that the complainant is clearly looking for, then the complaint should be referred on to the Complaints Officer for advice or for handling. Complainants should be encouraged to speak openly and freely about their concerns. And they should be reassured that whatever they may say will be treated with appropriate confidentiality and sensitivity.

6.7 Some complainants may prefer to make their initial complaint to someone who has not been involved in their care. In these circumstances they should be counselled to address their complaints to the Complaints Officer or, if they prefer, to the Chief Executive. While front-line staff should always encourage complainants to be forthcoming in expressing their concern and anxiety, particularly where they are disappointed with the care they have received, this should never be done at the expense of overriding the right of complainants to make their complaint to the Complaints Officer or the Chief Executive.

6.8 Front-line staff also need to be empowered to use the information they gain from complaints to improve service quality. Mechanisms for achieving this can be agreed at team level and will be particularly important for sharing information relevant to the work of other teams, for example, those responsible for hotel services.

Need for Flexibility

6.9 The Citizen's Charter Complaints Task Force defined a complaint as 'an expression of dissatisfaction requiring a response'. In the majority of cases, complaints are made orally. All complaints, whether oral or written, should receive a positive and full response, with the aim of satisfying the complainant that their concerns have been listened to, and offering an apology and explanation as appropriate.

6.10 When deciding whether or not to pass the complainant on to the Complaints Officer, front-line staff will need to take into account the seriousness of the oral complaint and the possible need for more independent investigation and assessment. While the main role of the Complaints Officer is to investigate complaints and to satisfy complainants, this must not preclude the Complaints Officer from advising front-line and other staff in the resolution of complaints.

6.11 ***All written complaints must receive a response in writing from the Chief Executive. Some oral complaints are sufficiently serious, or difficult to resolve, that they should be recorded in writing by the Complaints Officer. These complaints should also receive a written response from the Chief Executive.***

6.12 Anyone handling a complaint, and particularly complaints officers handling written complaints, must ensure that any response given to a complainant which refers to matters of clinical judgement is agreed by the clinician concerned and, in the case of medical care, by the consultant concerned.

6.13 There may be occasions when a communication is critical of a service or the quality of care, but is not intended as a complaint. Chief Executives will wish to ensure that their organisations are receptive to comments and suggestions, whether critical or positive, as well as to complaints. Such communications are a useful form of feedback from patients/clients, which can be used to improve the quality of service, and also to give encouragement to staff when they are doing well.

Family Health Services

6.14 From 1 April 1996 there will be a term of service obligation on family health services practitioners to have in place and to operate practice-based complaints procedures which comply with minimum national criteria. For general practitioners, it has been agreed that minimum criteria will be along the following lines:

- administration of practice-based procedures must be practice-owned;
- practices must give the procedures publicity;
- practices must ensure it is clear how to lodge a complaint, and to whom;
- an initial response should normally be made within two working days;

- the person nominated to investigate the complaint should make all necessary inquiries such as interviews, if appropriate, of the complainant, general practitioner(s) and practice staff;

- an explanation should normally be provided within two weeks (ie ten working days);

- local schemes with additional features must be approved by the Board and local representative committees.

6.15 It is in everyone's interest that Local Resolution at practice level is successful. Practices may decide to bid for additional funding for staff to set up and operate the new procedures, and HSS Boards will be asked to consider reasonable bids favourably. [**NB: Steering Group to comment on para 6.15**]

6.16 There will be a role for HSS Boards in the family health services Local Resolution process where, for example, a complainant does not wish to have a complaint dealt with by the practice. HSS Boards will need to have lay conciliators available as a service to complainants and practices, which complainants may wish to use. Conciliators should not be practising professionals as this may give rise to accusation of bias by the complainant or complained against. In certain cases, HSS Boards and their staff will need to act as intermediaries in order to secure an investigation by, and explanation from the practice, rather than providing a conciliation service.

Completion of Local Resolution

6.17 It may be appropriate for the entire process of Local Resolution to be conducted orally, without any written communication. Where, however, the complainant indicates that they are not satisfied with the oral response, or where the person dealing with the complaint considers that the complainant may wish to take the matter further, it is recommended that Local Resolution may be best rounded off with a letter to the complainant. For complaints against HSS Trusts and HSS Boards the time limit for such a request to be made will be **twenty working days.** This communication should be aimed at satisfying the complainant that the complaint has been fully and fairly investigated, with an appropriately couched apology where things have gone wrong, and what is to be done to prevent a recurrence.

Performance Targets for Local Resolution in HSS Trusts/Boards

6.18 Most oral complaints should be resolved on the spot or within two working days. Where this is not possible, and for formal written complaints, the HSS Trust/Board should aim to make either an initial acknowledgement to the complainant **within two working days** or, if they are able to resolve the complaint fully within this time, to respond **in five working days.** For written complaints, and oral complaints recorded in writing, acknowledgements should always be in writing.

6.19 Full investigation and resolution of all types of complaints should be sought **within twenty working days,** while recognising that there is likely to be great variation in the nature of complaints and in the ability of complainants to cope with their part of the process.

6.20 Recognising that the primary purpose of Local Resolution is to satisfy the complainant wherever possible, while being scrupulously fair to staff, these targets should be used with discretion. Where the targets are not being met, it is very important for the complainant to be informed of the delay, the reasons for it, as well as the revised timetable for dealing with the complaint.

7 Convening an Independent Review Panel

Action by the Complainant

7.1 ***Complainants who are dissatisfied with the response from the HSS Trust/Board as a result of the Local Resolution process may refer a request for an Independent Review panel to the convener either orally or in writing. For complaints against HSS Trusts/Boards this request should be made <u>within twenty working days</u> from the completion of the Local Resolution process. Any request for an Independent Review panel received either orally or in writing by any other member or employee of the HSS Trust/Board should be passed on to the convener <u>immediately</u>.***

7.2 A complainant may make a request for an Independent Review panel either orally or in writing. The twenty day time limit for making the request applies to the initial request and not to the making of the subsequent written statement (see paragraph 7.31).

