Patient and Client Council – *Assessment of Impact of Advocacy Function*

Final Report

June 2026

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PCC PATIENT & CLIENT COUNCIL

Foreword

Foreword



The PCC has undergone significant transformation in recent years. Since 2021 we have implemented and evolved a restorative and early resolution approach to our independent advocacy service.

This is underpinned by PCC's statutory functions, including to '*provide assistance to individuals making or intending to make a complaint relating to health and social care services'*. Independent advocacy support, focused on restorative resolution, is designed to support members of the public in resolving issues at the earliest possible stage, by facilitating engagement between service users and HSC providers. It involves listening to concerns, facilitating understanding and mediating a response towards identified and mutually agreeable resolutions. It focuses on encouraging learning, reducing harm and repairing trust.

Delivering this model has demonstrated significant benefit to members of the public, staff and the wider HSC system. It has highlighted the potential to save the system money by reducing the time and resources spent on complaints processes, and other processes resulting from avoidable patient harm.

To explore and determine the evidence in support of this, PCC commissioned the Innovation Consultancy Service within the Department of Finance, to independently and impartially assess and quantify the benefits, both financial and non-financial, of PCC's restorative approach and independent advocacy practice model, within health and social care across Northern Ireland. We also asked them to identify the enablers required for implementation, to inform the scaling of this approach.

The findings are clear; in the area of complaints resolution alone, **shifting even 50% of HSC complaints to early resolution could save the HSC system £4-6million per year.** Through our independent advocacy work, PCC delivered an early resolution rate of 57% of cases in 2025-26.

Foreword

The report also demonstrates that such an approach improves the public's experience of HSC services, and reduces the burden on HSC staff of stressful and prolonged complaints processes. This increases the psychological safety of staff and can generate an environment more focused on learning from feedback and complaints.

It concludes that PCC is leading this approach across the UK and Ireland and makes a number of recommendations on how restorative approaches, through independent advocacy focused on early resolution and mediation, may be further embedded within the HSC system and delivered at scale. I am pleased that this report establishes an NI-specific evidence base, supporting the valuable role that restorative approaches play in reducing the impact of healthcare harm.

This report forms part of a wider evidence base PCC has developed on the benefits and possibilities of pursuing a regionalised approach to independent advocacy in Northern Ireland, including our recently published Advocacy Casebook, and Advocacy Thought Paper.

I would like to acknowledge and thank the Innovation Consultancy Services' team and all those who engaged with them to deliver this report, including colleagues from across the HSC, members of the public and PCC staff members. I would also like to acknowledge the support of PCC's Sponsor team under the Chief Nursing Officer, when PCC sought to commission this report in 2024.



Meadhbha Monaghan
Chief Executive

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Acknowledgements

ICS wish to express their sincere thanks to the Patient and Client Council; and other key stakeholders consulted, and all those who contributed to the Research. The information they provided, and their co-operation greatly assisted the completion of this project and the development of this report.

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1. Introduction

Introduction

Introduction

Innovation Consultancy Services (ICS) was commissioned by the Patient and Client Council (PCC) to undertake an assessment of the impact of the changes to its model for delivering its advocacy function.

Terms of Reference

The agreed Terms of Reference for ICS's involvement in this assignment are as follows:

1) *"To quantify the impact and benefits, both financial and non-financial, of the advocacy practice model to the public and rest of the HSC system."*

To achieve this, we will undertake the following activities:

- Comparison of the cost (in terms of time and salary costs) of the complaints process vs the cost of a case which is resolved through advocacy. While this report seeks to assess the impact of the PCC's early resolution advocacy model, it is recognised that impacts cannot be wholly isolated from the wider HSC complaints handling processes. Findings should therefore be interpreted as indicative rather than wholly attributable to advocacy alone.
- Analysis of the patient / client experience, looking at time taken to resolve, level of patient involvement and satisfaction levels.
- Assess the qualitative benefits to the HSC system of early resolution vs. complaints process. This should include an assessment of the impact on staff experience during both processes.

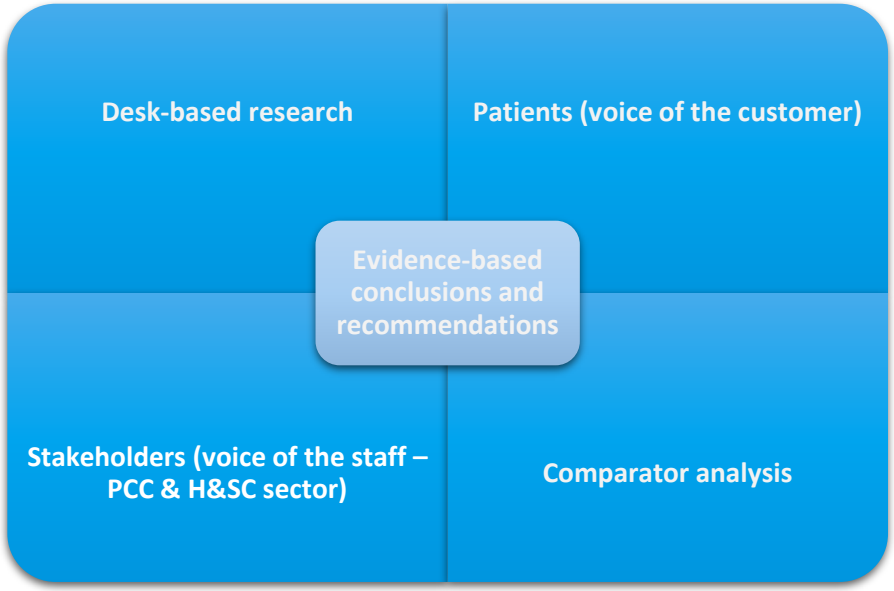
2) *"To identify the enablers required for the implementation of an early resolution approach, in order to develop an understanding of work required to scale the approach further."*

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2. Research Methods & Approach

Research Methods & Approach

This section provides an overview of the significant and varied research methods undertaken as part of the assignment, which enabled the research team to triangulate findings from a number of sources and arrive at robust evidence-based conclusions and recommendations. This included a mix of: desktop/document review; consultations and workshops Trust staff, PCC staff and management; and comparator analysis.



Research activity / description

Activity	Overview
Desktop research	Over 30 documents reviewed: literature / research papers; strategy docs; business plans; comparators reports.
Consultations	Consultation interviews: • PCC management team • PCC staff • Trust staff and management • NIPSO
Comparator analysis	Desk-based review of Scotland, Wales, Republic of Ireland delivery
Survey	Survey to service users / patients (facilitated through PCC)
Financial assessment of models	Undertaking a research-based assessment of the financial cost and timelines associated with early / local resolution against a more comprehensive complaints / tribunal process.

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3. Context & Literature Review

Context

Introduction & Background

The Patient and Client Council (PCC) was established under the Health and Social Care (Reform) Act (NI) 2009 as an independent body advocating for patients, clients, carers and communities. The role of the PCC is to be an independent, informed and influential voice that makes a positive difference and advocates for people across Northern Ireland in Health and Social Care.

