The Northern Ireland Health and Personal Social Services

Complaints

Listening...Acting...Improving

Guidance on Implementation of the HPSS Complaints Procedure

March 1996

HPSS Executive

Contents

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 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 Executive 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, Health and Social Services Boards and Trusts, Health and Social Services Councils and other key interests.

1.5 Interim Guidance was published in December 1995.

2 Purpose of the Guidance

2.1 This Guidance complements the Directions and Regulations (see paragraphs 4.1 and 4.2) which provide the statutory and therefore the mandatory framework of the complaints procedure. Implementation will be on 1 April 1996. It aims to provide advice for those tackling the practical details of how the policy objectives of *Acting on Complaints* are to be achieved. It updates the earlier advice contained in the Interim Guidance.

2.2 The Guidance is not designed to be all-embracing. Trusts and Boards, and Family Health Service (FHS) practitioners are expected to design and operate their complaints procedure within the spirit of the Guidance, while adhering to the legal requirements of the appropriate Directions and Regulations. It is recognised that the size and complexity of the various organisations will result in different models emerging for the management of complaints. It is hoped that in due course different experiences will be exchanged so that lessons can be learnt.

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;
- separation of complaints from disciplinary procedures;
- more rapid, open processes, with an emphasis on early resolution;
- fairness for staff and complainants alike;
- an approach which is honest, thorough, and with the prime aim of resolving the problem and satisfying complainants concerns; and
- 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.

3.3 Great emphasis is placed on 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. Boards, Trusts and FHS practitioners are therefore urged to concentrate on developing the awareness of front-line staff to the value of satisfying complainants early on, and to establish protocols for an open, positive response to complaints. The successful handling of Local Resolution is the key to the success of the new procedure.

4 Framework

Legal Framework

4.1 The following Directions are being made to implement the new complaints procedure:

- Directions to Health and Social Services Boards on Procedures for Dealing with Complaints about Family Health Services Practitioners;
- Directions to Health and Social Services Trusts and Boards on HPSS Complaints Procedures;
- Directions to Health and Social Services Boards on Miscellaneous Matters Concerning Complaints.

4.2 The following Regulations are being made and will affect the implementation of the new complaints procedure:

- The General Medical and Pharmaceutical Services (Amendment) Regulations (NI) 1996;
- The General Dental Services (Amendment) Regulations (NI) 1996;
- The General Ophthalmic Services (Amendment) Regulations (NI) 1996;
- The Health and Personal Social Services (Fundholding Practices) Amendment Regulations (NI) 1996;

Access to Health and Social Services Records

4.3 Any patient who has a complaint about any aspect of an application to obtain access to health records under the *Access to Health Records (Northern Ireland) Order 1993* may now make a complaint under this complaints procedure as an alternative to making an application to the courts. Patients still have the right to take matters to a court if they remain dissatisfied with the outcome of an investigation. Where the complaint relates to a decision to withhold access to all or part of the record the panel's role is to advise the record holder of their opinion. It remains the responsibility of the record holder to decide whether access should be granted. Care must be taken to ensure that in reporting the outcome of an investigation into a complaint about access to health records, the patient does not obtain information to which he or she is not entitled under the Order. This is particularly important when access has been denied on the grounds that it would cause serious harm to the physical or mental health of the patient or any other individual; or the information relates to or was provided by a third party who could be identified from that information and who had not consented to its disclosure.

4.4 Where the patient has sought access to his/her health records without the formality of an application under the Order, any complaint should be dealt with in the same way as if a formal application had been made. Access to health records compiled before 30 May 1994 (other than on computer) is at the discretion of the record holder, having regard to the fact that such records were not compiled in the expectation that they would be disclosed to the patient. This is an additional factor to bear in mind when considering whether to grant access to such records. It remains current policy that patients should be allowed to see what is written about them in their health record whenever possible. Complaints records should be kept separate from health records, subject to the need to record any information which is strictly relevant to the patient's health in their health records.

4.5 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.

Confidentiality

4.6 The use of the patient's/client's personal information to investigate a complaint is a purpose for which it is not necessary to obtain the patient's/client's express consent. Care must be taken at all times throughout the complaints procedure to ensure that any information disclosed about the patient/client is confined to that which is relevant to the investigation of the complaint, and only disclosed to those people who have a demonstrable need to know it for the purpose of investigating the complaint. Even so, it is good practice to explain to the complainant that information from his or her health or social services records may need to be disclosed to the complaints officer, clinical assessors, and panel members. If the patient/client objects the effect on the investigation will need to be explained. The patient's/client's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

4.7 Where a complaint is made on behalf of a patient/client who has not authorised someone to act for him or her (*see paragraph 5.10*) care must be taken not to disclose personal health or social services information to the complainant, unless the patient has expressly consented to its disclosure.

4.8 The duty of confidence applies equally to third parties who have given information or who are referred to in the patient's/client's records. Particular care must be taken where their records contain information provided in confidence, by, or about a third party who is not a health or social services professional. Only that information which is relevant to the complaint should be considered for disclosure and then only to those within the HPSS who have a demonstrable need to know it in connection with the investigation. It must not be disclosed to the patient/client unless the person who provided the information has expressly consented to the disclosure.

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

4.10 Draft guidance on '*The Protection and Use of Public Information*' is due to be issued shortly for consultation.

Use of Anonymised Information

4.11 Where anonymised information about patients/clients and/or third parties would suffice, identifiable information should be omitted. Anonymisation does not of itself remove the legal duty of confidence but, where all reasonable steps have been taken to ensure that the recipient is unable to trace the patient/client and third party identity, it may be passed on for a justifiable purpose. Where a patient/client or third party has expressly refused permission for the use of information, then it can only be used where there is overriding public interest in doing so.

4.12 Complaints about non-disclosure of other information which may be requested should not be dealt with under the HPSS complaints procedure. Such requests should be considered under the proposed Code of Practice on Openness in the HPSS. Draft guidance on the Code of Practice on Openness will be issued for consultation by the HPSS Executive shortly.

4.13 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

4.14 Boards will **not** be involved in resolving complaints about services provided by Trusts. There will, however, need to be both Local Resolution and Independent Review arrangements for dealing with complaints about purchasing decisions by Boards or GP Fundholders, and services for HPSS patients/clients purchased from the independent sector by Trusts, Boards or GP Fundholders. Boards will also need to have in place arrangements to deal with complaints about their administrative functions, particularly in relation to providing family health services. While most of this guidance is focused on complaints against 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

4.15 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.

4.16 In cases of mixed complaints relating to the actions of two HPSS bodies - for example two Trusts, or a FHS practitioner and a Trust - where a complainant wishes to pursue related complaints to Independent Review and is content with the arrangement, the convenors involved should liaise with the aim of establishing close cooperation with the respective bodies. While, legally, separate panels would need to be established, they may nonetheless comprise the same panel chairman, and in some cases the same third panel member. The chairman could establish close working arrangements for the two or more panels - possibly meeting in the same place and on the same day. While each panel would make its own separate report the chairmen may be able to ensure commonality of findings and that appropriate advice was given, possibly by the same assessors.

4.17 It is important to recognise that the review procedure for continuing care is not a complaints procedure. If a complainant decides instead to complain directly to the Commissioner, he will have discretion to waive the normal requirement that, before there is an investigation by the Commissioner, the HPSS complaints procedure should have been exhausted. As with all complaints, the Commissioner will need to be convinced that there are prima facie grounds for an investigation related to hardship or injustice.

Coroner's Cases

4.18 The fact that a death has been referred to the Coroner's Office does not mean that all investigations into a complaint need to be suspended. It is important for the Trust or FHS practitioner to initiate proper investigations regardless of the Coroner's inquiries, and where necessary to extend these investigations if the Coroner so requests.

Private Pay Beds

4.19 The complaints procedure will cover any complaint made about the Trust's staff or facilities relating to care in private pay beds, but not to the private medical care provided by the consultant outside his HPSS contract. The procedure applies in similar fashion to any private places provided in residential homes operated by Trusts.

5 Preparatory action

Note: Some sections of the Interim Guidance are reproduced in ***bold/italics*** indicating *mandatory requirements* of the new procedure, most of which will be established in *Directions and Regulations* (*see paragraphs 4.1 - 4.2*). Other mandatory requirements arise from existing legislation and/or common law.

Formal Procedure

5.1 *Trusts, Boards and FHS practitioners must establish a complaints procedure and take steps to publicise the arrangements.*

5.2 It will be a requirement for all Trusts/Boards to have a formally adopted written complaints procedure for complaints against themselves.

5.3 FHS practitioners will be required to establish and operate a Board approved complaints procedure within their practices. This applies to all individuals, and public or private companies who appear on the Board's list of contractors and practitioners undertaking to provide family health services.

Grievance Procedure

5.4 It is important to recognise that the HPSS complaints procedure is designed to address patients and clients complaints, not staff grievances, which will continue to be handled separately. Local procedures will also cover more general grievances. Disputes on contractual matters between Boards and FHS practitioners should not be handled through the complaints procedure. Staff of Boards and Trusts may complain about the way they have been dealt with under the complaints procedure and, provided they have exhausted the local grievance procedure, may complain to the Commissioner for Complaints. FHS practitioners may complain to the Commissioner about the way they have been dealt with under the complaints procedure.