Action by the Convenor

7.3 The request for a panel should be followed up by the appointed convener immediately. The convener should make arrangements so that a complainant's request for an Independent Review panel can be acknowledged in writing.

7.4 ***Before deciding whether to convene a panel, the convener must obtain a statement signed by the complainant setting out their remaining grievances and why they are dissatisfied with the outcome of Local Resolution.***

7.5 The convener will need to understand as quickly as possible why the complainant remains dissatisfied. It is important for the convener to obtain the complainant's statement, in as explicit and detailed a form as possible, before commencing investigations. Experience shows that complainants frequently do not set out clearly what their grievances actually are, or refer to things that have already been investigated or even dealt with. The convener should ensure complainants are aware of how to seek independent help in drawing up statements if they wish, for example from HSS Councils or patients' advocates. If the complainant has already clearly set out their remaining grievances, and there is no need to amend this, then the convener should not require a new statement to be drawn up.

7.6 Even when dissatisfied with the outcome of Local Resolution, a complainant does not have an automatic right to move to Independent Review. Complainants do, however, have the right to put their case directly to the Commissioner should a convener decide not to establish a panel. The Commissioner will be able to recommend that a panel should be established, or investigate the matter him or herself if this is more appropriate.

Role of the Convener

7.7 The role of the non-executive convener is crucial to triggering events under Independent Review. While the convener acts as a non-executive director of the HSS Board and not as an independent person, it is important that the convener distances him or herself from those involved in the complaint. The convener's role is to ensure the complaint is dealt with impartially at the convening stage. It is not the convener's function to defend those complained against, but rather to ascertain whether all opportunities for satisfying the complainant during Local Resolution have been explored and fully exhausted. And what issues, if any, should be referred to a panel. To this end the convener will need to obtain a full picture of the events relating to the complaint.

7.8 If the convener decides to convene a panel he or she should decide on the panel's terms of reference. The convener should advise the complainant of the matters which the panel will investigate and any which the panel will not investigate, for example disciplinary matters, or matters that have already been dealt with adequately. The convener's statement to the panel of its terms of reference should not be an interpretation or embellishment of the complainant's written grievance, but set out clearly what are the issues he or she believes the panel should investigate.

7.9 While the convener can decide that a panel will be established, it must be set up formally as a committee of the HSS Board. In making the decision on whether to convene a panel, the convener will contact one of the independent lay chairman on the HSS Board's list. This should not be the same person who will chair the panel, if it is convened. The purpose of this contact is to provide the convener with an external independent view and to aid him or her in assessing the grievance. It is, however, ultimately the convener's decision as to whether or not to recommend proceeding with the establishment of a panel and to explain why he or she made this decision. (For role of independent lay chairmen - see paragraphs 8.7 -8.8.)

Criteria for establishing a Panel

7.10 *In deciding whether to convene a panel, the convener will consider, in consultation with an independent lay chairman from the HSS Board's list, whether:*

- *the HSS Trust/Board can take any further action short of establishing a panel to satisfy the complainant;*
- *the HSS Trust/Board has already taken all practical action and therefore establishing a panel would add no further value to the process.*

The convener will need to take fully into account the advice of the independent lay chairman, although ultimately it is for the convener alone to decide whether or not to direct the establishment of a panel.

7.11 The convener should not consider the potential cost of setting up a panel as being a factor in his or her decision to recommend moving to Independent Review.

Clinical Advice to the Convener

Clinical Complaints

7.12 *Where the convener considers that a complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement, he or she must take appropriate clinical advice in deciding whether to convene a panel.*

7.13 The convener must take appropriate clinical advice in deciding whether to convene a panel when he or she considers a complaint relates in whole or in part to action taken in consequence of the exercise of professional clinical judgement - ie any judgement that is made by a member of the clinical professions in the HPSS by virtue of their knowledge and skill, which a layman could not make. These will be known as 'clinical complaints'.

7.14 This process will be important in informing the convener about any particular clinical considerations which he or she should take into account, and whether, for instance, there is any further practical action which could still be taken through the Local Resolution process. The key lies in the concept of action taken in consequence of clinical judgement.

7.15 Clinical judgement can be exercised by any of the recognised clinical professions working within the HPSS to provide care: doctors, nurses, midwives, health visitors, dentists, pharmacists, optometrists, clinical psychologists, members of professions supplementary to and allied to medicine, paramedics and ambulance technicians, laboratory and other scientific and technical staff. It is for the convener to decide whether a complaint appears to be a clinical complaint and from whom to seek appropriate clinical advice. Such advice is expected to come at least initially from within the HSS Board, but not from anyone who is in any way associated with the complaint. Advice may need to be sought from outside the HSS Board.

7.16 Where medical advice is needed, conveners are recommended to seek this initially from the HSS Board's Director of Public Health, who in turn may suggest who else would be qualified to advise. Where the Director of Public Health is the subject of the complaint, or where possible conflict of interest arises, some other appropriate independent medical opinion, such as that of the Department's Chief Medical Officer, should be sought.

7.17 In other cases where there is not an obvious local independent professional to consult it would be appropriate for the convener to seek advice from a nominated assessor in the appropriate profession on the central list held by the HSS Board. Such an adviser would be nominated by the HSS Board from the list of clinical assessors for panels.

7.18 In the case of family health services, clinical advice to the convener will come from an independent practitioner from the same profession as the practitioner who is being complained about, whose name will come from a list of practitioners nominated by the relevant local professional representative committee, or as otherwise agreed with the professions.