The core functions of the PCC, as defined by statute are:

- **Listen** to the views and experiences of patients and clients.
- **Advise** the Department, HSC bodies, and the public.
- **Encourage and facilitate** involvement of patients and the public in health service design and delivery.
- **Promote** health and social care improvements.
- **Provide** a complaints support service (advocacy).

Approach

Since 2019, the PCC has undergone significant administrative transformations in its complaints handling strategy. The more process driven methods of the past have been replaced with an **early resolution model**, designed to prioritise ***timely, person-centered*** *and* ***realtime*** methods of addressing the concerns raised by patients, clients and carers. These changes have been driven by a commitment to enhance transparency, accessibility and responsiveness in the complaints process and aims to resolve issues quickly, reduce distress, and promote system learning and trust-building.

The implementation of this early resolution model began in 2019, as part of the PCC's broader commitment to improving the experience of individuals engaging with health and social care services. This shift aimed to address concerns and complaints more swiftly, reducing the need for prolonged, formal investigations and legal processes and fostering a more responsive, person-centered approach to service improvement.

Rationale

This early resolution function is designed to support individuals in resolving issues at the earliest possible stage by facilitating communication between service users and Health and Social Care (HSC) providers. It involves listening to concerns, clarifying misunderstandings, and helping to identify mutually agreeable solutions without the need for escalation.

Context

Rationale *cont'd*

This approach not only empowers individuals but also contributes to a culture of openness and continuous improvement within the HSC system.

The PCC early resolution model offers several benefits including those outlined below.

Benefits	Description
Faster resolution	Individuals get answers and action sooner
Improved satisfaction	Service users feel heard, which can enhance trust and reduce anger
Lower system burdens	Fewer complaints escalate into time-consuming, administrative heavy, formal reviews Positive impact on waiting lists
Better staff- user relationships	Facilitated conversations improve mutual understanding
Enables learning and quality improvement	Patterns of concern can inform services changes
Reduced stress and emotional burden on staff, patients and clients	Avoidance of lengthy complaints process can reduce the emotional impact on those engaged in the process

To operationalise this model, the PCC invested in staff development, equipping its team with training in conflict resolution, mediation, and effective communication.

Organisational structures were adapted to support quicker response times and more direct engagement with service users. Additionally, the PCC worked to strengthen its relationships with HSC Trusts, fostering a collaborative environment where "***HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC.***"[1]

[1] Microsoft Word - Guidance in relation to the Health and Social Care Complaints Procedure - April 2023

Literature Review – *Introduction*

The early resolution of patient complaints is increasingly recognised as a pivotal strategy in enhancing healthcare system efficiency. By addressing grievances promptly, healthcare systems can potentially reduce waiting lists, minimise staff-related costs, and decrease legal settlements. This review examines the impact of early complaint resolution within the NHS, with a particular focus on Northern Ireland, and offers comparative insights from the Republic of Ireland and the broader UK context.

Impact on waiting lists

A study by the NIHR found that people on long NHS waiting lists used significantly **more** healthcare resources than those not waiting. For example:

- Patients waiting for trauma and orthopedic treatment had, on average, 4 more secondary care contacts and 4 more prescriptions per year than matched controls.[1]
- Those waiting for cardiothoracic surgery had 17 additional secondary care contacts annually.[1]

This increased demand places further strain on already stretched services. By resolving complaints early—especially those related to delays—patients may be more likely to remain engaged with their care pathway, reducing the likelihood of additional GP visits, emergency admissions, or mental health referrals.

In Northern Ireland, the Health and Social Care (HSC) system faces significant challenges with waiting lists having some of the longest in the UK. As of early 2025, over **400,000 people** were waiting for a first consultant-led outpatient appointment.[1]

Significant investment is being made to address these waiting lists. The **Elective Care Framework (ECF)**, updated in 2023, introduced measures such as:

- **Mega Clinics** and **Rapid Diagnosis Centers** to increase throughput.
- **£215 million** allocated in 2025 to reduce waiting times, including **£85 million** for red flag and time-critical care.

Delays in addressing patient complaints can exacerbate these waiting times, as unresolved complaints or disputes, may lead to repeated consultations or escalations, which can stall treatment pathways and increase administrative burdens within the system.[2]

[1] People on long waiting lists use more healthcare resources
[2] NHS under pressure Northern Ireland[2] Home - NHS Resolution

Literature Review – *Introduction*

How to save £12 Billion: Improving Mental Health and Wellbeing in the NHS

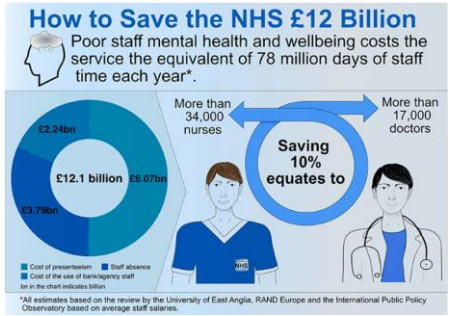
Financial Impact of Mental Health related staff absences

Whilst it is difficult to access precise figures on staff absences related to complaints processed across the UK and Ireland, the available reports highlight a clear connection between workplace stressors- such as those arising from complaints- and increased absenteeism due to mental health issues.

Data indicates a significant financial burden on both the NHS and HSE due to staff absenteeism linked to stress and mental health issues.

Key Statistics:

- The NHS incurs approximately **£12.1 billion**[1] annually due to poor staff and clinician mental health:
  - **Presenteeism:** £6.07 billion
  - **Staff absence:** £3.79 billion
  - **Use of bank/ agency staff:** £2.24 billion
- In 2023, nurses in England collectively took nearly **7 million sick days,** with 24.3% attributed to stress, anxiety or depression. This equates to each nurse taking approximately one week off due to stress-related illness.[2]
- A UK- wide survey conducted by UNISON in 2024, which included Northern Ireland, reported that **31% of NHS staff** had taken time off in the previous 12 months due to mental health issues like stress and anxiety.[3]
- In 2023/24 the Northern HSCT reported a cumulative sickness absence of **8%**, with stress identified as the main cause of absence amongst staff.[4]
- In 2023/24, the HSE report that 1.7 million workers in the Republic of Ireland experienced work-related ill health, with approximately half of those cases being linked to stress, depression or anxiety.[3]



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[1] IPPO NHS Staff Wellbeing report_LO160622-1849.pdf
[2] 'Dangerous stress levels have become normalised' | News | Royal College of Nursing
[3] Mental health absences adding to NHS staffing crisis | News, Press release | News | UNISON National
[4] Annual Quality Report 2023/24 - Northern Health and Social Care Trust