Publicity

5.5 *Trusts, and Boards 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 make a request for an Independent Review panel;*
- *under what circumstances a complainant may approach a Board with a complaint about a FHS practitioner;*
- *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.*

(*See paragraph 6.14 for FHS practitioners.*)

Who may complain

Trusts and Boards

5.6 *Complainants will be existing or former users of a Trust's or Board's services and facilities. People may complain on behalf of existing or former patient's/clients provided they have their consent. If the patient/client is unable to act then consent is not needed. Where the Complaints Officer, or Convenor at the Independent Review stage, does not accept the person as a suitable representative of a patient/client who is unable to give consent, they may refuse to deal with the representative, and may nominate another person to act on the patient's/client's behalf.*

Family Health Services Practitioners

5.7 *Complainants will be existing or former patients of a practitioner who has arrangements with a Board to provide family health services. Complaints may be made on behalf of existing or former patients by anyone who has the patient's consent. If the patient is unable to act then consent is not needed. Where the Board's Complaints Officer, or the Board's Convenor at the Independent Review stage does not accept the person as a suitable representative, they may refuse to deal with the representative, and may nominate another person to act on the patient's behalf.*

5.8 Complaints can be made about the purchase or provision of any services, treatment and care for a patient/client. A person who has been refused any services, treatment and care can also complain under the complaints procedure.

5.9 A FHS practitioner may also complain to the Board about a patient. In the event of a complaint being made by a FHS practitioner about a patient, the Complaints Officer from the Board will make a written report to the practitioners with a copy, if appropriate, sent to the complainant.

5.10 The question of whether a complainant is suitable to represent a patient/client who is unable to give consent depends in particular on the need to respect the confidentiality of the patient/client, and to any known wishes expressed by the patient/client that information should not be disclosed to third parties.

5.11 Trusts, Boards and FHS practitioners should, as a matter of good practice, ensure that they deal sensitively and effectively with complaints by visitors, contractors and other users of their facilities.

Time Limits on Initiating Complaints

5.12 *Normally a complaint should be made:*

- *within six months of the incident that caused the problem, or*
- *within six months of the date of discovering the problem, provided that this is within twelve months of the incident.*

There is discretion to extend this time limit where it would be unreasonable for the complaint to have been made earlier; and where it is still possible to investigate the facts of the case.

5.13 A complaint should be made as soon as possible after an event. The discretion to vary the time limit should be used flexibly, and with 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.

5.14 When a complaint is made outside of the time limit the Complaints Officer or

appropriate FHS practitioner will be responsible for considering an extension of the time limit.

5.15 If the discretionary extension of the time limit is rejected by the Complaints Officer then the procedure will be as follows:

- the complainant may complain about the refusal to exercise discretion to waive the time limits;
- if the refusal is maintained, the complainant may request the convenor to consider setting up a panel for Independent Review of the complaint about refusal to waive the time limit: the normal requirements as to convening decisions will apply - including the time limit for a convening request;
- the convenor may then decide to take no further action; or
- to refer the complaint back for Local Resolution, or
- to set up a panel to consider the complaint.

5.16 If the convenor decides to refer the complaint about the time limit back to the Trust/Board, the Complaints Officer - or Chief Executive if it is referred specifically to him/her - should review very carefully the decision not to accept the complaint in the light of the convenor's conclusion that further action through Local Resolution is possible.

5.17 If the Convenor rejects the request, then the complainant has the right to complain to the Commissioner for Complaints.

Complaints Officer

5.18 *The Trust/Board must have a designated Complaints Officer, who is readily accessible to the public.* The prime role of the Complaints Officer is to oversee the complaints procedure. The detailed role and functions should be decided by the Trust or Board. The functions of the Complaints Officer may be performed personally, or by a person authorised by the Trust/Board to act on his/her behalf.

5.19 The Complaints Officer may be:

- the Chief Executive,
- a senior manager reporting directly to the Chief Executive; or
- particularly in large Trusts a senior manager reporting to the Chief Executive through a Director, but with personal access to the Chief Executive when appropriate.

While it is not essential for the title to be used, it is nevertheless important that the person with the role of Complaints Officer should be easily identifiable to the public and staff alike. (*See paragraph 5.21 for equivalent role for FHS practices.*)

5.20 It is for the Trust and Board to decide on the Complaints Officer's exact role. This may be either to investigate or advise, or both. He/she will need access to all relevant records which are essential for the investigation of a complaint referred to him/her. He/she should also be able to investigate and resolve 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 also provide support and help to staff who respond to complaints.

5.21 *FHS practices must nominate one person to administer the complaints procedure and to identify that person to patients.*

5.22 FHS practices will decide who is most appropriate to be responsible for the practice complaints procedure, together with an alternative to act if this person is the subject of the complaint. Complainants may be unhappy at the prospect of having their complaint dealt with by someone who is already involved in their care and who may be the subject of the complaint. If contacted by a complainant, the Board should be ready to provide assistance to both the complainant and the practitioner to resolve the complaint at practice level, bearing in mind the Board may become formally involved if the decision is made to proceed to Independent Review. (*See paragraphs 6.15 and 6.16.*)

Role of Health and Social Services Councils

5.23 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. Trust and 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 Convenor

5.24 *The Board must appoint at least one person to act in the role of convenor, who may not be one of its own employees. At least one of the persons appointed must be a non-executive director of the Board.*

5.25 The convenor will consider requests by complainants for Independent Review panels to be set up. The discretion to appoint more than one non-executive director 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 convenor to represent the Board on the panel, if it is established. This will also relieve pressure on the original convenor who may be involved in more than one convening request. The concept of a 'lead' convenor, or 'convenor's office', may be useful. The convenor will need support staff. In organising this the Board will need to demonstrate impartiality, for example, where the remaining grievance relates in some way to the handling of the complaint during Local Resolution. (*See paragraph 8.47.*)

5.26 Convenors may be appointed from any of the non-executive directors, although chairmen are not recommended to take on this role other than in exceptional circumstances. Convenors will be indemnified for this duty in the same way as for their other non-executive director duties.

5.27 Boards should be sensitive to concerns about bias and the appointment of practising clinicians, or recently retired HPSS staff, should be exceptional. The convenor should be fully appraised of guidance and issues relating to their role. Boards may wish to appoint additional people on a 'consultancy' basis, specifically to act as convenors. People appointed to take on this task may act in the role of convenor, including serving on the panel. Their terms of appointment by the Board should ensure that their role is explicit and they have appropriate indemnity cover. (*See paragraph 8.48.*)

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

Separation of Complaints and Disciplinary Procedures

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

5.30 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 reveal information about serious matters which indicate a need for disciplinary investigation.

5.31 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.

Trusts/Boards

5.32 In the case of Trusts/Boards, papers that have accumulated during the investigation of the complaint may be passed to the appropriate person in the Trust/Board who will be considering the need for a disciplinary or other form of investigation (*see paragraph 5.35 for other relevant forms of investigation*). The papers can be made available for a disciplinary investigation.

FHS Practitioners

5.33 In the case of family health services, the Service Committee procedure will not be used to investigate complaints made on or after 1 April 1996. Formal complaints already under investigation before that date will be completed under the service committee procedures. From 1 April 1996 complaints will be investigated using the new procedure and the need for local disciplinary action will only be considered after the handling of a complaint has been concluded. Only if action is 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.

5.34 Information gathered as part of the Local Resolution process by the practitioner belongs to the practice. The information will be kept separate from the patient's health record. Therefore the Board has no right of access to it. The Commissioner for Complaints does, however, have wide-ranging powers which can be used, if necessary, to require the production of information and documents.

Hospital and Community Health Services

5.35 *If any complaint received by a member or employee of a 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 independent inquiry into a serious incident under Article 54 of the Health and Personal Social Services (Northern Ireland) Order 1972;*

iv *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 convenor 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 Trust/Board for dealing with such matters.

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

The complaints procedure will not deal with matters relating to that part of the complaint which is 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 or iv above, the complaints procedure should be similarly modified until such action is concluded.

When any action as set out above has been concluded, that part of the original complaint which has been referred to a different procedure should only recommence where there are matters in the complaint which have not been dealt with through that action.

5.36 When a decision is made to embark upon a disciplinary investigation, the processing of the complaints procedure ceases in respect of all matters that are the subject of disciplinary proceedings. There may well be other aspects of the original complaint not covered by the disciplinary inquiry which 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.

5.37 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 taken through the disciplinary procedure.

5.38 The complainant may well ask at this point to be informed of the outcome of the disciplinary inquiry. 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.

5.39 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.

5.40 It is most important that the complainant is satisfied with the action being taken by the 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 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.

5.41 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 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. Those parts of the original complaint

not included in the reference to the professional regulatory body should continue to be investigated under the complaints procedure.

Possible Claims for Negligence

5.42 *The complaints procedure should cease if the complainant explicitly indicates an intention to take legal action in respect of the complaint.*

5.43 If a complainant 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 persons in the Trust/Board responsible for dealing with risk and claims management. 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.

5.44 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, if appropriate, an apology offered to the complainant as appropriate. 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 and the complained against being appropriately advised in writing.

5.45 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 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. In the case of family health services, Local Resolution is the responsibility of the practitioner*

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 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 - see Appendix 1. 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. It is for Trusts/Boards to consider whether there would be an advantage in offering access to conciliation. (*See paragraph 6.17.*)

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 in knowing 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 - before doing anything else - 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. Whoever within the organisation receives the complaint 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 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 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 an important 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.