Social Services Complaints

7.19 ***Where the convener considers that a complaint relates in whole or part to action taken in consequence of the exercise of professional judgement, he or she must take appropriate professional advice in deciding whether to convene a panel.***

7.20 The convener must take appropriate social services advice in deciding whether to convene a panel when he or she considers a complaint relates in whole or in part to action taken in consequence of the exercise of professional judgement - ie any judgement that is made by a member of the social services profession in the HPSS by virtue of their knowledge and skill, which a layman could not make.

7.21 In the case of personal social services the convener is recommended to seek professional advice initially from the HSS Board's Director of Social Services who in turn may suggest who else would be qualified to advise. Where the Director of Social Services is the subject of the complaint, or where possible conflict of interest arises, some other appropriate independent social services opinion, such as that of the Department's Chief Social Services Inspector should be sought.

Decision of the Convener

7.22 Conveners are advised that they should not recommend the setting up of an Independent Review panel where:

- any legal proceedings have commenced, or there is an explicit indication by the complainant of the intention to make a legal claim against a Trust/Board, or one of their employees, or against a family health services practitioner; or
- it is considered the HSS Trust/Board has already taken all practicable action and therefore establishing a panel would add no further value to the process: consideration of the cost of instituting an Independent Review is not an appropriate reason for refusing to proceed; or
- further action as part of Local Resolution is still believed to be appropriate and practicable - even, for example, conciliation - so that referral back to the Chief Executive is considered preferable to beginning the Independent Review process.

7.23 ***The convener must inform the complainant, and any person alleged in the complaint to have taken any part in the action complained of, in writing of his or her decision as to whether or not to advise that a panel should be set up, setting out clearly the reasons for any decision to refuse a panel, and whether or not he or she believes there is further action the HSS Trust/Board could take.***

7.24 ***Where a panel has been refused, the complainant should be advised of the right to complain to the Commissioner.***

7.25 ***The convener must inform the Chief Executive of the HSS Trust/Board of his or her decision as to whether or not to advise that a panel should be set up and whether he or she believes there is further action which the HSS Trust/Board could take as part of Local Resolution.***

Response to Complainant

7.26 Both the complainant and the complained about must be informed in writing of the convener's decision as to whether or not to recommend that an Independent Review panel be set up. The convener should send to the Chief Executive of the HSS Trust/Board a copy of his or her communication to the complainant, which explains the decision, together with a copy of the written statement obtained from the complainant.

7.27 The convener must set out the reasons for any decision to refuse a panel as fully as possible so that the convener's views are clearly available should the complainant decide to exercise the right to refer the complaint on to the Commissioner. This right should be recorded in the letter from the convener to the complainant. The intention is to ensure that the complainant is fully informed of the reasons for not convening a panel and, if appropriate, why the convener believes there should be a reference back to Local Resolution.

7.28 ***If the complainant remains dissatisfied he or she may refer the complaint back to the convener to reconsider whether an Independent Review panel should be convened.***

Action by the Board

7.29 In order to avoid delay, HSS Boards are advised to arrange for delegated powers to be given to the Chief Executive and an alternate executive director to formally establish a panel as soon as the advice of its convener becomes known. The convener will likewise advise the HSS Trust/Board when he or she has decided against establishing a panel. If the recommendation of the convener is that Local Resolution should be reactivated, this should be expedited.

Performance Targets for Convening

7.30 The convener will arrange for acknowledgement of the complainant's request for an Independent Review panel within two working days.

7.31 Convening should not be a re-run of the action taken during Local Resolution. While recognising that assimilation of written and oral facts, and the conduct of adequate consultation all need time if they are to be exercised thoroughly, the period required for a decision to be made as to whether to convene an Independent Review panel should not normally exceed four weeks (ie twenty working days) from the date of the complainant's request being received by the convener.

8 Independent Review

Purpose of the Panel

8.1 The purpose of an Independent Review panel is to consider the complaint according to the terms of reference provided by the convener, and in the light of the written complaint or statement provided to him or her by the complainant. The panel will investigate the facts of the case, taking into account the views of both sides. It will set out its conclusions, with appropriate comments and suggestions, in a written report.

Establishing the Panel

8.2 *Independent Review panels will be composed of three members:*

- *an independent lay chairman appointed by the HSS Board;*
- *a convener or alternate (non-executive of the Board); and*
- *an independent person appointed by the HSS Board, or in the case of services purchased by GP Fundholders, a representative of the fundholding practice which purchased the service if the fundholder wishes.*

Where the convener decides, after consultation with the independent lay chairman and after taking appropriate clinical advice, that the complaint is a clinical complaint, the panel will be advised by at least two independent clinical assessors nominated by the HSS Board following advice from the relevant professional representative bodies. In the case of social services complaints two independent assessors will be nominated by the HSS Board following advice from the BASW (NI).

The panel is to be established as a committee of the Board and the assessors are to be appointed by the Board to advise the panel.

In considering a complaint from, or on behalf of, a person suffering from mental disorder, and where the complaint relates to the care and treatment of that mental disorder, the convener should consider co-opting a member of the Mental Health Commission onto the panel.

Appointment of Panel Members

8.3 HSS Boards will be responsible for recruiting independent lay chairmen and lay panel members. Criteria for selecting panel members should include:

- interest in the subject,
- impartiality and judgmental skills and,
- experience in working in small groups tasked with producing reports, where possible.

8.4 The names of persons held on the lists for the role of independent lay chairman and the third panel member for family health services panels will all be those of lay people. They should not be practising or retired HPSS staff or members of any of the clinical or other professions, neither should they be lay non-executive directors of other HSS Trusts/Boards. No panel member, other than the convener, will have any previous formal links with the Board establishing the panel. There will always be a majority of lay members on the panel. Recruitment will be in accordance with equal opportunities policy.