Literature Review

Benefits of Early Resolution of Medical Complaints on Staff and Clinicians

Early resolution of complaints in healthcare settings has been shown to significantly reduce stress and emotional burden on clinical staff, improve workplace morale, and foster a culture of openness and learning. NHS Resolution, the national body responsible for handling claims and disputes in England, has consistently advocated for early resolution as a means to reduce the adversarial nature of complaints and litigation. Their strategy emphasizes that resolving concerns early helps preserve professional relationships, reduces the likelihood of formal legal action, and allows clinicians to focus on patient care rather than prolonged disputes.[1]

In the Republic of Ireland, a report by Medical Protection revealed that 91% of doctors involved in prolonged clinical negligence claims experienced concerns about their mental well-being, 78% of respondents rated their wellbeing as 'worse' while the claim was ongoing compared to before and 70% were worried about the wellbeing of their loved ones. Some healthcare professionals stated they needed psychotherapy and professional help, and others even mentioned having suicidal thoughts while undergoing a claim and some considering leaving the profession.[2]

It goes on to say how the experience is "*made worse by a slow process where delays are rife and without mechanisms, such as pre-action protocols or case management, to allow for early resolution of a claim".*

"It was horrendous. I had to leave medicine after it. I developed severe anxiety during the course of the claim and PTSD. I lost my career in medicine and I am devastated about that. I knew I could never go through the same again."[2]

The adversarial nature of prolonged complaint processes can lead to burnout, increased sick leave, and higher staff turnover, all contributing to elevated staffing costs.[2]

Research has highlighted how effective early resolution of complaints significantly enhances staff and clinician experience by reducing stress, fostering a culture of openness, and promoting professional development.

At Newcastle upon Tyne Hospitals NHS Foundation Trust, the implementation of Early Intervention Meetings (EIMs) facilitated face-to-face discussions between complainants and staff. This approach led to 98% of staff participants expressing willingness to engage in future meetings, citing feelings of support and constructive engagement.[3]

[1] Home - NHS Resolution
[2] medical-protection-tort-reform-policy-paper-final.pdf
[3] How early, direct engagement improved the experience of staff and complainants | Parliamentary and Health Service Ombudsman (PHSO)

Literature Review

Benefits of Early Resolution of Medical Complaints on Staff and Clinicians *cont'd*

The Parliamentary and Health Service Ombudsman (PHSO) noted that NHS Complaint Standards, emphasizing early resolution, provided clarity and consistency, thereby increasing staff capacity and skill in handling complaints without negatively impacting their time[3].

Trust-level policies, such as those from The Rotherham NHS Foundation Trust, highlight that early resolution supports both patients and staff by promoting fairness, reducing escalation, and encouraging timely feedback loops[3]. In Northern Ireland, while specific regional data is limited, the principles align with broader UK practices.

These policies stress that early engagement with complainants can prevent issues from becoming complaints, which in turn reduces the psychological toll on healthcare professionals and supports a more constructive, less punitive environment. Furthermore, early resolution models contribute to a learning culture within healthcare organisations. By addressing concerns promptly, staff are more likely to view feedback as an opportunity for improvement rather than a threat, which enhances engagement and professional development[4].

[3] NHS Complaint Standards: the value of good complaints handling | Parliamentary and Health Service Ombudsman (PHSO)
[4] policy_for_the_management_of_concerns_and_complaints_1.pdf

Impact on Staff Experience



Lower Risk of Formal Escalations: Timely resolution of concerns reduces the likelihood of complaints escalating to formal grievances or legal disputes. This proactive approach reduces stress and emotional burden on staff associated with prolonged complaints processes.

Reduced Stress and Burnout: Addressing complaints promptly can prevent prolonged conflicts, thereby reducing stress and emotional exhaustion among staff.

- Evidence indicates that complaints processes are associated with significantly poorer mental health outcomes among clinicians. A UK study found that 16.9% of doctors with a current or recent complaint reported moderate–severe depression (compared to 9.5% without complaints), while 15% reported moderate–severe anxiety (compared to 7.3%). (BMJ Open, 2015)
- Significant and enduring distress experienced by staff during complaints and how this is exacerbated by a lack of systematic support offered.

Improved Morale and Job Satisfaction: A proactive approach to resolving issues fosters a positive work environment and enhances staff confidence.

- Patient Experience Network systematically changed the way it managed complaints (aligning with PCC) and has found it improved staff engagement in complaints process; increasing satisfaction amongst complainants and staff

Enhanced Communication Skills: Engaging in early resolution processes encourages staff to develop effective communication skills, leading to better interactions with patients. Research indicates that staff responses to complaints are influenced by interpersonal skills and belief about the **value of complaints**. Engaging early in the resolution process encourages staff to develop effective communication skills, leading to better interactions with patients and a more positive work environment

Literature Review

Benefits of Early Resolution on Patient Experience

There is a growing emphasis that **early resolution** and **person-centered approaches** to complaint handling in healthcare significantly enhance patient experience by fostering a culture of trust, reducing anxiety, and ensuring that concerns are addressed promptly, collaboratively and empathetically.

According to NHS England's *Patient Experience Improvement Framework*, organisations that adopt early and informal resolution approaches are more likely to be **rated highly** by the Care Quality Commission (CQC), as these approaches contribute to a culture of openness, responsiveness, and continuous learning, all of which are key to improving patient satisfaction[1].

NHS Resolution, which supports the NHS in managing concerns and disputes, highlights that early resolution not only preserves resources but also **improves patient outcomes** by reducing the adversarial nature of complaints processes. Their strategy emphasizes that timely, compassionate responses to concerns can prevent escalation and foster a more positive perception of care received[2].

Whilst there is an acknowledgement that this **person-centered approach,** grounded in the principles of empathy, respect and shared decision making, aligns with the **NHS Constitution** and the **HSC Complaints Policy** in Northern Ireland, patients find that their complaints process experience often does not.[3]

A Healthwatch report[4] issued earlier this year noted that "the NHS does not consistently welcome, handle, respond or learn from complaints in a patient-centered manner." It reported that only 9% of patients who experienced poor care, in England, filed complaints with over half dissatisfied with the process and outcomes.

Key problems with the existing NHS complaints and feedback processes have been identified including:

- Delays and Bureaucracy
- Lack of personalization
- Poor communication
- Lack of closure or learning

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1 nhsi-patient-experience-improvement-framework.pdf
2 Home - NHS Resolution
3 Harnessing the power of language to enhance patient experience of the NHS complaint journey in Northern Ireland: a mixed-methods study
4 Briefing

Literature Review

Addressing these problems, especially through **early resolution models** can lead to:

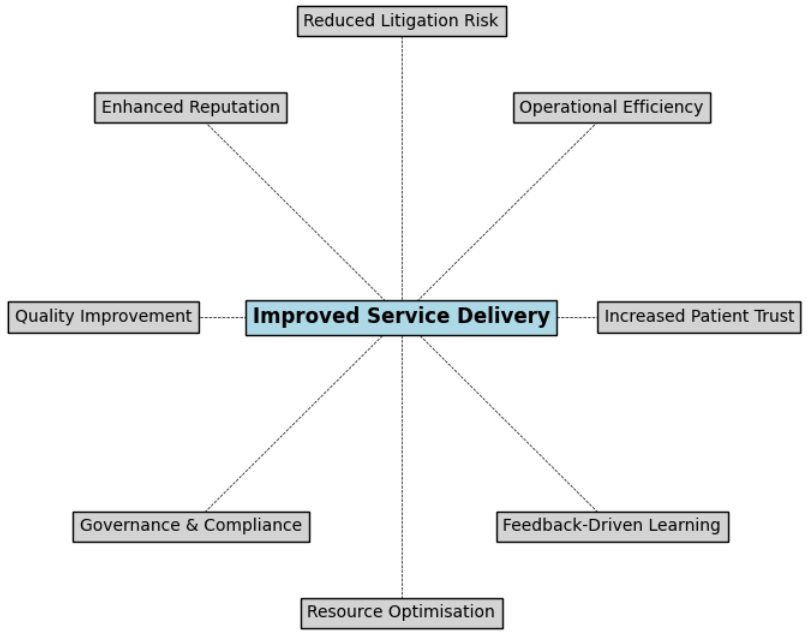
- Faster resolution
- Improved patient satisfaction
- Reduced formal escalation
- Greater trust in the healthcare system

A study focusing on Northern Ireland highlighted that patients prioritise being **listened to**, having their **experiences acknowledged**, and receiving **sincere apologies** when warranted. When these needs are unmet, complaints often escalate, potentially leading to legal action. Effective communication and early engagement were found to prevent such escalations and improve patient satisfaction.[1]

In practical terms, early resolution models have been associated with measurable improvements in patient experience metrics. For example, NHS England reported a jump in patient experience scores from 59% to 92% over two years in trusts that implemented continuous improvement and early engagement strategies[2]. While specific data from Northern Ireland is limited, the Health and Social Care (HSC) system shares similar values and structures with NHS England, and the Patient and Client Council (PCC) has incorporated early resolution principles into its advocacy and complaints support services. These efforts aim to ensure that patients feel heard and respected, which is central to improving overall care experiences.

[1] nhsi-patient-experience-improvement-framework.pdf
[2] NHS England » NHS delivery and continuous improvement review: recommendations

Impact on Service



Increased Patient Trust and Satisfaction: Patients who feel their concerns are heard and addressed promptly are more likely to trust and be satisfied with the service.

Operational Efficiency and service improvement: Resolving issues quickly conserves time and resources that would otherwise be spent on extended investigations. Patient complaints provide valuable feedback, highlighting areas for improvement and guiding quality enhancement initiatives.

Regulatory and Reputation Benefits: A responsive approach to complaints demonstrates good governance, reducing the risk of regulatory scrutiny and enhancing the organization's reputation.

Reduced risk of escalation and litigation: Addressing concerns promptly can prevent complaints from escalating into formal grievances, referral to Ombusdam or legal disputes. This not only reduces the risk of costly legal action but also minimises the negative impact and perception of the Trust's reputation.

Literature Review – *rationale*

General Early Resolution vs Complaints Process	Early resolution through local advocacy is significantly more cost-effective and time-efficient than complaints or tribunal processes. Local advocacy typically involves limited staff time and minimal investigation, often being resolved through direct engagement within a matter of days., while tribunal cases require 3–5× more staff time and incur substantial legal fees. Early resolution also improves patient satisfaction and reduces stress for all parties involved.
Sourced Estimates of Health-Related Complaints vs Early Resolution	Evidence from England suggests that only around 9% of individuals who experience poor care go on to make a complaint, often reflecting a lack of confidence in the system. Local advocacy services resolve a majority of cases early—e.g., 57% of cases handled by the PCC in Northern Ireland were resolved without escalation (2023/24). This highlights the importance of accessible and trusted advocacy services in encouraging early resolution..
Northern Ireland-Specific Health Complaint Data and PCC Insights	The Patient and Client Council (PCC) in Northern Ireland handled 810 new cases in 2023–24, a 42% increase from the previous year. They resolved 57% of cases early and supported 662 individuals directly. The PCC operates a relationship-based, patient-centered advocacy model, engaging with patients through themed platforms and helplines. Feedback indicates high satisfaction, with only 5 complaints received against the PCC that year.

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[1] People on long waiting lists use more healthcare resources
[2] NHS under pressure Northern Ireland[2] Home - NHS Resolution

Literature review - conclusions

The Patient and Client Council (PCC) has evolved from an administrative complaints support model to an early resolution approach since 2019, prioritizing timely, person-centered engagement. Literature strongly supports early resolution as a means to improve patient satisfaction, reduce stress for staff, and enhance system efficiency. Evidence from the UK and Ireland highlights that unresolved complaints exacerbate waiting lists, increase healthcare resource use, and contribute to staff burnout and absenteeism. Early resolution mitigates these risks by fostering trust, reducing adversarial processes, and enabling learning. Comparative studies show that early resolution aligns with best practice standards and is increasingly recognized as essential for sustainable healthcare delivery.

Early resolution is not only a patient-centered innovation but a strategic necessity for the HSC system. It reduces operational and emotional burdens, improves staff morale, and supports continuous improvement. The literature confirms that embedding early resolution within complaints handling frameworks can deliver measurable benefits in efficiency, cost avoidance, and patient experience. PCC's model positions Northern Ireland as a leader in this space, though further formalisation and system-wide adoption could amplify impact.

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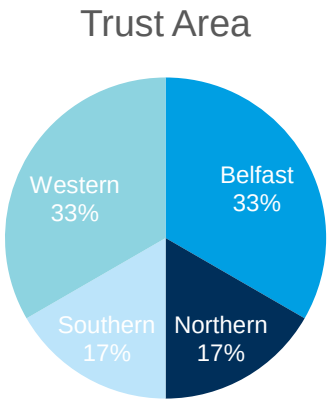
4. Primary Research findings & themes:

- The Patient experience
- The Staff experience
- Views from the H&SC Sector

Patient Experience (1/3)

Introduction

A total of 18 survey responses were received, representing patients from four of the five HSC Trusts in NI. No responses were received from individuals residing within the South Eastern Trust area. The distribution of respondents across the Trusts is illustrated in the below pie chart. This was intended as a targeted group to understand the in-depth experience and not intended to be an assessment of the overall service.



Engaging PCC

When asked how respondents first heard about the PCC, one-third of respondents (n=6) reported discovering the organisation through an online search engine, while just over one-fifth (n=4%) were informed through word of mouth. Over half of the respondents (56%; n=10) submitted a concern or complaint on their own behalf. Among those who acted on behalf of someone else (44%; n=8), the majority were advocating for a parent.

The most common reason for contacting the PCC was dissatisfaction with patient experience, cited by 45% (n=8) of respondents. A further 33% (n=6) indicated that issues related to diagnosis, operations, or treatment were also contributing factors. For 39% (n=7) of those surveyed, this was their first time engaging with the Trusts' complaints process, while the remaining 61% (n=11) had previous experience with it.

