The MDU's guide to the combined

Health and social care complaints procedure

Northern Ireland

From 1 April 2009 there is a common complaints procedure for health and social care[1]. The procedure has two stages: local resolution, and referral to the Northern Ireland Commissioner for Complaints (Ombudsman). For complaints that cover more than one aspect of care, for example, primary care and social care, there is a statutory obligation for the relevant organisations to co-operate to resolve complaints. One of the key features of the complaints procedure is that it should be seen as an opportunity to learn from matters complained about. Finally, new monitoring and reporting requirements are intended to provide information so that commissioners of healthcare and the public will be able to evaluate a health or social care body's complaints record.

The health and social care complaints procedures have at their core four key principles:

- Openness and accessibility – flexibility in how complaints are investigated coupled with support to complainants;
- Responsiveness – to provide an appropriate, proportionate response to complaints;
- Fairness and independence; and
- Learning and development

Scope of the complaints procedure

A complaint may be made about the provision of care or services by any health or social care organisation, including primary and secondary care organisations. The directions do not prohibit healthcare organisations from responding to complaints about access to a deceased patient's clinical records (to avoid court proceedings under the Access to Health Records (Northern Ireland) Order 1993). In contrast, however, complaints about data protection or freedom of information legislation are excluded from the complaints procedures.

Further exclusions include staff grievances, disciplinary procedures (whether contractual or brought by a regulatory body), child protection and protection of vulnerable adult matters, criminal investigations and "independent inquiries", which could include coroners' inquests.

The procedure does not allow complaints investigations to be run in parallel with disciplinary action brought against the same healthcare professional, but it does allow complaints to be investigated where the subject matter is separate from the disciplinary issues. A trust chief executive, or senior partner in a GP practice, should write to a complainant in such circumstances indicating the issues that the complaint investigation will cover.

In relation to civil claims, the procedure distinguishes between actual or intended formal legal action, and correspondence channelled through a solicitor. Where patients have indicated their intention to bring proceedings in relation to a clinical negligence claim, complaints should cease. However, the mere fact that a solicitor makes the complaint on behalf of a patient does not mean that there are formal legal proceedings, and such complaints can continue.

There is also a general principle where a complaint is not investigated (or investigation ceases) that when the matter that led to it is concluded, the complaint investigation can start, or continue. However, this is a complex area as there are some groups of exclusion where such an obligation to initiate or resurrect an investigation does not apply (eg complaints relating to contract of employment or to child protection inquiries). You may wish to contact the MDU in such cases.

Where a decision is made not to investigate (or discontinue investigation of) a complaint, the chief executive (or senior partner) must notify the complainant and any subject of the complaint of that decision. Similar notification must be given where a previously excluded complaint is to be investigated. The MDU recommends that members give such notifications in writing.

1 The Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009 and Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers 2009.

Making a complaint

A complaint may usefully be defined as an expression of dissatisfaction that requires response[2]. Complainants may be current or former patients of a healthcare organisation, someone who has been refused care by the health or social care organisation, or someone acting with the patient's authority (such as someone with parental authority for a child and an appropriate person for a deceased patient, normally a close relative or executor). Competent children may make a complaint in their own right. In the Directions relating to Family Health Services there is explicit provision for a GP to make a complaint to the health board about the behaviour of a patient. However, such situations are likely to arise very rarely and we would suggest that you contact the MDU for advice before deciding on what action, if any, to take.

A complaints manager, in consultation with a trust chief executive, or practice senior partner, must decide whether a complainant acting for a child, incapable adult or deceased individual has "sufficient interest" in the welfare of that individual and is a suitable person to act as a representative. If the complaints manager considers that the complainant does not have sufficient interest to make a complaint, then the senior person in the healthcare organisation must write to the complainant to explain the reasons for the decision.

Normal considerations of confidentiality apply and complainants should be informed of the extent to which their personal information will be used to investigate concerns they have raised. If complainants object, their wishes should be respected though they should be informed that their decision may have an impact on the extent to which the matter can be investigated, or indeed that it will not be possible to investigate the complaint without consent.