8.5 HSS Boards are responsible for putting in place arrangements for holding lists of independent chairmen and lay panel members. It will be the responsibility of Boards to organise access to broad training for independent chairmen and panel members and to decide their appropriate allocation to panels. HSS Boards may find it helpful in liaising with each other in finding an appropriate chairman and panel members, where circumstances demand a wider trawl. Call-off from these lists should be organised in a balanced, independent way, so that no one panel member becomes regularly linked with a particular HSS Trust/Board.

8.6 It is for HSS Boards to issue formal letters covering the appointment of panel members to serve on a specific panel, including indemnity cover, and to ensure that arrangements are made to let panel members have appropriate background and briefing papers, together with the names of the assessors who have been appointed to assist their particular panel.

Role of Independent Lay Chairmen

8.7 There are two roles for independent lay panel chairmen:

- helping conveners, by providing independent advice and support during the convening period; and
- chairing panels when established.

When considering a particular complaint these roles should be separated and the tasks given to two different people.

8.8 Once the convener's decision to establish an Independent Review panel has been made and the convener has set out the panel's terms of reference, responsibility for leading the organisation of the panel's business falls to its independent lay chairman.

Function of the Panel

8.9 *The function of the panel is to:*

- *investigate the aspects of the complaint as set out in the convener's terms of reference, taking into account the complainant's grievance as recorded in writing to the convener;*
- *make a report setting out its conclusions, with appropriate comments and suggestions.*

The panel will have no executive authority over any action by the Trust/Board, or family health services practitioner, and may not make any suggestion in its report that any person should be subject to disciplinary action or referred to any of the professional regulatory bodies.

8.10 The panel should be proactive in its investigations, always seeking to resolve the complainant's grievance in a conciliatory manner, while at the same time taking a view on the facts it has identified. The panel should be flexible in the way it goes about its business, choosing a method or procedure appropriate to the circumstances of the complaint. It should not act in a confrontational manner. Resolution of the complaint may be sought by the full panel, with its assessors, through separate meetings with the complainant and the complained against, or - very exceptionally - together, or through smaller meetings involving, say, any one member of the panel, with or without an assessor.

8.11 *The panel will decide how to conduct its proceedings, having regard to guidance issued by the HPSS Management Executive, within the following rules:*

- *the panel's proceedings must be confidential;*
- *the panel must have access to all the records held by the HSS Trust/Board relating to the handling of the complaint;*
- *if the complaint is a clinical complaint, the panel must have access to the relevant parts of the patient's/client's health/social services records;*
- *the panel must give both the complainant and any person complained against a reasonable opportunity to express their views on the complaint;*
- *if any of the panel members disagree about how the panel should go about its business, the chairman's decision will be final;*
- *when being interviewed by any members of the panel or the assessors, the complainant and any other person interviewed may be accompanied by a person of the complainant's choosing, who may speak to the panel members/assessors - except that no person interviewed may be accompanied by a legally qualified person acting in a legal capacity.*

8.12 The chairman of the panel has discretion as to how the panel should operate. Panels should work informally and be flexible in their approach in order to respond appropriately to differing kinds of complaint. The panel process should not be a tribunal process involving formal cross-examination of witnesses, nor should it be confrontational. Panels should not operate in an adversarial, legalistic way. Neither the complainant nor the complained against may be legally represented. The complainant may however be accompanied on all occasions by a person of their choosing, who, even if legally qualified, may not act in a legal capacity. At the chairman's discretion it may be felt appropriate for the complainant to be accompanied by both a relative, for emotional support, and an adviser, say from the HSS Council.

8.13 Any person mentioned in the complaint who is interviewed may be similarly accompanied by a representative of their trade union or professional organisation, or appropriate manager or colleague, who can act in a capacity of personal adviser. Only with the approval of the chairman may those accompanying the complainant and the complained against contribute to the panel's proceedings.

Identification of Assessors

8.14 ***The independent clinical assessors' role is to advise and make a report, or reports, to the panel on clinical complaints.***

The assessors should decide, in consultation with the panel, how to go about their business, having regard to guidance issued by the HPSS Management Executive.

8.15 Where the complaint is wholly or partly related to clinical matters, panels must be advised by at least two independent clinical assessors on relevant matters. The role of an assessor is to advise the panel or its individual members. Assessors should not act independently to resolve a complaint. Where a complaint raises issues about more than one medical specialty or health and social care profession, at least one assessor for each medical specialty or health or social care profession should be available to advise the panel. In cases where only one discipline is under scrutiny there will be two assessors from the relevant discipline. In some cases it may be appropriate for there to be more than two assessors and it will be for the convener and independent lay chairman of the panel to make this decision.

8.16 HSS Boards will hold copies of the lists of assessors for hospital and community health services, family health services and social services.

8.17 The professional bodies' role in ensuring that lists of appropriate independent assessors, who are acceptable to the profession concerned, are kept up to date, will be crucial to the general standing and efficacy of the assessor system:

- the BMA has undertaken to continue this role for hospital medical and dental staff;
- the Central Committee for Community Dental Services of the British Dental Association will undertake this role for community dentists;
- discussions are currently taking place with the professional representative bodies for nursing, to ensure that appropriate independent nursing assessors, acceptable to the profession, are identified;
- local medical committees will make arrangements for preparing lists of appropriate assessors in family health services;
- approaches are being made to those professional bodies who represent other professions which might be involved to ensure that lists are available from April 1996.

8.18 HSS Boards will select assessors to serve individual panels. Normally assessors will be selected from names of those working outside the geographical area of the HSS Trust/Board concerned, but there will be discretion on this point. If the HSS Board has any difficulty in determining appropriate assessors they should consult the appropriate professional body.