When asked what prompted them to reach out to the PCC, respondents frequently mentioned poor communication from consultants and Trusts, as well as frustration with long waits for results, diagnosis and surgery. Some respondents stated they engaged with PCC representatives at outreach events via information stands, while one respondent noted they had been signposted to the PCC by the DoH.

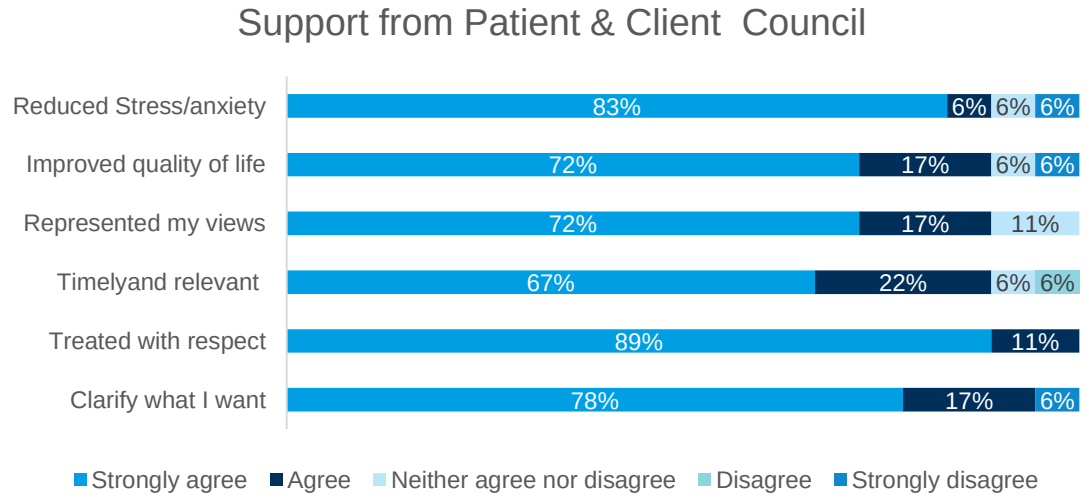
Patient Experience (2/3)

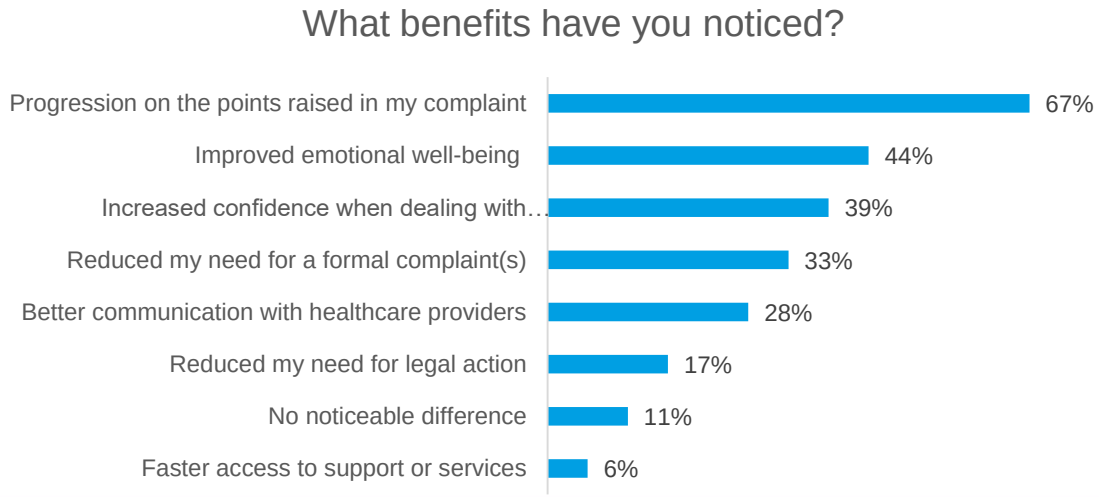
Quality of Support

With regard to the support provided by the PCC, responses were broadly positive. All respondents agreed that they were treated with respect. A large majority, (94%; n=17) agreed or strongly agreed that the PCC helped them clarify what they needed or wanted in order to address their concern. In terms of emotional support, 89% (n=16) agreed or strongly agreed that the PCC helped reduce their feelings of stress and anxiety. Similar results were produced for the following questions: respondents felt that the actions taken by the PCC improved their quality of life, that their views were well represented, and that the information they received was both timely and relevant.

Benefits

Respondents went on to state that since engaging with the PCC, they have noticed a number of benefits. In particular, 67% (n=12) reported seeing progression on the points they had raised, 44% (n=8) experienced improved emotional well-being, and 39% (n=7) felt an increase in confidence when dealing with healthcare providers. A full breakdown of the benefits realised is included in the diagram to the right.

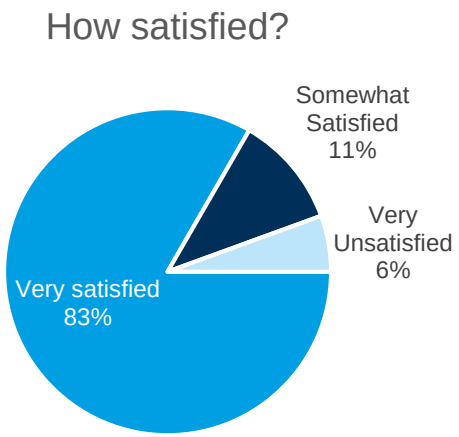




Patient Experience (3/3)

Reflections

Out of all respondents, 72% (n=13) stated that their complaint or concern had been resolved. In terms of their overall experience with the PCC, 94% (n=17) reported being satisfied or very satisfied with the support they received. The full breakdown of satisfaction levels is presented in the diagram below.



Further to this, respondents were asked if there was anything they found particularly helpful. Many consistently highlighted the emotional relief and reassurance they felt through the PCC's involvement. The PCC was seen as instrumental in bringing people to the table and providing access to meetings and information that respondents did not believe they could have achieved on their own. Several individual case workers were also mentioned by name, with comments praising their professionalism, compassion, and dedication.

When asked if there were areas where the PCC could improve, some respondents suggested the need for greater awareness and outreach so that more people are informed about the services available and how to access them. One respondent felt that the PCC's advocacy was limited to facilitation and expressed a desire for the organisation to take a more assertive role in reminding Trusts of their statutory duty of care. Another respondent noted that a follow-up after the resolution of their case would have been appreciated.

Staff Experience – *PCC staff*

This section outlines the findings from primary research conducted by ICS to explore the perceived impact of the early resolution model on both staff and patient experiences within PCC. Insights were drawn from two focus group sessions, which revealed several recurring themes. Participants consistently reported that the complaints process often fell short of meeting patient needs, whereas the early resolution model was viewed as more effective, timely, responsive and person-centred.

PCC staff underscored the importance of adopting a person-centered approach, ensuring that each client's unique circumstances are central to the complaints process. They acknowledged that many clients were reluctant to initiate complaints but felt compelled to do so in order to have their concerns recognised. Frequently, clients were less concerned with personal resolution and more driven by a desire to inform and improve future practice, aiming to prevent others from encountering similar challenges.