6.9 Front-line staff also need to be empowered to use the information they gain from complaints to improve service quality, particularly oral complaints or criticisms which are not actually complaints where people want something put right, but not investigated. 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.

Role of the Chief Executive

6.10 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 heeded, and offering an apology and explanation as appropriate, referring to any remedial action that is to follow.

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.*** The reply might take the form of a full personally signed response or a shorter letter covering a fuller report from another member of staff which the Chief Executive has reviewed and is content with.

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 Practitioners

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 agreed criteria. For general practitioners, it has been agreed that the minimum criteria will be:

- administration of practice-based procedures must be practice-owned and managed entirely by the practice - the Board will only become involved if the practice procedure does not appear to meet the criteria;
- the Board will only become involved in an individual complaint if asked to do so by the complainant and/or the practitioner;
- one person will be nominated by the practice to be responsible for overseeing

the administration of the procedure;

- practices must give the procedures publicity;
- practices must ensure it is clear how to lodge a complaint, and to whom;
- an acknowledgement or 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).

Action by the Board

6.15 There are two roles for 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, or is having difficulty in having the complaint dealt with by the practitioner Boards will, if both parties agree, act as '*honest broker*' between the complainant and the practitioner to resolve the complaint at practice level. Boards will also make lay conciliators available as a service to complainants and practices. Arrangements for appointing lay conciliators and, where appropriate, professional advisors to the lay conciliators are matters for the Board.

6.16 Patients and FHS practitioners need to feel confident in the new complaints procedure. When a Board is acting as intermediary between patient and practitioner by providing conciliation or arranging Independent Review it is essential that clear lines of communication are established between Board, patient and practitioner. This might be done via the Complaints Officer in the Board who can give information on the progress of the complaint. Within the Board only those who need to be involved in handling a complaint should be aware of its existence. Complaints about treatment provided under FHS arrangements may involve a statutory charge payable to the complainant. Boards will need to ensure that conciliators who may become involved fully understand the nature of such charges.

Family Health Services Conciliation

6.17 Conciliation is essentially a process of facilitating agreement between the complainant and practitioner, and may prove essential if complaints are to be handled successfully at practice level. It is most effective when used as early in the complaints resolution process as possible Boards should therefore continue to make conciliators available to practices where a conciliator's assistance is requested, either by the complainant or the practice. Confidentiality must be strictly observed during the process and conciliators should **never** be required to report to the Board the details of cases in which they are involved. Nor should conciliators provide information which might be used by the Board if there is an Independent Review of the complaint.

Completion of Local Resolution

Trusts and Boards

6.18 It may be appropriate for the entire process of Local Resolution to be conducted orally, without any written communication, leaving the complainant completely satisfied with the outcome. However, where for example:

- the person dealing with the complaint suspects that the complainant may wish to take the matter further; or
- the complainant is satisfied with the oral response but has expressed the wish for a formal response to close the case;

it is recommended that Local Resolution may be best rounded off with a letter to the complainant. Any letter concluding the Local Resolution stage (whether signed by the Chief Executive because it was a written complaint, or by some other appropriate person) should indicate the right of the complainant to seek Independent Review of the complaint, or any aspect of the response to it with which the complainant remains dissatisfied, and that the complainant has twenty-eight days from the date of the letter to make such a request.

FHS Practitioners

6.19 Guidance to FHS practitioners does not differentiate between the handling of oral and written complaints. In both cases practices are advised to round off the complaint by giving a written summary of the investigation and its conclusions to the complainant, also indicating their right to seek an Independent Review and that the complainant has twenty eight days to make that request. Local Resolution will end at this point. Practices have been advised to keep records of complaints handling - which should be kept separate from patients health records - both for using complaints to improve procedures and services, and in case they are needed to enable the practice to cooperate with later stages of the complaints procedure, including Independent Review.

6.20 It should be borne in mind that the right of the complainant to request the convenor to set up an Independent Review panel is not a right to proceed automatically to Independent Review. The subtlety of this distinction may often be lost on complainants who may well be angry at the time as a result of their dissatisfaction with the outcome of Local Resolution - whether or not a final letter has been sent to the complainant - will assist with reducing the time the convenor may have to spend researching the background of the complaint, in the event of an application by the complainant to proceed to Independent Review.

Performance Targets for Local Resolution

6.21 Recognising that the primary purpose of Local Resolution is to satisfy the complainant whenever possible, while being scrupulously fair to staff, the following targets should be used with discretion. Where these targets are not being met, it is very important for the complainant to be informed of the delay and the reasons for it, as well as the likely revised timetable for dealing with the complaint. Similarly, where a complainant withdraws a complaint, it is important that the persons complained against (in the case of family health services, the practitioner) are informed immediately.

Trusts and Boards

6.22 Most oral complaints will be resolved on the spot or within two working days. Where this is not possible, and where there is a formal written complaint, the 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, a response **in five working days**. For written complaints, and oral complaints recorded in writing, acknowledgements should always be in writing.

6.23 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. Given the complexity that arises in some complaints, a clear referencing and dating system is needed for all communications with patients and FHS practitioners. First class post or, exceptionally special delivery mail, should be used. All communications should be marked 'Private and Confidential' and/or 'Personal'.

Family Health Service Practitioners

6.24 The aim should be for FHS practitioners to complete the Local Resolution process within **ten working days**. The possibility, however, of the Board being asked to provide support or conciliation (*see paragraphs 6.15 - 6.17*) will inevitably extend the period of Local Resolution. In these cases it would not be unreasonable for the performance target to be extended.

7 Convening an Independent Review Panel

Action by the Complainant

7.1 *Complainants who are dissatisfied with the response from the Trust/Board or FHS practitioner as a result of the Local Resolution process may refer a request for an Independent Review panel to the convenor either orally or in writing. This request should be made within twenty eight working days 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 Trust/Board should be passed on to the convenor immediately.*

7.2 The twenty eight calendar day time limit for making the request applies to the period from the date when the letter was sent to the complainant at the conclusion of Local Resolution, including conciliation where it is used (*see paragraph 6.15 - 6.17*). The time limit for making the request applies to the initial request and not to the making of the subsequent written statement to the convenor (*see paragraph 7.4*).

Action by the Convenor

7.3 The request for a panel should be followed up by the appointed convenor immediately. The convenor 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 convenor 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 convenor will need to understand as quickly as possible why the complainant remains dissatisfied. It is important for the convenor to obtain the complainant's statement, in as explicit and detailed a form as possible, before starting his/her inquiries. The complainant should be encouraged to submit the written statement as quickly as possible so that a response can be made within the twenty-eight day time limit. Experience shows that complainants frequently do not set out clearly what their grievances actually are, or set out clearly why they are dissatisfied. The convenor 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. Alternatively, the convenor, or member of staff, may prepare the statement for the complainants approval. If the complainant has already clearly set out their remaining grievances, and there is no need to amend this, then the convenor should not require a new statement to be drawn up. Complainants need to be advised of the various options that are open to the convenor for dealing with the complaint at this stage.

7.6 Those who are complained against, including the FHS practitioner, should always be advised in writing of what the complainant has formally stated as his/her grievance. the initial communication to the practitioner advising that there is a request for Independent Review of a complaint involving them might contain details of the secretary of other individual nominated by the local representative committee to help practitioners deal with complaints.

7.7 When dissatisfied with the outcome of Local Resolution, a complainant does not have an automatic right to move to Independent Review (*see paragraph 6.20*). There may be occasions when the convenor feels that Local Resolution has been adequately pursued - in that the complaint has been properly investigated and an appropriate explanation given - and that nothing further can be done, although the complainant remains dissatisfied. The safeguard for the complainant lies in the right to put their case directly to the Commissioner should a convenor decide not to establish a panel. The Commissioner will be able to consider whether to recommend that:

- the initial decision of the convenor should be reconsidered; or
- it seems to him more appropriate to investigate the complaint himself.

Role of the Convenor

7.8 The role of the convenor is crucial to triggering events under Independent Review (*see Appendix 2*). It is important that the convenor distances him or herself from those involved in the complaint. The convenor's role is to ensure the complaint is dealt with impartially at the convening stage. It is not the convenor'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 convenor will need to obtain a full picture of the events relating to the complaint. It is not the convenor's role to try to resolve the complaint on his/her own.

7.9 Before the convenor decides to convene a panel he or she will consult with the independent lay chairman on the 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 convenor with an external independent view and to aid him or her in assessing the grievance. It is, however, ultimately the convenor'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 8.9 - 8.10*).

7.10 The convenor will decide on the panel's terms of reference. He/she should advise the complainant of the matters which the panel will not investigate, for example which the Trust/Board has decided should be subject to disciplinary investigation - except for FHS practitioners, where consideration of disciplinary action is not an option at this stage. - or matters that have already been dealt with adequately as well as those which will be dealt with. The convenor'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. Similarly, the convenor should make it clear in writing the reasons for deciding why a panel should not be established. Failure to do so will be criticized by the Commissioner for Complaints if the complaint is subsequently referred to him.

Criteria for Establishing a Panel

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

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

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

7.12 The convenor 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 Convenor

Clinical Complaints

7.13 *Where the convenor 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.*

7.14 The convenor 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'.

7.15 This process will be important in informing the convenor 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.

7.16 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 allied to medicine, paramedics and ambulance technicians, laboratory and other scientific and technical staff. It is for the convenor 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 Board, but not from anyone who is in any way associated with the complaint. Advice may need to be sought from outside the Board.