Complaints may be made orally or in writing at the outset. Oral complaints must nonetheless be recorded in writing (or at least summarised in written form) and a copy of the written record provided to the complainant. Certain oral complaints may be resolved on the spot by front line staff, in which case guidance[2] published by the Department for Health, Social Services and Public Safety (DHSSPS) states that further action under the complaints procedure is unnecessary.

Although complaints may be made to any staff member, the complaints manager is responsible for investigating them. Every health and social care organisation must have a nominated complaints manager.

Complaints about GPs are normally made by patients direct to the practice. However, complainants can make their complaint direct to the health board and that organisation must offer the complainant the option of forwarding the complaint to the practice, or the health board can act in the role of "honest broker" to facilitate investigation of the concerns raised. The term honest broker is defined in the directions as where the health board's complaints manager acts as an intermediary in an attempt to resolve the complaint. This will normally be best achieved by mediation, which allows individuals to respond, or by the provision of conciliation services. The health board must record and monitor complaints that it receives and responds to.

Time limits

Complaints should normally be brought within six months of the date of the incident giving rise to the concerns or, where the complainant became aware of cause for complaint later, the period is either six months from the date of knowledge or 12 months from the date of the incident, whichever is shorter. There is discretion to extend these time limits and the MDU would encourage you to investigate complaints where it is possible to do so (for example, where notes still exist and where it is reasonable in the circumstances to investigate the matter). If it is not possible to extend the time limits we would advise members to explain this to the complainant and to give reasons.

Accountability and publicity

Health and social care trusts and boards must appoint a senior person within their organisations to take responsibility for ensuring that there is a complaints procedure that can adequately investigate and consider complaints. However, that senior person can delegate the responsibility for ensuring that the organisation complies with the complaints regulations and learns lessons from them. This senior person would normally be a senior member of trust management (a director), or a clinical governance lead in primary care. The complaints procedure emphasises the importance of continuous change and improvement as a result of learning from concerns raised.

Organisations are required to ensure the complaints procedure is given adequate publicity so that patients and their relatives understand the procedure and know how to use it. This may include putting up posters, notices in waiting rooms and practice/trust literature as well as information provided by health boards and trusts.

Duty to co-operate

There is a requirement that all relevant organisations co-operate to ensure that complaints involving more than one health or social care body are investigated thoroughly

2 *Complaints in health and social care: standards and guidelines for resolution and learning,* DHSSPS April 2009.

and that a full and comprehensive response is provided. Such co-operation would include providing information to the person co-ordinating the response, attending meetings and answering questions asked of individual organisations.

Complaints manager

A key person in the practical handling of complaints is the complaints manager. Each health or social care organisation must designate a complaints manager whose function is to acknowledge, investigate, consider and draft responses to complaints, as well as ensuring that relevant matters are considered under the organisation's clinical governance procedures. Complaints managers should be trained appropriately so they can discharge their responsibilities properly.

Practical aspects of responding to complaints

The MDU recommends that you discuss the complaint at the outset with the complainant to ensure both parties are agreed upon its scope and this will allow you to draw up an investigation plan and clarify the outcomes that the complainant expects to enable satisfactory resolution. If it seems that you may need to exceed the statutory timescales in order to make a thorough investigation and provide a report, this will also need to be agreed (see below). It is important to keep the complainant informed of relevant developments, particularly if delays are expected.

Complaints must be acknowledged promptly, within two working days in the case of trusts, and three working days in primary care. In primary care, you must provide the health board with a copy of the complaint within three working days, where the complainant permits this to happen. If the complainant refuses permission, the MDU recommends that you notify the health board that you have received a complaint, but that permission to disclose it has been withheld.

Within the acknowledgement, complainants must be told of their right to seek assistance from the Patient and Client Council. The investigation into the complaint should normally be completed within 20 working days for trusts and 10 working days for GPs, though if it will not be possible to achieve these targets, you need to give complainants the reasons for the delay and tell them when they will receive a response.

In joint complaints there should be appropriate liaison between the various organisations concerned, with the complainant's permission. The organisations will need to agree between them what aspects of the complaint each organisation will address.

Investigations have to be carried out in a manner that is non-adversarial and that promotes the principles of fairness and consistency. The thoroughness of the investigation should be proportionate to the concerns and sufficient to identify all relevant facts and factors to inform the response, as well as identifying matters that contribute to the process of learning.