"Clients need to feel respected with closure and answers…"

"…difficult conversations need to happen but that doesn't mean the experience has to be negative…"

"…even when the outcome isn't exactly what the client has asked for the experience can be positive…"

Staff Experience – *PCC staff*

Communication and Engagement

Complaints process

PCC staff felt that clients consistently reported dissatisfaction with the complaints process. Common concerns included **prolonged response times**, **unclear or unsatisfactory communication**, and a **lack of clarity** around responses to issues raised that often led to **misunderstandings**. Many clients described the process as overly bureaucratic and heavily reliant on written correspondence, which delayed the initiation of early resolution efforts.

Frustration was frequently expressed over the absence of direct communication with the Trusts, by way of one-to-one conversations or meetings, particularly the inability to receive straightforward answers to specific questions. Clients also reported a disconnect between themselves and the Trust administrative staff handling their complaints, who often lacked awareness of their individual circumstances. Additionally, PCC staff reported instances where clinicians were unaware of the complaints being raised by their patients.

These systemic barriers contributed to a negative overall experience. There were concerns amongst the PCC staff that there was a very real risk of the existing complaints process re-traumatising patients and exacerbating their frustration rather than resolving their concerns.

PCC staff expressed concern over the inconsistent levels of cooperation received from Trusts, despite operating within a clear legislative framework. They observed that the degree of collaboration varied not only between Trusts but also across individual directorates. Staff perceived a general reluctance among Trust personnel to deviate from the traditional complaints pathway, which often hindered the adoption of more flexible approaches. Additionally, they noted frustration that information about PCC's support services was typically included only at the end of the Trust's initial response to complaints—by which point the formal process was already underway, limiting opportunities for early intervention.

PCC staff highlighted that the Trust staff who they had engaged with, particularly at a senior level, were often less stressed by the early resolution process as they too were keen to resolve the patient complaint, or at least address the issues raised.

"There are less professionals involved with early resolution and the outcomes are generally more positive with less bureaucracy."

Staff Experience – *PCC staff*

Complaints process continued

PCC staff highlighted that patients felt frustrated by the often generic nature of responses and 'holding' communication that did not address the individuals request for answers or information.

From discussion with PCC staff it became apparent that the complaints process in the Trusts is initially managed by an administerial team who would have no direct knowledge of the patient or client's circumstance. Cases were identified where the consultant or clinician was unaware of the fact that their patient had made a complaint or the impact of delayed follow up appointments or surgery.

It was felt that there was an awareness, on the part of the Trusts, of the bureaucratic nature of the complaints process and that many people will just give up as time moves on which impacts trust in the Trusts.

Early resolution approach

Staff felt that patients valued the **face-to-face interactions** that are offered by the PCC and the speed at which they could begin talking to a member of PCC staff. Staff acknowledged that many patients want to be *"listened to and understood"* and not just receive a procedural response.

Staff members felt that the early resolution approach allowed them to intercede on behalf of the client and deal directly with clinicians or individuals within the Trust to expedite the speed of resolving the complaint. They were able to act as a conduit for the patient with regards to expediting appointments

"The formal process…with red tape and permissions can often take months to get to the point where PCC would have started."

Members of staff detailed their experience of cases, where the patient complaint had been identified and understood, the PCC engaged directly with secretaries of clinicians and other healthcare providers to act on behalf of their client and take steps to resolve the complaint directly.

*"Early resolution is looking for a **solution** rather than a **response**."*

Staff Experience – *PCC staff*

Case study

In the 6 month wait for a follow up consultant appointment, an individual visited their GP 27 times, 10 of which resulted in A&E visits and several of these were by ambulance.

The PCC arranged an appointment with the consultant and a supporting package with the district nurse negating the need for further visits.

Case study

As a result of a perceived lack of willingness from the

Trust to engage with a client who, at the time, did not wish to make a formal complaint, the client proceeded to engage a solicitor and embarked on a compensatory legal route, taking out a 'fitness to practice' case against a clinician.

PCC staff noted the severity of the impact that the complaints process could have on patients, including suicidal ideation, feelings of being re-traumatized, negative impacts on the health of their families, an increase in sick days or having to leave their employment and an increase in GP appointments and counselling services.

It is important to note that in the same way there is a spillover effect across the budgets of many departments in NICS. If an Individual is no longer able to retain employment this can lead to increased pressure on PIPs and housing budgets.

PCC staff felt that early resolution helped to positively and holistically impact the lives of some of their clients.

Staff Experience – *PCC staff*

Barriers to engagement

PCC staff felt that some of the biggest barriers to the Trusts engaging with PCC and the early resolution model include:

- **Education:** an understanding of who PCC are, their legislative powers, what their current (rather than their past) role is in patient complaints and knowledge on how the existing PCC early intervention model works and when/how to signpost complainants;
- **Permissions:** a clear delineation of who has permissions within a Trust to recommend/ advise patients to consider an early resolution model. This needs to be considered at the complaints administrative staff level. Engagement with service managers or other key contacts rather than administrative staff;
- **Process:** a formalised process around advocacy that identifies the PCC at a level before the complainant is engaged in the complaints process. Moving out of the existing space standardised approach to complaints and looking at alternatives.
- **Training:** training should be given to Trust staff about how to deal with the complaints they receive so they have the tools for when they are challenged by the public. Many patient complaints come from the individual feeling disrespected by Trust staff.

Staff Experience – *Trusts*

This section outlines the findings from primary research conducted by ICS to explore the perceived impact of the existing complaints model on staff within the Trusts. Insights were drawn from three staff interviews revealing several issues. Participants consistently reported that the formal complaints process often fell short of meeting staff needs.

It was reported even when complaints are not upheld they may still be a mental burden for staff and can create an increase in mental health problems and absenteeism.

PCC were reported to provide a *'good middle ground'* and providing space for a dialogue when families won't engage with the Trust themselves.

"the longer it goes on the bigger the impact on staff…

"when staff have gaps in information, they fill them in with worst case scenarios…"

"More pressure on staff can lead to worse patient care… the impact of stress and anxiety on the brain can shut down critical thinking and problem solving ability"

Primary research - conclusions

Survey responses and staff consultations confirm strong support for PCC's early resolution model. Patients reported high satisfaction (94%) and emotional relief, with 72% achieving resolution and 67% noting progression on their concerns. Staff emphasized that early resolution enables direct engagement, faster outcomes, and avoids bureaucratic delays inherent in complaints processes. Trust staff acknowledged that prolonged complaints increase stress and impair decision-making, while PCC provides a constructive middle ground. Barriers identified include inconsistent Trust cooperation, lack of awareness, and limited formal pathways for early intervention.

Primary research validates the effectiveness of early resolution in improving patient and staff experiences. The model reduces stress, accelerates problem-solving, and fosters collaborative relationships. However, systemic barriers—such as limited Trust engagement and absence of standardized early resolution protocols—must be addressed. Scaling early resolution will require formal recognition within HSC complaints frameworks, enhanced training, and proactive signposting to PCC services.