7.17 Where medical or other clinical advice is needed, convenors are recommended to seek this initially from the Board's Director of Public Health, or equivalent professional officer, who in turn can direct the convenor to a suitable nominee from the list of clinical assessors. Where the Director of Public Health, or other professional officer, is the subject of the complaint, or where possible conflict of interest arises, some other appropriate independent medical, or other clinical opinion, such as the Department's Chief Medical Officer, should be sought. In those cases where an area officer for each of the professions allied to medicine does not exist the convenor should approach the particular service manager in the first instance, who in turn can direct the convenor to a suitable nominee from the list of clinical assessors.

7.18 In the case of family health services, the convenor should seek initial clinical advice from the Board's relevant Adviser, who in turn can direct the convenor to an independent practitioner from the same profession as the practitioner who is being complained about. The practitioner's name will come from a list of practitioners nominated by the relevant local professional representative committee, or as otherwise agreed with the professions or, in the case of GP fundholders, by the local GP fundholding groups within the Board or, by agreement, by local medical committees working with local GP fundholding interests.

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

7.20 The convenor must take appropriate professional social work 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 social work judgement - ie any judgement that is made by a member of the social work 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 convenor is recommended to seek professional advice initially from the 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 Convenor

7.22 Convenors 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 that the Trust/Board, FHS practitioner 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
- it is believed further action as part of Local Resolution is appropriate and practicable:
  - either referral back to the Trust/Board Chief Executive, for consideration is thought preferable to beginning the Independent Review process; or
  - an invitation by the convenor to the FHS practitioner to reconsider Local Resolution, possibly with conciliation, as preferable to instituting the Independent Review process;
- for Trust/Board employees, it is considered that there is a prima facie case for a disciplinary investigation (*see paragraphs 5.31 - 5.32*) and referral by the convenor to the responsible officer in the Trust/Board is appropriate. The setting up of an Independent Review panel would follow automatically if no disciplinary investigation was pursued.

7.23 *The convenor 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 a panel should be appointed, setting out clearly the terms of reference or the reasons for any decision to refuse a panel, and whether or not he or she believes there is further action the Trust/Board/FHS practitioner 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 convenor must inform the Chief Executive of the Trust/Board of his or her decision as to whether or not a panel should be set up, or whether he or she believes there is further action which the Trust/Board could take as part of Local Resolution.*

Response to Complainant

7.26 Both the complainant and the respondent must be informed in writing of the convenor's decision as to whether or not an Independent Review panel is to be set up. The convenor should send to the Chief Executive of the Trust/Board, and the FHS practitioner concerned a copy of his/her communication which explains the decision to the complainant.

7.27 The convenor must set out the reasons for any decision to refuse a panel as fully as possible so that the convenor's views are clearly available should the complainant decide to exercise the right to refer the complaint to the Commissioner. This right should be recorded in the letter from the convenor 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 convenor believes there should be a reference back to Local Resolution.

7.28 *If the complainant remains dissatisfied following the reference back to the Trust/Board/FHS practitioner he/she may refer the complaint once again to the convenor to reconsider whether an Independent Review panel should be convened.*

Action by the Board

7.29 In order to avoid delay, 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 convenor is known. The convenor will likewise advise the Trust/Board when he/she has decided against establishing a panel. If the recommendation of the convenor is that Local Resolution should be reactivated, this should be expedited by the Chief Executive.

Performance Targets for Convening

7.30 The convenor 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 twenty working days** (ie four weeks) from the date of the complainant's request being received by the convenor.

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 convenor, 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 Board;*
- *a convenor (non-executive director of the Board) or appointed person; and*
- *an independent person appointed by the Board.*

Where the convenor 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 Board following advice from the relevant professional representative bodies. In the case of social services complaints two independent assessors will be nominated by the 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.

8.3 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 convenor should consider co-opting a member of the Mental Health Commission onto the panel.

8.4 In order to avoid accusations of bias members or officers of HSS Councils will be excluded from panel membership.

Appointment of Panel Members

8.5 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.

8.6 The names of persons held on the lists for the role of independent lay chairman and the third panel member will all be those of lay people. Only exceptionally will they be recently retired HPSS staff or lay non-executive directors of other Trusts/Boards. Practising or retired members of the clinical professions should not be chosen for this role. No panel member - other than the convenor or alternative person - should have any past or present links with the Board establishing the panel. The chairman and third panel member will always be lay people. Recruitment will be in accordance with equal

opportunities policy.

8.7 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. 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 Trust/Board.

8.8 It is for 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. The complainant should be informed of the panel members and assessors appointed to conduct the Independent Review. Respondents should similarly be advised of the panel members and assessors appointed to conduct the Independent Review.

Role of Independent Lay Chairman

8.9 There are two roles for the independent lay panel chairman (*see Appendix 4*):

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

The Board will formally appoint the panel chairman, bearing in mind the need for indemnity cover in respect of the advice given to the convenor by the chairman during the convening period.

8.10 Once the convenor's decision to establish an Independent Review panel has been made and the convenor 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

8.11 *The function of the panel is to:*

- *investigate the aspects of the complaint as set out in the convenor's terms of reference, taking into account the complainant's grievance as recorded in writing to the convenor;*
- *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.

8.12 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 person complained against. It is a matter for the panel to decide

whether the complainant and the person complained against should be brought together at the same meeting; similarly whether smaller meetings involving, say, any one member of the panel, with or without assessors, are appropriate in the circumstances.

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

- *the panel's proceedings must be held in private;*
- *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 their choosing, who may speak to the panel members/assessors - except that no person interviewed may be accompanied by a legally qualified person acting as an advocate.*

8.14 The panel will have access to all the records held by the Trust/Board relating to the handling of the complaint. FHS practitioners will be asked to make available their records of 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 health records.

8.15 The panel has discretion as to how it should operate. It has a duty to keep records, bearing in mind the possibility of future investigation by the Commissioner for Complaints. Panels should work informally and be flexible in their approach, so that they can respond appropriately to differing kinds of complaint. The panel chairman will be the final arbiter. The panel should not act as a tribunal involving formal cross-examination of witnesses, nor should it operate in a confrontational, adversarial, or legalistic way.

8.16 Neither the complainant nor the respondent may be legally represented. The complainant may, however, be supported on all occasions by a person of their choosing who, even if legally qualified, may not act in a legal capacity. This could be an adviser, say from the HSS Council, who may speak on behalf of the complainant. It may also be appropriate for the complainant to be accompanied by a second person, such as a relative, for emotional support.

8.17 Any person mentioned in the complaint who is interviewed may be similarly supported by a representative of their trade union or professional organisation, or appropriate manager or colleague, who can act in the capacity of personal adviser.

Identification of Assessors

8.18 *Where the complaint is wholly or partly related to clinical matters, panels must be advised by at least two independent clinical assessors. The independent clinical assessors' role is to advise and make a report, or reports, to the panel on the clinical aspects of complaints. The assessors should decide, in consultation with the panel, how to exercise their responsibilities having regard to guidance issued by the HPSS Executive and their professional bodies.*

8.19 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 convenor and independent

lay chairman of the panel to make this decision.

8.20 Boards will hold copies of the lists of assessors for hospital and community health services, family health services and social services complaints, and assessors with experience of exercising clinical judgement in a purchasing context.

8.21 The professional bodies' role in ensuring that lists of appropriate independent assessors, who are acceptable to the profession concerned, are kept up to date (and revised at least annually), 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;
- Nursing professional bodies will ensure that appropriate independent nursing assessors, acceptable to the profession, are identified;
- local medical committees will make arrangements for preparing lists of appropriate assessors from general medical practitioners;
- assessors for GP fundholding complaints will be nominated by recognised local fundholding groups working in conjunction with local medical committees;
- Boards will nominate clinicians with experience in exercising clinical judgement in a purchasing context;
- the British Association of Social Workers (NI) will undertake this role for social services;
- Those professional bodies who represent other professions which might be involved will ensure that lists are available.

8.22 Boards will select assessors to serve individual panels. Normally assessors will be selected from names of those working outside the geographical area of the Trust/Board concerned, but there will be discretion on this point. If the Board has any difficulty in determining appropriate assessors they should consult the appropriate professional body. Boards will also have access to the lists held in Great Britain, where it is appropriate to appoint an assessor from outside Northern Ireland.

8.23 Boards will need to ascertain the availability of assessors before making formal appointments. Normally assessors for hospital and community health services and social services complaints will be selected from outside the Board area concerned. In the case of FHS panels assessors should be chosen from a list held by the Board and nominated by the local representative committees or, in the case of GP fundholders, by recognised local GP fundholding groups working in conjunction with local medical committees. FHS assessors should not come from within the Board area of the practice or practitioner against whom the complaint was made. When selecting assessors it is important that they have no connection with any of the parties to the complaint. This might call into question their independence or objectivity in respect of the complaint. When there is doubt about the choice of an assessor the Board should contact the appropriate professional body.

Appointment of Assessors

8.24 Responsibility for formally appointing and communicating with the chosen assessors will rest with 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.

Release of Assessors

8.25 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. 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 (*see paragraphs 8.20 - 8.23*).

Role of Assessors

8.26 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 (see Appendix 5).