Appointment of Assessors

8.19 Responsibility for formally appointing and communicating with the chosen assessors will rest with HSS Boards, who should issue letters covering their appointment to assist a specific panel, including indemnity cover. They will ensure that arrangements are made to let the assessors have appropriate documentation. Legal advice is being sought on the question of indemnity cover for assessors and this will be covered in the final Guidance.

Release of Assessors

8.20 The role of the assessor is crucial to the success and impartiality of the new complaints procedure. If the role is to be carried out thoroughly and successfully, then assessors will need to be granted prompt release from their commitments. HSS Trusts and other employers are encouraged to recognise that the system of assessors will only work successfully if there is recognition that release needs to be granted quickly, so that delays can be avoided.

Role of Assessors

8.21 The role of the assessors is to advise the panel, as and when required, on those aspects of the complaint involving clinical (or other professional) judgements. Where the complaint is wholly or partly related to clinical matters, at least one assessor will always be present whenever the full panel meets, including panel meetings with any of those concerned with the complaint. Assessors will, at the panel's discretion, and if requested by either the complainant or the complained against, attend meetings that might be set up between them and individual members of the panel. Where assessors are of different disciplines, each should, when possible, be present when matters relevant to that discipline are likely to arise.

8.22 ***The assessors must have access to all the records held by the HSS Trust/Board relating to the handling of the complaint and to the patient's/client's health and social services records. Assessors will need to acquaint themselves of any circumstances where a patient or client has not been granted access to their full record, or where the patient has asked for information to be withheld from other parties.***

8.23 Assessors may interview/examine complainants, who may if they wish have a person of their choosing present. Assessors should check if the patient/client has ever been denied access to all or part of their health or social services record. Where the complainant is not the patient/client, care must be taken not to disclose information which would breach confidentiality of patient/client information. Assessors should not explain their findings to either the patient/client or complainant at this stage, before advising the panel of their views.

Assessors' Reports

8.24 It will be open to assessors to provide combined or individual reports. The assessors' reports should not be made available to the complainant - or the consultant/clinician/other professional complained about - in advance of the reports being made available to panel members. The panel may decide, in consultation with the assessors, to release their reports to the complainant and the complained against if it is believed this will aid resolution of the complaint. Otherwise assessors' reports will only become accessible to them as part of the panel's final report, initially as a draft.

8.25 Assessors should take care their reports contain no information which may cause serious harm to the physical or mental health of the patient/client or of any individual, nor contain information about, or provided by, a third party who can be identified from the information - unless they have consented to its disclosure. This excludes information about, or provided by, a health or social care professional involved in the and patient's/client's care.

8.26 ***The assessors' reports must be attached to the panel's final report when it is issued. If the panel disagrees with the assessors reports it must state why it has disagreed.***

8.27 Where the chairman of the panel finds it appropriate to meet the complainant - for example, as a way of rounding off resolution of the complaint - at least one of the assessors should, if the complaint relates to a clinical matter, be present in order to give a personal explanation to the complainant of any clinical findings by the assessors.

Panel's Final Report

8.28 The panel should provide the complainant and the person complained about, with a copy of its draft report to check its factual accuracy within, say, a period of **fourteen days** before it is formally issued in its final form. The assessors' reports should be made available in time for their preliminary circulation with the panel's draft report. Those receiving the draft report should be reminded of their duty of confidentiality, bearing in mind the work of the panel has been conducted in private. The complainant, and anyone complained about, should be asked to inform the panel if he or she wishes to

consult on the content of the draft report with an adviser who has not been previously involved in the complaint, such as the HSS Council.

8.29 ***The panel's final report must be sent to:***

- ***the complainant (subject to the duty to confidentiality and the safeguards referred to in paragraph 8.25);***
- ***the patient/client if a different person from the complainant and alive and competent to receive it (subject to the safeguards referred to in paragraph 8.25);***
- ***the clinical assessors or other professional assessors as appropriate;***
- ***the HSS Trust/Board Chairman and Chief Executive;***
- ***the Chairman and Chief Executive of the independent provider, where the complaint is about services provided by the independent sector;***
- ***the Board Chairman and Chief Executive or GP Fundholder who purchased the service concerned.***
- ***the practitioner, where the complaint is about family health services;***
- ***in the case of GP Fundholder complaints the Director of Primary Care and Purchasing Development in the HPSS Management Executive***

Appropriate extracts of the report must be sent to any person alleged in the complaint to have taken any of the action complained of.

The report is confidential and must not be sent to any other person or body.

8.30 The panel's final report should set out the results of its investigations, outlining its conclusions, with any appropriate comments or suggestions. The panel may not make any recommendations or suggestions relating to disciplinary matters.

Follow-up Action

8.31 ***Following receipt of the panel's report, the Chief Executive must write to the complainant informing them of any action the HSS Trust/Board is taking as a result of the panel's deliberations. And of the right of the complainant to take their grievance to the Commissioner if they remain dissatisfied.***

8.32 HSS Trusts/Boards should consider what arrangements are necessary for ensuring that action is taken on the outcome of Independent Review panel reports. And that action in individual cases has been taken where it had been earlier agreed to do so. HSS Trusts/Boards will also be responsible for ensuring that the action taken is communicated quickly and clearly to the complainant.

8.33 It needs to be made very clear to the complainant when the complaints procedure has been completed. The Commissioner will normally only embark on an investigation when the procedure has been exhausted. Completion will be when the Chief Executive writes to the complainant advising of the outcome of the Board's consideration of the panel's report. For family health services/GP Fundholders completion will be when the panel's report is sent to the complainant. The convener must ensure that the panel's report is sent with a letter advising the complainant of their right to complain to the Commissioner.

8.34 In any case where a panel comments about changes to family health services as a result of the panel's deliberations, the HSS Board may seek to establish what, if any, action the practitioner intends to take.