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5. Comparator Analysis

Comparator Analysis - *Approach*

This section provides an overview of the complaints support picture in neighboring comparator jurisdictions (**Wales, Scotland, ROI**) as well as another sector which deals with complaint resolution (**Labour Relations Agency**) as agreed with PCC.

To provide insight on how other jurisdictions support citizens in raising issues and making complaints, this part of the research considered areas such as (but not limited to):

1. *What advocacy organisations exist in the jurisdiction;*
2. *What scale do these organisations operate on;*
3. *What is their legislative origin and statutory mandate; and*
4. *Is there any evidence of success.*

In tackling this element of the research, the Research Team carried out significant desk-based research across the four jurisdictions. The Research Team had originally planned to undertake follow-up consultations with Wales and RoI to supplement the findings, however were unable to obtain a contact within these organisations. As such, the comparator analysis is based solely on the desk-based research.

The research report considers each of the jurisdictions separately, and then concludes with a number of key takeaways, which may help contextualise and inform the current advocacy model of PCC.

Comparator Analysis – *Wales*

In Wales, similar to Northern Ireland, there is an established process within the healthcare organisation for raising a concern or making a complaint. In Wales this is known as the 'Putting Things Right' process. Established under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, Putting Things Right aims to make it easier for people to raise concerns and to be supported through the process.

The process starts with when a patient or someone associated with a patient raises a concern to NHS Wales. This concern is then reviewed by the Executive Nurse Director and Assistant Director of Patient Experience and graded dependent on the seriousness of the complaint – this will dictate the level of investigation needed. The complainant is then contacted to agree an investigation question and informed that the aim is to address their concern in 30 working days (earlier literature stated 2 to 5 working days or up to 30 but the more recent documentation just states 30 days). Early resolution (within 2 days) is encouraged where possible If the complainant is not satisfied with the response they can escalate the complaint to the Public Services Ombudsman for Wales.

This process has been somewhat effective in resolving complaints quickly with 2023/24[1] statistics for complaints showing that of the 19,062 complaints received by health boards, 17.1% were resolved early. While we do not have directly comparable figures on how many complaint in NI were resolved within 2 days, we can see that of the 4,779 complaints that were received by the Trusts, 44.1% were responded to within 20 working days with an average response time of 331 days [2].

To assist citizens in the process of making complaints, the **Health and Social Care (Quality and Engagement) (Wales) Act 2020**, established Lais; an independent organisation created to assist and advocate for people in Wales regarding matters of health and social care. Lais's core functions are to; engage with people in Wales about their experiences in the Welsh healthcare system, to represent these views to policy makers in the NHS and the Welsh government, to promote awareness of its role and services across Wales and to **advocate and support** people who need to raise a complaint through the NHS or local government complaints procedures.

Llais is funded from the Welsh parliament and receives **£7.17 million**, serving a population of just over 3.3 million people this works out to roughly **£2.15 per capita.** This is £1 more per capita than the operating costs of the PCC at £1.15 per capita for a similar remit and to perform very similar functions.

Support for citizens is offered in a very similar manner to PCC; people can get in contact for any range of concerns about the healthcare they received and Llais will either give advice, signpost them to the appropriate service or take on an advocacy role in helping patients to make a formal complaint. Llais' advocacy function operates in a similar manner to that of the PCC; support and advice is given throughout the complaints process from a staff member with a National Advocacy Qualification. Although running an effective advocacy function, Llais do not mention early resolution in their reports or on their website so there are no available figures or information on the speed or efficacy with which they help complaints to be resolved.

Comparator Analysis – *Wales*

One notable difference between Llais and PCC is the use of volunteers; In addition to their 106 staff, Llais have 151 volunteers that perform a variety of functions such as collecting feedback from patients, helping with online activities, attending meetings as a representative of Llais and helping to engage local communities. The help of these volunteers to fulfil core functions, likely frees up capital to spend on qualified advocacy and support staff. In contrast to this, PCC do not use volunteers but use staff to fulfill these functions and as such a larger proportion of their budget goes to non-advocacy functions as compared to Llais.

Governance

The governance structures of both Llais and PCC can be seen in fig 1 and fig 2. As can be seen the governance structures are very similar with a chief executive or senior team (called Tim Arwain in the case of Llais) that are responsible for the day-to-day running of the organisation and report to a governing board which also oversees separate renumeration and risk committees. **Impact**

A total of 2,759 contacts were made to Llais for help and of those 1,249 were helped with their enquiries and **1510 were helped to take forward a concern or complain**t (the breakdown of support and advocacy is not disclosed). **Compared to PCC which received 3,972** contacts through their connect phone service and supported 1,059 individuals with advice and information in addition to the 810 advocacy cases that it supported – the organisations then handle roughly the same caseload. The process for these cases appears to differ slightly with PCC placing an emphasis on early resolution, stating that 57% of cases were resolved prior to a formal complaint. In contrast to this, Llais do not explicitly mention early resolution or publish statistics on how quickly cases are resolved, though their process points people to their service provider or the putting things right procedure as an initial step, both of which would encourage an early resolution where possible.

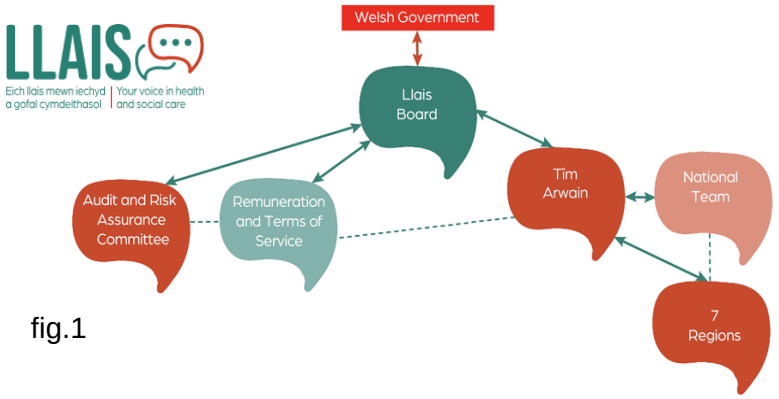


fig.1



fig.2

Comparator Analysis – *ROI*

In the Republic of Ireland (RoI) the state healthcare service (HSE) has a 4 stage model for complaints handling as can be seen in fig 3. Those wanting to raise a complaint or issue directly with the HSE can speak directly to the service with which they have a problem, fill out an online form, email, write or call the complaints service or are signposted to specific complaints officers on the HSE website. Once a complaint is received it goes through stage 1. This stage is similar to that of the early complaints stages in Wales and the wider NHS where an early resolution is sought if possible (within 2 days). The NI HSC system is not as clearly defined as other jurisdictions so it is not clear what the HSC stages are or whether early resolution is sought. Though the emphasis on point of contact resolution is likely beneficial, HSE do not track this metric and so there is no data to evaluate the impact of this stage.