8.27 ***At least one assessor must be present when the panel, or a member of the panel interviews either or both of the parties on occasions when matters relating to the exercise of clinical (or other professional) judgement are under consideration.***

8.28 The assessors must have access to all the patient's/client's health and social services records held by the Trust/Board/FHS practitioner which together with information about the handling of the complaint. Assessors will need to acquaint themselves with any circumstances where a patient or client might be denied access to information on the record, or where the patient has asked for personal information to be withheld from other parties.

8.29 Assessors may interview/examine complainants, who may 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 breach patient/client confidentiality. Care must also be taken not to breach third party confidentiality. Assessors should not normally explain their findings to either the patient/client or complainant at this stage, before advising the panel of their views.

8.30 Assessors may also interview any person complained against, who may have a person of their choosing present. They should not normally explain their findings to the person complained against before advising the panel of their views.

8.31 There may be occasions when a patient's/client's health/social services record is no longer in the possession of the person complained against. In these circumstances, every effort should be made by the Trust/Board to provide the person complained against with access to it for the purpose of framing a response. In the case of a FHS practitioner, if it is appropriate to return the record then the whole, or relevant part of the record might be photocopied or inspected at the Trust's/Board's premises.

Assessors' Reports

8.32 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.

8.33 Assessors should take care - since their reports may be made available at a later date to others than just panel members - that 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 should they contain information about, or provided by, a third party (other than a health or social care professional) who can be identified from the information - unless he/she has consented to its disclosure.

8.34 *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.*

8.35 If 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 be present if the complaint relates to a clinical matter. The assessor should be able to give a personal explanation to the complainant of any clinical findings.

Panel's Final Report

8.36 The panel may find it helpful to provide the complainant and the person complained about, with the opportunity to check a draft report for 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 that the report is confidential to them and the panel members. 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. The responsibility for ensuring the panel completes its report within the target time limit rests with the panel chairman.

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

- *the complainant;*
- *the patient/client if a different person from the complainant and alive and competent to receive it;*
- *any person named in the complaint;*
- *any person interviewed by the panel;*
- *the clinical assessors or other professional assessors, as appropriate;*
- *the Trust/Board Chairman and Chief Executive;*
- *the practitioner, where the complaint is about FHS practitioners/GP fundholders;*
- *the Director of Performance Review and Secondary Care in the HPSS Executive;*
- *in the case of GP Fundholder complaints the Director of Primary Care and Purchasing Development in the HPSS Executive;*
- *the Chairman and Chief Executive of the independent provider, where the complaint is about services provided by the independent sector.*

The report will have a restricted circulation. The panel will not send it to any other person or body. The panel chairman has the right to withhold any part of the report and all or part of the assessor's report in order to ensure confidentiality of clinical information.

8.38 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.

8.39 The complainant may wish to show the report to a representative of the HSS Council or other appropriate adviser. The Chief Executive may need to show the report, or sections of it, to Board members and a FHS practitioner may need to show it to colleagues in their practice. These, and any other similar arrangements, will need to protect the overall confidentiality of the report.

Follow-up Action by Trusts/Boards

8.40 ***Following receipt of the panel's report, the Chief Executive must write to the complainant informing them of any action the 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.***

8.41 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. Trusts/Boards will also be responsible for ensuring that the action taken is communicated quickly and clearly to the complainant.

Completion of the Complaints Procedure

8.42 It needs to be made very clear to the complainant when the complaints procedure has been completed. The Commissioner for Complaints will normally only embark on an investigation when the procedure has been exhausted.

Trusts/Boards/GP Fundholders (*see Appendix 6a*)

8.43 Completion of the complaints procedure for Trusts/Boards - except in the case of FHS practitioners (*see paragraph 8.46*) - will be when the Chief Executive writes to advise the complainant of the outcome of the Board's consideration of the panel's report and the complainant's right to complain to the Commissioner. It is recognised that it may take a Trust/Board some time to consider how to respond to a panel's report, particularly if there are policy review or changes which need consultation with others before a final decision can be made. Nevertheless, the Chief Executive should strive to communicate to the complainant in writing - **within twenty working days** from the publication of the panel's report - any matters such as a formal apology, approval of a ex-gratia payment, or an indication of the timescale in which the Board has agreed to consider policy issues, plus information about their right to complain to the Commissioner if they are still dissatisfied. If, following this action, the Board takes any further decisions relating to the outcome of the case, then the complainant should be appropriately informed by the Chief Executive.

8.44 Completion of the complaints procedure for complaints about services purchased by Boards or GP Fundholders from the independent sector, is when the panel's report is sent to the complainant by the Board Chief Executive. The Chief Executive should send the panel's report to the complainant and the independent provider under suitable cover letters as soon as possible after receiving it. The covering letter must advise the complainant of the right to refer their complaint to the Commissioner if still dissatisfied. If the panel has commented about the possibility or desirability of making changes to the services purchased by a Board, which are the subject of the complaint, the Chief Executive should consider, in consultation with the provider as necessary, how those services can be improved and the implications for the Board's purchasing policy. The Chief Executive will then wish to follow up the panel's report with a further letter setting out any changes which have been decided on.

8.45 In cases of care purchased by a GP Fundholder, the Chief Executive will also send the panel report to the fundholder. Where suggestions have been made about improvements to a service which has been purchased by a GP Fundholder, the Chief Executive will want to tell the complainant that he is inviting the fundholder to respond personally to the complainant on those matters. Likewise, when the Chief Executive is writing to the fundholder, he will want to suggest that a response goes from the practice direct to the complainant.

8.46 For services purchased by Trusts from the independent sector, the normal Trust complaints procedure will apply.

FHS Practitioners (*see Appendix 6b*)

8.47 Completion of the complaints procedure for family health services is when the panel's report is sent to the complainant by the Board's Chief Executive. The Chief Executive should send the report to the complainant and the practitioner under suitable covering letters as soon as possible after receiving it. The covering letter must advise the complainant of the right to complain to the Commissioner. If the panel has commented about the possibility of making changes to a practitioner's services or organisation the Chief Executive will want to tell the complainant that he/she is inviting the practitioner to respond personally to the complainant on these matters. Likewise, when the Chief Executive is writing to the practitioner, he will want to suggest that a response goes from the practice directly to the complainant.

Administrative Support, Fees and Expenses

8.48 The Board will provide any administrative support which the convenor, the independent lay chairman, the panel and its assessors need. All the expenses arising out of the Independent Review process, including any fees or expenses paid to panel members and assessors, will be met by the Board establishing the panel. Boards will need to determine the level of administrative support that will be necessary for the convening and Independent Review processes, bearing in mind the fluctuating nature of the demand for this support.

Panel Members

8.49 Panel members, including convenors, will be eligible to receive travel expenses, subsistence, and loss of earnings allowances. Boards should indicate in appointment letters that the particular panel chairman and third panel member will be appropriately indemnified.

Assessors

8.50 Arrangements for payments to independent assessors of all professions while advising a particular panel, together with eligibility for travel expenses and subsistence allowances, will be advised separately by the HPSS Executive.

8.51 Arrangements for funding locum expenses of certain FHS practitioners, and the responsibility for the payment of locums in respect of other assessors, will be advised separately by the HPSS Executive.

8.52 Assessors will be formally appointed by Boards to a particular panel and as such will be covered for indemnity while carrying out their role as advisers.

8.53 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

8.54 For complaints against Trusts/Boards the formal appointment of the panel members and assessors should be made **within four weeks** of the convenor'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 Trust/Board should write to the complainant **within four weeks** of the panel's final report informing them of any action the 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.

8.55 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 complainant approached the convenor with the request for a panel to be set up.

Summary of Time Limits and Performance Targets

8.56 Time limits and performance targets have been summarised in APPENDIX 7.

9 Complaints about Purchasing

Complaints about Purchasing Decisions by Boards

9.1 Complaints about 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 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 Board and they should receive a full explanation of the 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 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 Board must have a Local Resolution process and a designated Complaints Officer to deal with purchasing complaints and other complaints about the Board's own actions and decisions. It must appoint at least one or more of its non-executive directors to act as a convenor for the Independent Review of complaints about the Board. (*See paragraph 5.26 - 5.27 for guidance on the appointment of additional convenors.*) The Board will nominate an independent lay chairman to link with the convenor and to chair the panel, if one is established. The third member of the panel will be another independent lay person nominated by the Board.

9.3 Where a complaint concerns the exercise of clinical judgement, the 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, and about all uses of the allotted sum paid to the practice, 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, subject to the time limit for making complaints. 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 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 Board.

9.6 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.

9.7 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 Board must always 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 groups, working in conjunction with local medical committees and the 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 Board from a list of names put forward by the local medical committees in the 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, 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 Trusts will need to ensure that their contracts with independent providers specify that the provider will cooperate with the Trust's own Local Resolution and the Independent Review process. Boards, and GP Fundholders, should 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. Contracts made by Trusts/Boards/GP Fundholders should include a requirement on the independent provider and their staff to cooperate with any Independent Review process that is set up, and to indemnify them for the costs of setting up and running the arrangements.

9.11 Where a Trust has purchased the service concerned, it will be responsible for ensuring Local Resolution by the independent provider in the same way as for complaints about services the Trust provides direct.

9.12 Where the 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 Board or any fundholding practice within the Board's area. Such complaints must relate to the services in question.