8.35 It is recognised that it may take a HSS Trust/Board some time to consider precisely how it will respond to the panel's report, particularly if there are suggestions for policy review or changes which require consultation with others before a decision is made. Nevertheless, the Chief Executive should endeavour to communicate to the complainant in writing any matters such as a formal apology; approval of an ex-gratia payment; or an indication of the timescale on which the HSS Trust/Board has agreed to consider policy issues **within four weeks** of the publication of the panel's report. The complainant should also be informed of their right to complain to the Commissioner. If, following this action, the HSS Trust/Board takes any further decisions relating to the outcome of the case, then the complainant should be appropriately informed.

Administrative Support, Fees and Expenses

8.36 ***The HSS Board shall provide any administrative support which the convener, the independent lay chairman or the panel need. All the expenses arising out of the Independent Review process, including any fees or expenses paid to panel members and assessors, shall be met by the HSS Board.***

Panel Members

8.37 There will be a national policy on fees for panel members, which will be separately advised.

Assessors

8.38 There will be a national policy on fees and expenses for assessors which will be separately advised.

8.39 Where assessors find it more convenient to make their own arrangements for, say, typing their reports, they should agree a rate of payment with the Board in advance.

Performance Targets for Panels

8.40 For complaints against HSS Trusts/Boards the formal appointment of the panel members and assessors should be made **within four weeks** of the convener's formal letter to the complainant confirming his or her decision to recommend that a panel should be set up. While complaints are bound to vary in complexity, a panel should aim to complete its work **within twelve weeks** of the formal appointment of the panel members and assessors. The Chief Executive of a HSS Trust/Board should write to the complainant **within four weeks** of the panel's final report informing them of any action the HSS Trust/Board is taking as a result of the panel's report and of their right to complain to the Commissioner. The overall target for the Independent Review process is **six months** from the date when the complainant first requests a panel to the date when the Chief Executive writes following the panel's report.

8.41 In the case of family health services complaints, the aim is for panels to complete their work **within three months** of the date on which the complaint was first made (ie to the practice).

Summary of Time Limits and Performance Targets

8.42 Time limits and performance targets have been summarised in **APPENDIX 1**.

9 Complaints about Purchasing

Complaints about Purchasing Decisions by HSS Boards

9.1 Complaints about HSS Boards purchasing decisions may be made by, or on behalf of any individual personally affected by a purchasing decision taken by the Board. The complaints procedure may not deal with complaints about the merits of a decision where the HSS Board has acted properly and within its legal responsibilities. Of course, the public or the HSS Council may wish to raise general issues about purchasing issues with the HSS Board and they should receive a full explanation of the HSS Board's policy. These are not, however, issues for the new complaints procedure. Panels may criticise the way in which a purchasing decision has been reached - for example on the grounds that the HSS Board did not consult properly or take appropriate clinical advice - but where a purchasing decision has been taken properly and reasonably, panels will not be able to suggest an alternative decision.

9.2 The HSS Board must have a Local Resolution process and a designated Complaints Officer to deal with purchasing complaints. It must appoint one or more of its non-executive directors to act as a convener for the Independent Review of purchasing complaints. The HSS Board will nominate an independent lay chairman to link with the convener and to chair the panel, if one is established. The third member of the panel will be another independent lay person nominated by the HSS Board.

9.3 Where a complaint concerns the exercise of clinical judgement, the HSS Board will nominate at least two clinical assessors (or other professionals as appropriate) with experience of exercising clinical judgement in a purchasing context.

Complaints about Purchasing Decisions by GP Fundholders

9.4 Complaints about purchasing decisions by GP Fundholders may be made by, or on behalf of any existing or former patient of the fundholding practice concerned, from the time when it joined the fundholding scheme. Complaints will only be dealt with through the new complaints procedure if they are made by, or on behalf of a specific individual personally affected by a purchasing decision made by the GP Fundholder.

9.5 A complaint against a general practitioner who is also a fundholder will be treated as wholly or partly a purchasing complaint if any aspect of the complaint relates to a decision taken by the fundholder in the exercise of his or her fundholding duties. For example, a complaint about a decision as to whether or not to refer a patient may be partly about the provision of general medical services and the clinical judgement involved in deciding whether to refer a patient, and partly about the decision by the fundholder on the use of their budget. Panels may criticise the way in which a purchasing decision has been reached - for example on the grounds that the fundholder allowed concerns about their budget to interfere with a clinical decision about the needs of an individual patient - but where a purchasing decision has been taken properly and reasonably, panels will not be able to suggest an alternative decision.

9.6 GP Fundholders will be required as a condition of remaining in the fundholding scheme to set up and run a practice-based complaints procedure to deal with purchasing complaints. In practice this is likely to be subsumed within their practice procedures for dealing with family health services related complaints. They will also be required to cooperate with the complaints review procedures organised on their behalf by their HSS Board.

9.7 The Independent Review for complaints about purchasing decisions by GP Fundholders will follow the same structure as those for the review of family health services complaints.

9.8 Where a panel is convened to consider a complaint which relates wholly or partly to a purchasing decision by a GP Fundholder, the HSS Board must appoint assessors with experience of exercising clinical judgement in a purchasing context. These will normally be a GP Fundholder chosen in consultation with local fundholding associations and the HSS Board's Director of Public Health. If a panel is to consider a complaint which relates partly to a GP Fundholder purchasing decision and partly to the provision of family health services, one of the assessors should be a GP Fundholder and one a GP assessor nominated by the HSS Board from a list of names put forward by the local medical committees in the HSS Board's area.

Complaints about Services Purchased from the Independent Sector

9.9 Services for patients/clients may be purchased from the independent sector by Trusts, HSS Boards, or GP Fundholders. The new complaints procedure will apply equally to services provided by the independent sector. Complaints about the actual services purchased from the independent sector must be treated as such and not as complaints about purchasing decisions (although a complainant may also wish to complain about the related purchasing decision at the same time and may pursue this through the same procedure in parallel).