The manner of the investigation is largely at the discretion of the complaints manager, but it is advisable to agree the general approach with the complainant at the outset. As a matter of course it is essential to obtain detailed statements from the complainant, the person(s) complained about and other relevant witnesses. It may also be appropriate to use services provided by external individuals, including conciliators, independent medical assessors, and support/advocacy services for the complainant.

The complaints guidance lists eight standards that should be followed in order to reduce variability in the way in which complaints are dealt with between organisations. These are:

- **Accountability** – in terms of the procedures and ensuring that relevant directions are complied with;
- **Accessibility** – making the complaints procedure open and easily accessed by patients and their representatives;
- **Receiving complaints** – all complaints will be dealt with seriously, with courtesy and in a timely manner and will respect confidentiality;
- **Supporting complainants and staff** – including ensuring that complaints managers are trained, appropriate use is made of conciliation and lay or medical advice, and that complainants have access to advice and support;
- **Investigation of complaints** – these must be conducted promptly, thoroughly, openly, honestly and objectively;
- **Responding to complaints** – timescales will be met, where practicable, and all aspects of the complaint addressed;
- **Monitoring**; and
- **Learning**.

It is the MDU's experience that meetings can be an effective method of gathering information and in some cases can greatly assist the resolution of a complaint. You may wish to agree in advance areas of discussion with the complainant as well as who will be present at the meeting. You might wish to suggest that the complainant seeks support from a friend or from a support or advocacy service and the potential benefit

from using a conciliator should be considered. You should keep minutes and agree them afterwards, and reflect the key points in the final response to the complaint.

When the investigation is complete, the response that is drafted must accurately reflect the evidence obtained and the findings made. Where statements have been obtained from medical staff it is vital that they have the opportunity to comment on a draft of their evidence (and, ideally any conclusions and recommendations drawn from it) in order to ensure accuracy. The complaints manager and other individuals drafting the response should weigh the findings in order to reach fair, balanced conclusions that can be justified from the evidence obtained. Recommendations should also be fair, achievable, proportionate and take all opportunities to learn lessons from the complaint.

Although it is not unusual to offer the complainant the opportunity to respond to the response you provide to the complaint, it is important to ensure that this does not lead to protracted to-ing and fro-ing if agreement cannot be reached, and the complainant should be notified of the formal ending of local resolution. Complainants who are dissatisfied with the response should be advised of their right to take their complaint to the Ombudsman. The Ombudsman will normally only consider complaints where they have been brought within 12 months of the date when the complainant knew they had cause for complaint.

The senior person who is responsible for the organisation should normally sign-off of the final report, though this responsibility may be delegated. However, if the task is delegated it does not remove the overall accountability of the senior person.

Reporting and monitoring arrangements

All health and social care organisations have a duty to monitor complaints to ensure they are being addressed in an effective, efficient manner and that lessons learnt from them are considered and/or adopted, as appropriate. Records of complaints must be kept as well as outcomes and action taken as a result of complaints investigations.

Health boards will produce statistics on those from whom they commission services (notably GPs) on a quarterly basis, as well as a detailed annual report setting out numbers of complaints received, the nature of those complaints, timescales relating to their investigation and the number of occasions that the board acted as an "honest broker". Such reports must be suitably anonymised and must not include information that may identify patients. Annual reports will be publicly available and as a matter of routine will be sent to the relevant Health and Social Services Councils, the Regulation and Quality Improvement Authority (RQIA), the Ombudsman and the DHSSPS. It follows that there is a reciprocal obligation placed on GPs to provide statistical information to health boards to support quarterly and annual reports, as well as notifying the board of new complaints as they emerge (see above). Health trusts have similar monitoring and reporting obligations.

The data that is obtained from complaints will be analysed by the RQIA and disseminated by them from time to time.

Learning

The complaints procedure emphasises that health and social care trusts and boards must ensure that organisational learning flows from the analysis of complaints. The MDU has for many years advised members to consider complaints in accordance with local clinical governance arrangements to encourage and support organisational, regional and national learning. We suggest that practices consider integrating complaints investigation and clinical governance procedures where this is practicable.

For individual medico-legal advice:

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Web: **www.the-mdu.com**

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