9.13 If a complaint concerns the exercise of clinical judgement, the 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 A complaint under the procedures of the Registered Homes (NI) Order 1992 (through the Inspection Unit Manager of the relevant Board) if the independent provider is registered under that Order does not preclude a complainant pursuing a separate complaint under the HPSS complaints procedure.

9.15 If a complaint against an independent provider (registered under the Registered Homes Order) is not resolved locally, the convenor may, with the complainant's consent, delay the instigation of Independent Review until the Inspection Unit Manager of the Board registering the independent provider has had the opportunity to attempt to resolve the complaint.

9.16 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 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 *Acting on Complaints* confirmed that the jurisdiction of the NI Commissioner for Complaints would be extended to all complaints by HPSS patients and clients. A Bill amending and widening his powers in the *Commissioner for Complaints Act (NI) 1969* is expected to become law later this year.

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

- HPSS services provided by FHS practitioners, their staff, or their deputies or locums;
- actions taken 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 - currently the biggest single cause of grievances referred. The Commissioner will, for example, be able to investigate a complaint that a convenor 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 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 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 The following rules will apply in relation to complaints against hospital consultant medical and dental staff of Trusts under the previous clinical complaints procedure:

- if, by 1 April 1996, a complaint has not been referred on by the Trust to the Board's Director of Public Health, under the second stage of the old clinical complaints procedure, then the complaint should be dealt with under the new complaints procedure;

- if, however, the complaint has been referred to the Board's Director of Public Health before 1 April 1996, but a decision has not been made to set up an independent professional review, the Director of Public Health will, refer the complaint back to the convenor of the Board originally receiving the complaint, for consideration in accordance with the new complaints procedure. This will be as if a request for a panel had been made by the complainant to that convenor;

- if, on the other hand, before 1 April 1996, the Director of Public Health has made a decision on the complaint, including a decision to set up an independent professional review, then the complaint should be followed through under the old procedure by the relevant Board.

Costs of appointing assessors under the old procedure will be passed on by the Board to the originating Trust.

11.3 For FHS practitioners complaints, if, on or after 1 April 1996 a complaint is made relating to events which took place before that date, it will be investigated as follows:

- complaints relating to events which occurred on, or after 1 January 1996 will be investigated using the new procedure;

- complaints relating to events which occurred before 1 January 1996 will be investigated under the new arrangements only where the complainant can show that he or she had good cause for not making the complaint within the appropriate period under the service committee procedures.

11.4 Legislation to extend the powers of the NI Commissioner for Complaints to mirror that of the GB Health Service Commissioner Bill will be introduced as soon as possible. Complainants will not be able to refer complaints, in respect of clinical matters and about family health services, to the Commissioner until the legislation is enacted.

Local Monitoring and Recording of Complaints

12.1 *Management Boards of 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;*
- *Trusts/*Boards must publish annually a report on complaints handling and send copies to all Trusts/Boards and GP Fundholders with which it has contracts, all relevant HSS Councils and the HPSS Executive. This information should be included in Boards' Annual Reports.*

Reports must avoid any breaches of patient/client confidentiality.

** (Only relevant to complaints about Boards themselves. Complaints against FHS practitioners, GP fundholders, and independent providers will not be included.)*

12.2 In their role in monitoring implementation of the Charter for Patients and Clients, 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 learnt into quality improvement.

Collection of Complaints Statistics

12.3 The HPSS 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 will be through the completion by Trusts/Boards of the CH8 central return, which has been revised to take into account the new procedures. There will be a revised central return CHB to be completed by Boards for FHS complaints.

12.4 General medical practitioners and dentists will be required by their terms of service to provide Boards with information on the number of complaints received in each practice or surgery, to be included in this return. However, detailed information on Local Resolution will not be required. Boards will be required to provide information on cases which proceed to Independent Review, including those where the convenor decides that a panel investigation is not appropriate.

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-executive directors of Trusts/Boards should know how to react and what to do if approached 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 All FHS 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. 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

13.4 The HPSS Executive has distributed a training pack for Trusts/Boards to prepare their staff to undertake the Local Resolution complaints process.

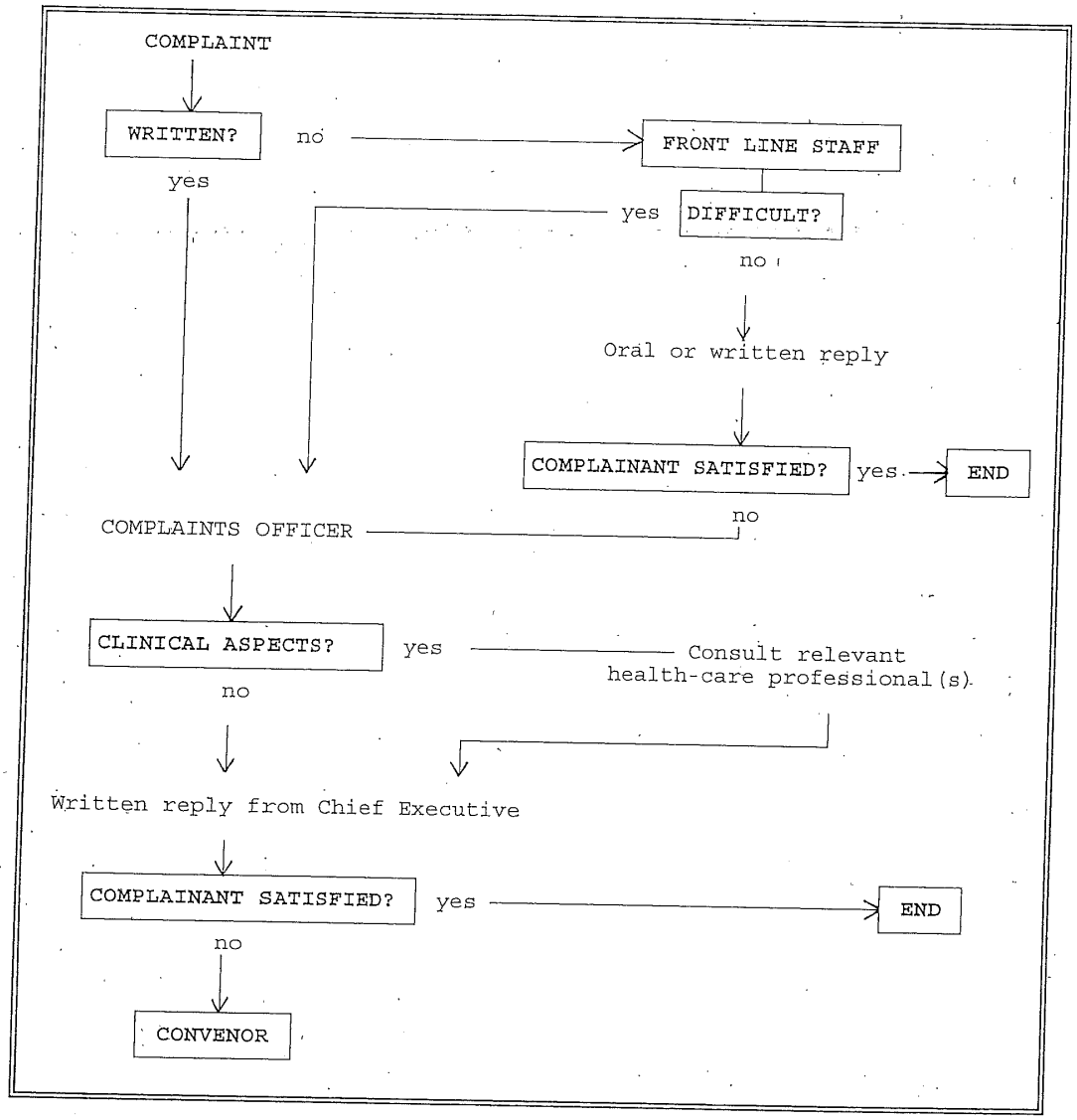
13.5 Guidance booklets for Family Health Service practitioners on practice-based complaints procedures have been distributed for every FHS practitioner, with particular emphasis on Local Resolution.

13.6 A further training pack covering the Independent Review panels will be available in April/May 1996.

13.7 Briefing material is being prepared for clinical assessors and will be distributed in June 1996.

LOCAL RESOLUTION FOR TRUSTS/BOARDS

(Local Resolution for family health services practitioners - see practice-based guidance booklets)



ROLE OF THE CONVENOR

The convenor will be a non-executive director of the Board, or a person specifically charged by the Board to act in this role, who will:

- respond to an oral or written request by a complainant who is dissatisfied with the outcome of Local Resolution (the complainant's request should be made within twenty-eight days of completion of the Local Resolution process: the convenor has discretion to extend this period if there are exceptional circumstances why there has been delay);
- formally acknowledge the request within two working days (the convenor will be appropriately assisted in his/her task by a manager appointed by the Board);
- immediately consult with one of the independent lay panel chairmen on the Board's list in order to consult over a decision as to whether or not to convene a panel;
- call for all papers and documents relating to the Local Resolution;
- advise any person who is complained against;
- request the complainant to provide a written statement to elucidate exactly why he/she remains dissatisfied, if the initial request is either not clear or not full enough (the convenor should ensure the complainant is aware of the help that is available from the HSS Council or other sources);
- seek appropriate independent clinical (or other professional) advice, where the convenor considers there is a clinical element to the complaint, initially approaching either local head of the profession concerned or obtaining advice from an appropriate person on the list of assessors, accessed through the Board;
- in consultation with the prospective independent lay panel chairman, decide whether or not a panel should be set up, within twenty working days of receiving the complainant's request;
- liaise with other convenors if the complaint involves more than one body.