9.10 HSS Trusts, HSS Boards, and GP Fundholders, will be required to specify in their contracts with independent providers that the provider must set up and run a local complaints procedure as far as possible identical to, and as effective as the Local Resolution which HPSS providers are required to provide. Independent providers must cooperate with the Independent Review procedure.

9.11 Where a HSS Trust has purchased the service concerned, the convening and panel stage of the review process will be organised by the HSS Board in the same way as for complaints about services the HSS Trust provides direct.

9.12 Where the HSS Board or GP Fundholder has purchased the service concerned, the convening and panel stages of the review process will be organised by the Board in the same way as for reviews of complaints against purchasing decisions. The questions to be addressed will, however, be about the services concerned. Complaints may be pursued in this way by, or on behalf of existing or former users of services purchased from the independent sector by either the HSS Board or any fundholding practice within the HSS Board's area. Such complaints must relate to the services in question.

9.13 If a complaint concerns the exercise of clinical judgement, the HSS Board will nominate at least two clinical assessors (or other professionals as appropriate) to advise the panel. If the complainant wishes to pursue a complaint both about the actual services, and the purchasing decision involved, the assessors must represent between them the appropriate experience for both aspects.

9.14 HSS Councils will continue to assist patients and clients who wish to complain about purchasing decisions, and to pursue general issues arising from these complaints with the HSS Board concerned. The complaints procedure does not affect existing requirements to consult extensively with HSS Councils and others on policy decisions.

10 Role of the NI Commissioner for Complaints (The Commissioner)

10.1 The jurisdiction of the Commissioner will be extended to all complaints.

10.2 For the first time the Commissioner will be able to investigate complaints about:

- family health services;
- actions take wholly or partly as the result of the exercise of clinical judgement;

10.3 It is intended that the new legislation should put beyond doubt the Commissioner's power to investigate complaints about any HPSS-funded care or treatment provided in whole, or in part, by non-HPSS providers.

10.4 The Commissioner will continue to investigate complaints about services provided, or not provided, and about maladministration where actual hardship or injustice has been caused to the complainant or to the person on whose behalf the complaint is made. These will include complaints about the way the HPSS has handled complaints - currentiy the biggest single cause of grievances referred. The Commissioner will, for example, be able to investigate a complaint that a convener has refused to recommend the setting up of an Independent Review panel, or that the Local Resolution or Independent Review investigations have been mishandled.

10.5 It is intended that complainants should have exhausted the new complaints procedure before referring a complaint to the Commissioner save that the Commissioner should have discretion in any individual case to override that requirement where he or she decides that it would not be reasonable for it to apply.

10.6 In deciding whether to investigate a complaint under the new jurisdiction, the Commissioner will expect to have access to all papers relating to both Local Resolution and Independent Review investigations. Where a case has been the subject of an Independent Review panel, these papers will include the report of the panel and the associated independent assessors' reports. In deciding whether to investigate a case, the Commissioner will wish to satisfy him or herself that there are grounds for intervention. The Commissioner will obtain independent professional advice as necessary to help him or her with cases involving clinical (or other professional) issues. The legislation defining the bodies and persons to whom the Commissioner must send the reports of his investigations will be amended to take account of his or her new jurisdiction.

10.7 HSS Trusts/Boards will need to ensure that appropriate references are made to the role of the Commissioner when publicising their new complaints procedure, and in the responses they make to individual complainants. Family health services practitioners and independent providers of services will need to take similar action.

10.8 The Commissioner proposes to publish a revised leaflet about these new powers for the public, HPSS staff and family health services practitioners who will operate the new system.

10.9 Transitional provisions relating to the Commissioner's new powers are referred to in Section 11.

11 Transitional Arrangements

11.1 It is intended that the new complaints procedure will become operational from 1 April 1996. It is recognised that there will need to be a transitional period during which existing complaints procedures will run in parallel with the new procedure. Complaints received before 1 April 1996 should be dealt with under old procedures. Any complaint first made on or after 1 April 1996 - notwithstanding whether the action concerned took place before or after 1 April 1996 - should be dealt with under the new complaints procedure.

11.2 Legislation to extend the powers of the Commissioner will set out any transitional provisions necessary for his/her investigations; further guidance on these provisions will be issued at a later date.

11.3 In view of the need to ensure the legislation to extend the powers of the NI Commissioner for Complaints mirrors that of the GB Health Service Commissioner Bill as it passes through its stages, a separate amending Order will be introduced in the 1995/96 programme. This means that Northern Ireland will not achieve a April 1996 date for redress to the Commissioner, but it is hoped to have the new legislation in place as soon as possible.

11.4 The HPSS Management Executive is aware that there are difficult transitional arrangements to be resolved, the details of which need further consideration: final Guidance will cover this issue.

Local Monitoring and Recording of Complaints

12.1 *Management boards of HSS Trusts/*Boards must receive quarterly reports on complaints, in order to:*

- *monitor arrangements for local complaints handling;*
- *consider trends in complaints;*
- *consider any lessons which can be learned from complaints, particularly for service improvement;*
- *HSS Trusts/*Boards must publish annually a report on complaints handling and send copies to all HSS Trusts/Boards and GP Fundholders with which it has contracts and all relevant HSS Councils.*

Reports must avoid any breaches of patient confidentiality.

** (Only relevant to complaints about HSS Boards themselves.)*

12.2 In their role in monitoring implementation of the Charter for Patients and Clients, HSS Boards are required to monitor the arrangements made by providers for dealing with complaints and action taken to improve performance as a result of complaints. An increase in the number of complaints is not, in itself, a reason for thinking that a service is deteriorating. It could mean that the organisation is becoming more responsive to complaints. The important point is to handle complaints well and to feed the lessons into quality improvement.