The convenor will decide not to establish a panel if:

- the complainant has commenced any legal proceedings, or proceedings explicitly threatened;
- the Trust/Board/family health services practitioner has already taken all action that is reasonably possible, so that a panel is unlikely to add anything to the outcome;
- further action is believed to be appropriate and practicable by the Trust/Board/family health services practitioner.

If the convenor decides to refuse a request for Independent Review, he/she must inform the following, in writing, of the reasons for the decision, and whether he/she believes that Local Resolution should be reactivated:

- the complainant, with advice of the right to appeal to the Commissioner of Complaints;
- the Chief Executive;
- any person who is complained against;
- the independent lay panel chairman with whom he/she has consulted;

- anyone else with whom he has consulted.

If the convenor decides that a panel should be convened, he/she will:

- decide the terms of reference for the panel, outlining the issues to be excluded from its consideration, eg any matters where the Trust/Board has instituted disciplinary investigation or referred on to a professional regulatory body;

- advise the complainant in writing of his decision and the terms of reference for the panel, the issues to be excluded from its consideration and why, and when the panel is likely to be set up;

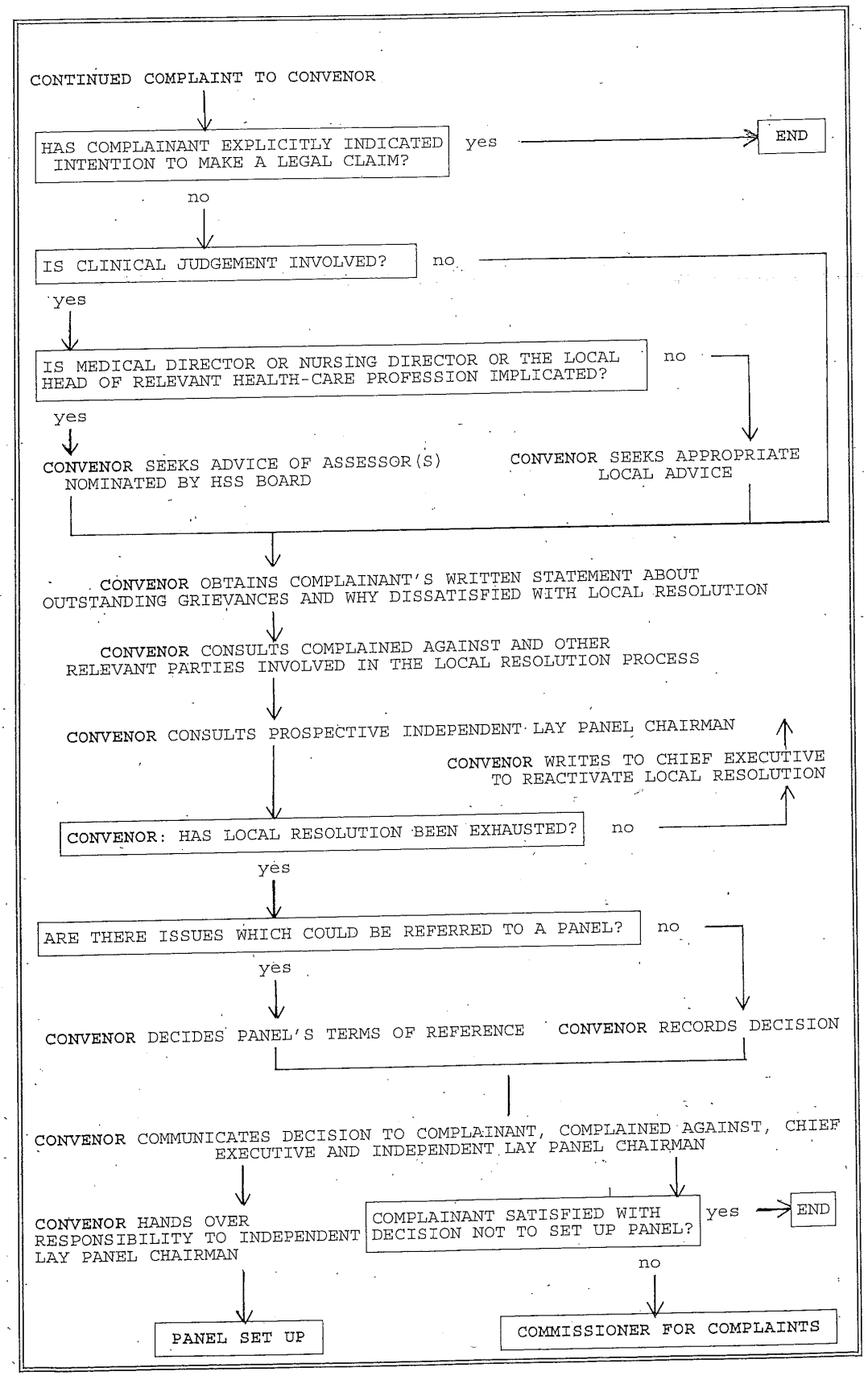
- advise any person who is complained against in writing of his decision and the terms of reference for the panel, the issues to be excluded from its consideration and why, and when the panel is likely to be set up;

- advise the independent lay panel chairman of his decision, with the terms of reference and the complainant's written grievance, thereby handing over responsibility for the next stage;

- advise the Chief Executive in writing of:

  - the decision and terms of reference of the panel;
  - the need for a further member of the panel;
  - whether there is a need to appoint assessors to assist the panel, and that appropriate arrangements should be made for their formal appointment;
  - the need for administrative assistance to support the panel.

CONVENING ROLE



ROLE OF THE INDEPENDENT LAY CHAIRMAN

The role of the independent lay chairman is in two parts:

First

- to help convenors, by providing independent advice and support during the convening period: prospective panel chairmen may need to read reports and documents that are passed to him/her by the convenor, but it is not for the convenor to make the ultimate decision as to whether or not a panel is to be convened;
- to keep a personal record of the part they have played in the convening process, in case of need for future reference, for example investigation by the Commissioner for Complaints.

Second

- once the decision has been made by the convenor to establish an independent review panel, to ensure that he/she understands the terms of reference being provided for the panel and to decide on arrangements for the panel's business;
- to decide with the other panel members how the panel should operate, and to make appropriate arrangements to ensure full records of the panel's activities are kept bearing in mind a possible subsequent investigation by the Commissioner for Complaints (the Board appointing the panel has responsibility for providing appropriate administrative support for the panel and its assessors);
- to ensure members of the panel and assessors have received appropriate documentation, including the convenor's report and the complaint's grievance as recorded in writing to the convenor;
- in the light of discussion with panel members and also, where appropriate, the assessors, to decide the way in which the panel will proceed with its business, always bearing in mind its objective is to resolve and satisfy the complainant's grievance, while at the same time being fair to staff who are involved in the complaint;
- to exercise discretion as chairman of the panel as to how the panel should operate if any of the panel members disagree about how the panel should go about its business: the chairman's decision will be final;
- to decide, with the panel, arrangements for meeting the complainant and those who are complained against, together with those chosen to accompany them;
- to agree with the panel and its assessors the way in which the latter will meet with the complainant and the complained against, and how they should make their report;
- to lead the panel in shaping its report, setting out the results of its investigations, outlining its conclusions, with any appropriate comments or suggestions;
- to ensure there are no recommendations or suggestions relating to disciplinary matters

contained in the report;

- to decide, with the panel and, when appropriate, its assessors, what parts of the draft report are to be shown to the complainant and any person complained against;

- to ensure the work of the panel maintains momentum and as far as possible meets the target time limit for the panel to make its final report and, where this is likely to be exceeded, that an appropriate explanation is forthcoming to the complainant and those involved in the complaint;

- to send the report as formally required under the complaints procedure, ensuring its confidentiality.

ROLE OF THE ASSESSOR

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.

The following set of questions is meant to be a framework within which all health care professions can operate. The questions are meant to be an *aide memoire*; they will not all be relevant in a particular complaint, so they will need to be tailored to the individual complaint; and they will need to be adapted for each profession.

1. Were the actions of the health care professional(s) based on a reasonable and responsible exercise of clinical judgement of a standard which could reasonably be expected of his/her/their peers by patients in similar circumstances?

2. Did the health care professional(s) respect the right of the patient (and the relatives/carers with the patient's consent) to influence decisions about his/her care?

3. Did the actions of the health care professional(s) conform with the codes of practice and/or rules of his/her/their profession(s)?

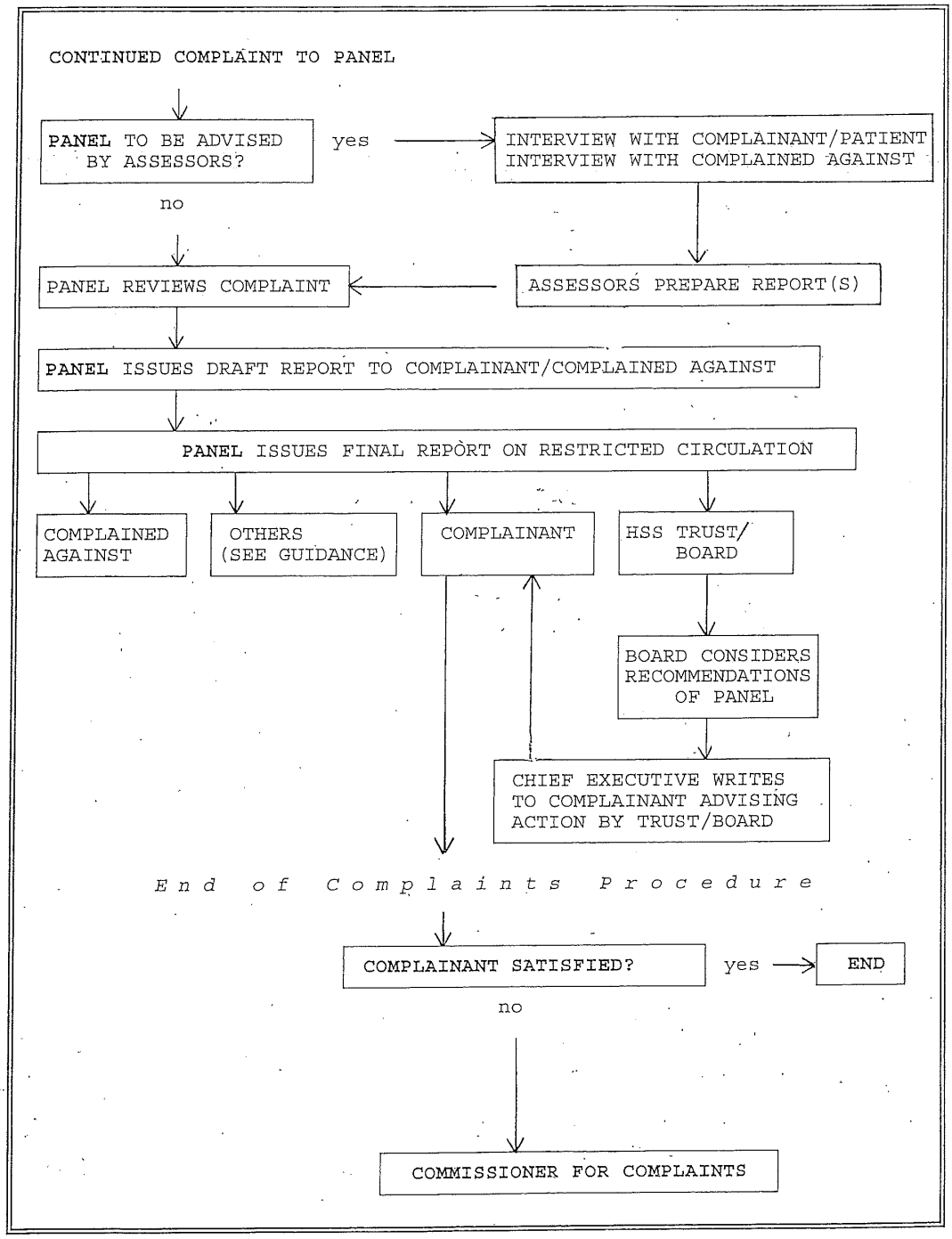
4. Was the necessary information and/or support expert professional advice available to the health care professional(s) to enable him/her/them to form a proper judgement and offer appropriate care?

5. Did the health care professional(s) fail to recognise the limits of his/her/their professional competence?

6. If there was delegation to a junior (or subordinate) member of staff of responsibility for the care of the patient, was it agreed? and did the health care professional satisfy himself/herself that the junior (or subordinate) member of staff was competent to undertake that care?

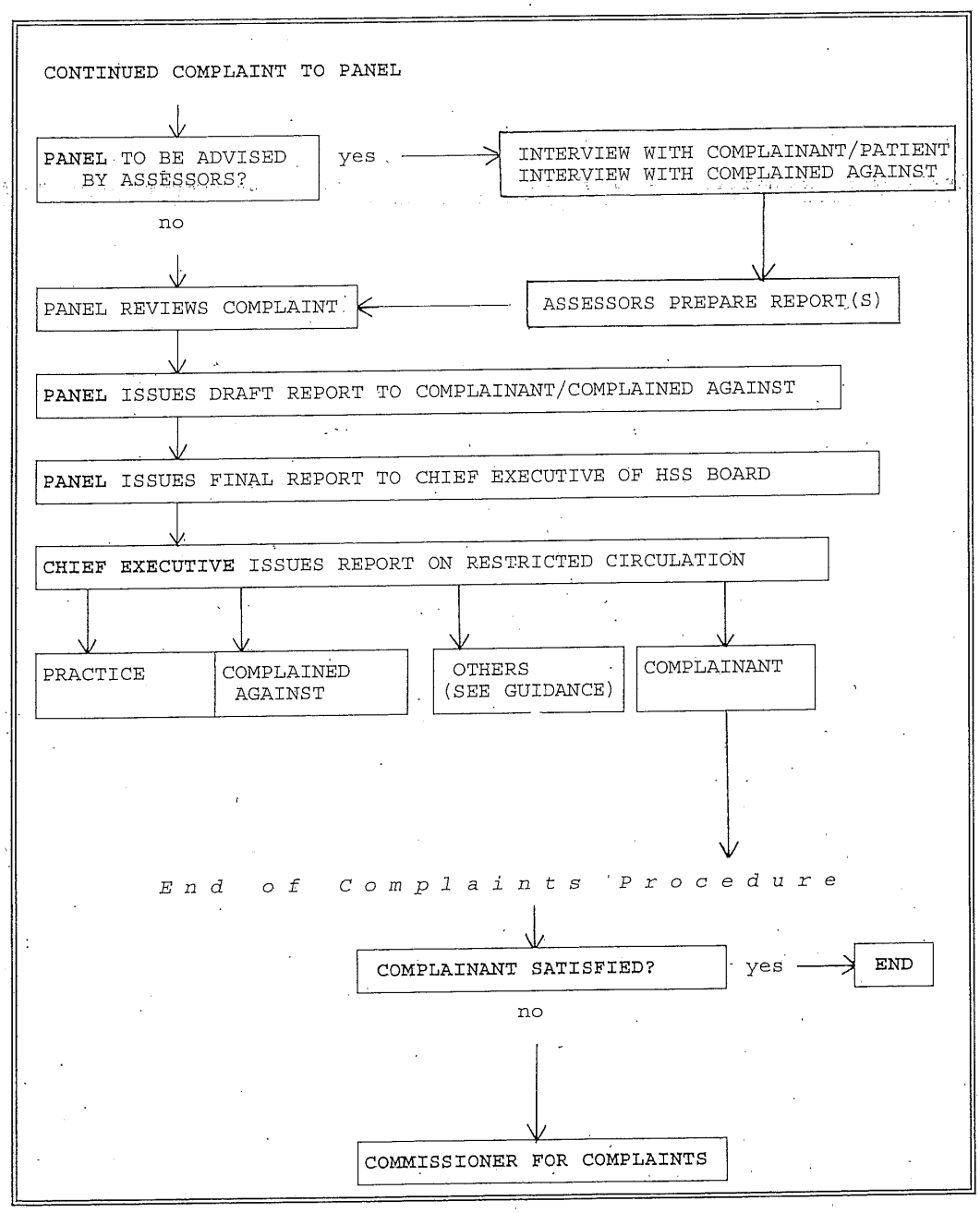
7 Was there failure to refer the patient to another health care professional?

INDEPENDENT REVIEW FOR TRUSTS AND BOARDS



APPENDIX 6b

INDEPENDENT REVIEW FOR FHS PRACTITIONERS



SUMMARY OF TIME LIMITS/PERFORMANCE TARGETS

EVENT	TIME ALLOWED	PARAGRAPH
Original complaint	6 months from event, *or* 6 months of becoming aware of a cause for complaint, but no longer than 12 months from event: discretion to extend	5.12
Local Resolution		
Oral complaint	Dealt with on the spot or referred	6.22
Acknowledgement	2 working days of receipt, *or* full reply within 5 working days	6.22
Full response, by trust/Board, *or* family health services practitioner	20 working days of receipt, *or* normally 10 working days for practice-based complaints or, if this is not possible, as soon as reasonably practicable thereafter.	6.23 6.24
Complainant to apply for Independent Review	28 calendar days of receipt of response to Local Resolution	7.1
Independent Review for Trust/Board complaints		
Acknowledgement by convenor of request for Independent Review	2 working days of receipt	7.30
Decision by convenor to set up panel, or not	20 working days of receipt of request	7.31
Appointment of panel members	20 working days of decision by convenor to establish a panel	8.53
Draft report of panel	50 working days of formal appointment of panel and assessors	8.53
Final report of panel	10 further working days	8.53
Response to complainant by Board	20 working days of receipt of panel's report	8.53
Independent Review for family health services practitioner complaints		
Acknowledgement by convenor of request for Independent Review	2 working days of receipt	7.30
Decision by convenor to set up panel, or not	10 working days of receipt of request	8.54
Appointment of panel members	10 working days of decision by convenor to establish a panel	8.54
Draft report of panel	30 working days of formal appointment of panel and assessors	8.54
Final report of panel	10 further working days	8.54
Final report sent to complainant by chief executive of Board	5 working days of receipt of panel's report	8.54