12.3 Consideration should be given to collection of local data on:

- oral complaints not recorded in writing;
- patient/client comments and suggestions; and
- changes in practices and procedures as a consequence of complaints handling.

This should be supplemented by surveys of patient and client satisfaction on the way in which complaints are handled. Such information will enable providers to improve their quality of service, and help to inform purchasers in the contracting process.

Collection of Complaints Statistics

12.4 The HPSS Management Executive will continue to monitor the number and type of complaints made in Northern Ireland. Arrangements for the collection of information on hospital and community services/family health services complaints to be advised at a later stage. **[NB Dr Erskine to advise on information needs and possible arrangements]**

13 Training

13.1 Training will be the key to making the new complaints procedure effective. All HPSS bodies will need to take action now to ensure that staff understand the intentions that lie behind the new procedure and how the new processes will work.

13.2 All staff and non-executives of HSS Trusts/Boards should know how to react and what to do if confronted by a complainant. The initial response to someone who feels aggrieved can be crucial in establishing the confidence of the complainant that their grievance will be treated appropriately. Steps should be taken to improve the awareness of staff to the fundamental importance of responding well to complaints. Improving the communications skills of staff throughout the organisation must be a priority to ensure that complaints handling is improved.

13.3 There will be special training needs which will have to be addressed during the run up and early transitional period of implementing the new procedure, particularly for the following:

- front-line staff;
- Complaints Officers;
- non-executives who are to become conveners, or their understudies;
- independent lay chairmen;
- panel members;
- HSS Council staff.

13.4 All family health services practitioners will be required to operate Local Resolution procedures within their practices. The intention is to create a channel for constructive discussion and information-seeking so that, wherever possible, the relationship between a patient and their practitioner can be maintained, or saved. Family health services practitioners, who have until now dealt with service committee procedures, will perhaps be facing the greatest cultural change of all. HSS Boards will need to work positively with local representative committees to assist practices, particularly in the early stages, and to ensure that training and support is available for practitioners, practice managers, and staff who are introducing Local Resolution into their practices.

Regional Initiatives

13.5 A series of seminars on a HSS Board by Board basis are being planned for early in the new year to assist in raising awareness of the need for total change to make the implementation of the new procedure a success.

13.6 The HPSS Management Executive will make training material that is being developing by the NHS Executive available to HSS Trusts/Boards to prepare their staff for the new procedure. A training pack will be published in January 1996 for HSS Trusts/Boards to prepare their staff to undertake the Local Resolution complaints process. A further training pack covering the Independent Review panels will be available in April 1996. This will also help, together with skills training being prepared nationally by ACHCEW, to meet the special needs of HSS Council staff. A further training pack covering the Independent Review panels will be available in February.

13.7 Work is underway on a guidance booklet for family health services practitioners, which will be published early in the new year.

13.8 A bibliography of information on the principles and practices in handling complaints is published alongside this Interim Guidance. *[NB to be revised to include NI references.]*

14 Timetable for Implementation

14.1 The new complaints procedure will be implemented on 1 April 1996. It is recognised that the appropriate legislation for introducing the Commissioner's new powers will not have received the approval of Parliament by this date. The Minister, however, does not see this as a reason for delay in implementing the new procedure.

14.2 HSS Trusts/Boards should be in a position to operate a Local Resolution process when handling complaints by April 1996. It is not anticipated that further guidance will be needed on this part of the new procedure, although some of the processes for family health services practices and practitioners are still subject to formal national negotiation.

14.3 The intention is that the Directions and Regulations needed to underpin the new complaints procedure will be published in January/February 1996, together with final Guidance.

14.4 A timetable for implementation is given at Appendix 2.

TIME LIMITS/PERFORMANCE TARGETS

WORST CASE SCENARIO

Time Limits

		Maximum Number of Weeks to Complete Stages
1.	For complainant to initiate	**Original Incident** 52 (12 months)
2.	complaint	**Complaint Identified** 26 (6 months)

Performance Targets

3.	**Local Resolution** of complaint by HSS Trust/Board	4
4.	Complainant considers outcome of Local Resolution and whether to apply to convener	4
5.	Convening period	4
6.	Identification and appointment of panel members and assessors	4
7.	**Independent Review** by panel - report prepared	12
8.	HSS Trust/Board considers panel's report: Chief Executive writes to complainant	4

Overall Timescales

9.	New HPSS complaints procedure timescale	32 (8 months)
10.	Maximum timescale	84 (20 months)

[WP5:Interim2.Dra, 29 November 1995]

TIMETABLE FOR IMPLEMENTATION

APPENDIX 2

	HPSS ME Action	Local Action
DECEMBER	Publish *Interim Guidance* Issue requirements for regional returns of complaints data	Service to start setting up systems Service to adjust monitoring systems
JANUARY 1996	Further discussion with the professions' national bodies about establishing lists of assessors Seek candidates for lists of independent lay chairmen and panel members Publish practice-based *FHS Complaints* booklet	 Distribute *FHS Complaints* booklet
FEBRUARY	*Local Resolution* training pack available	Cascade by HSS Boards/Trusts Develop *Local Resolution* training
FEBRUARY - MARCH	Regional Seminars/Conference New *FHS Regulations* on Complaints and Discipline made *Directions* made Publish *Final Guidance* Publish training material for *Independent Review* panels	 Begin training for *Independent Review* panels
MARCH	Publish *Complaints Leaflet*	Make leaflet available to public
APRIL	*Local Resolution and Independent Review* comes into force	Staff commence new procedures and transitional arrangements
DECEMBER -	*NI Commissioner for Complaints (Amendment) Order* made	