If the complaint is unresolved in stage 1 it moves on to stage 2 which is a more formal investigation of the complaint. In 2023/24 HSE received and examined 14,819 stage 2 complaints and responded to 72% of these within 30 working days. Whilst not an exact comparison, NI Trusts recieved 4,779 complaints in the same period and responded to 44.1% of them within 20 working days with an average response time of 33.1 working days.

If the complainant is not satisfied with the outcome of stages 1 or 2 then the complaint is progressed to stage 3 which is an internal complaint review where the outcome of stage 2 is reviewed internally. If the complainant is still unsatisfied with the outcome they can proceed to stage 4 which is an independent review of the complaint, for example by the Office of the Ombudsman. This final stage; the Ombudsman as the final place to appeal is common to all the jurisdictions looked at here.

Some hospitals also have a Patient Advocacy Liaison Service (PALS). This is a service run by and funded by the HSE that acts as a point of contact between patients, their families or careers and the hospital. They're focused on trying to improve the patient experience by listening and responding to patients and offer some limited advocacy support to people wishing to make a complaint. This service also exists in England however does not exist in NI or Wales.

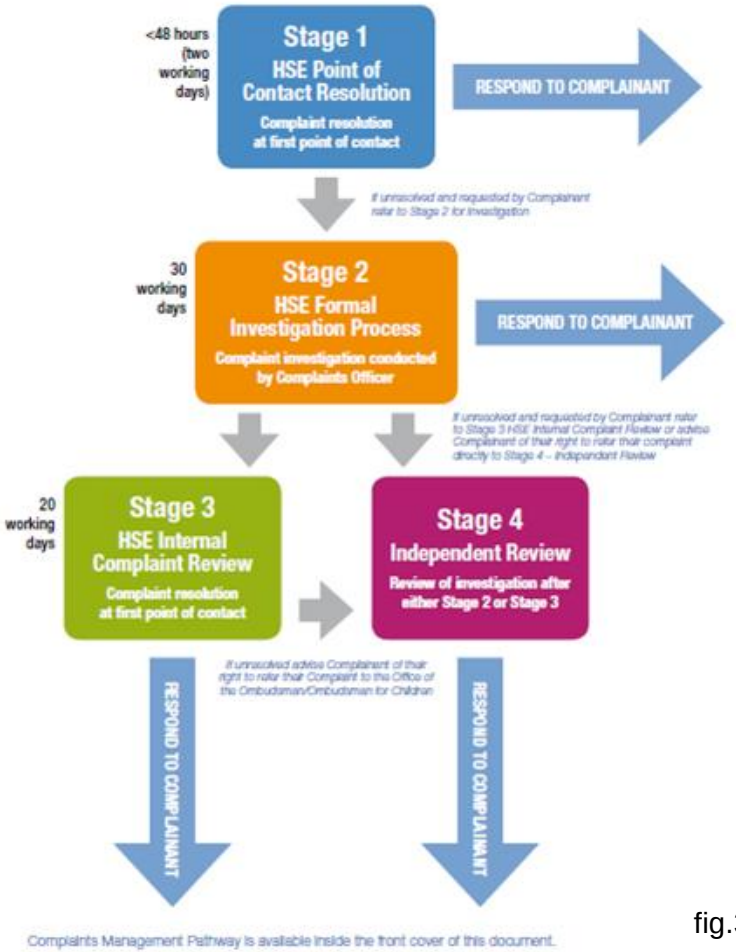


fig.3

Comparator Analysis – *ROI*

Similarly to Wales and NI, the RoI have an additional independent service that supports those making a claim to the medical system in which they've been treated. In RoI this organisation is the Patient Advocacy Service (PAS). The PAS was established in 2019 as an independent body by the National Advocacy Service (NAS) which specializes in advocacy for those with disabilities. PAS is not a statutory body but operates under a Memorandum of Understanding (MoU) with the Health Service Executive (HSE) which recognizes that every person has the right to make a complaint about the service they have received from the HSE. Whilst not founded in legislation, PAS is guided by the **The Assisted Decision-Making (Capacity) Act 2015**, which establishes the presumption of capacity and the right to support in decision-making, stating that advocates must respect the will and preferences of individuals as well as providing a Code of Practice for Independent Advocates via the Decision Support Service (DSS). PAS **The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023** also affects PAS mandating that health and social care providers inform patients and families about independent advocacy supports, including PAS. In 2023 the **Amendments to the Care and Welfare Regulations (2023)** then expanded PAS's advocacy remit to private nursing homes.

Although the core functions stated by PAS in their documentations are entirely based around **advocacy,** their annual reports highlight much the same functions as Llais and PCC serve in Wales and NI. That is to say that alongside their advocacy and patient support they also **input into social and health policies** through stakeholder engagement as well as **collecting feedback** and views **through public consultations** and engaging in **work to raise the profile of PAS**.

The PAS is funded from the Department of Health which gives NAS approximately €1.36 million* annually to run the service, however PAS is not funded from the HSE. This is the same funding model as PCC and Llais which both receiving funding from the Departments of Health in their respective jurisdictions allowing them to remain independent.

One notable difference is that the PAS now also cover complaints about private nursing homes in Ireland as well as acute hospital incidents whereas PCC and Llais only cover complaints related to HSC and NHS services. The opposite of this is also a valuable insight though; PAS only support people in making complaints about acute hospital issues whereas PCC and Llais also support any service provided by the NHS such as gp, dentist or other healthcare areas – thus having a more potential sources for complaints.

While a formal process for advocacy or support is not outlined by PAS, from their publications it seems as though the process is similar to that of the PCC and Llais. That is to say that a complainant gets in contact through email or the phone and depending on the nature of their issue is helped with either advice and information or is supported in making a formal complaint and given 1 to 1 advocacy where necessary. This seems to be roughly the same process that Llais and PCC go through in supporting complainants as well. It is worth noting though that PAS suggest going to the point of contact within the HSE first to register the issue before approaching PAS, an approach shared by Llais in Wales. PAS use the Health Complaints Analysis Tool (HCAT) developed by London School of Economics to categorise the severity of complaint issues and seem to be the only organisation of the comparators that use this system.

Comparator Analysis – *ROI*

Governance

As well as the NAS board, PAS are also accountable to the Department of Health and in particular the health minister. This is structured through a forum which serves in a similar capacity to a board, their functions are: to provide strategic advice on the establishment, development, evolution, performance and monitoring of the PAS, support the National Patient Safety Office (NPSO) in the development of patient safety complaints/advocacy standards, key performance indicators (KPIs) and codes of practice, receive reports on the performance and activity of the PAS through a set of agreed KPIs and submit an annual report to the Minister for Health. While the lack of clarity in governance structure makes it difficult to say for certain, the governance of PAS appears to be broadly similar to that of PCC and Llais; reporting to an independent board with some limited oversight from the Department of Health allowing them to remain an independent organisation. This is a necessary separation to allow them to advocate effectively against the HSE when necessary.

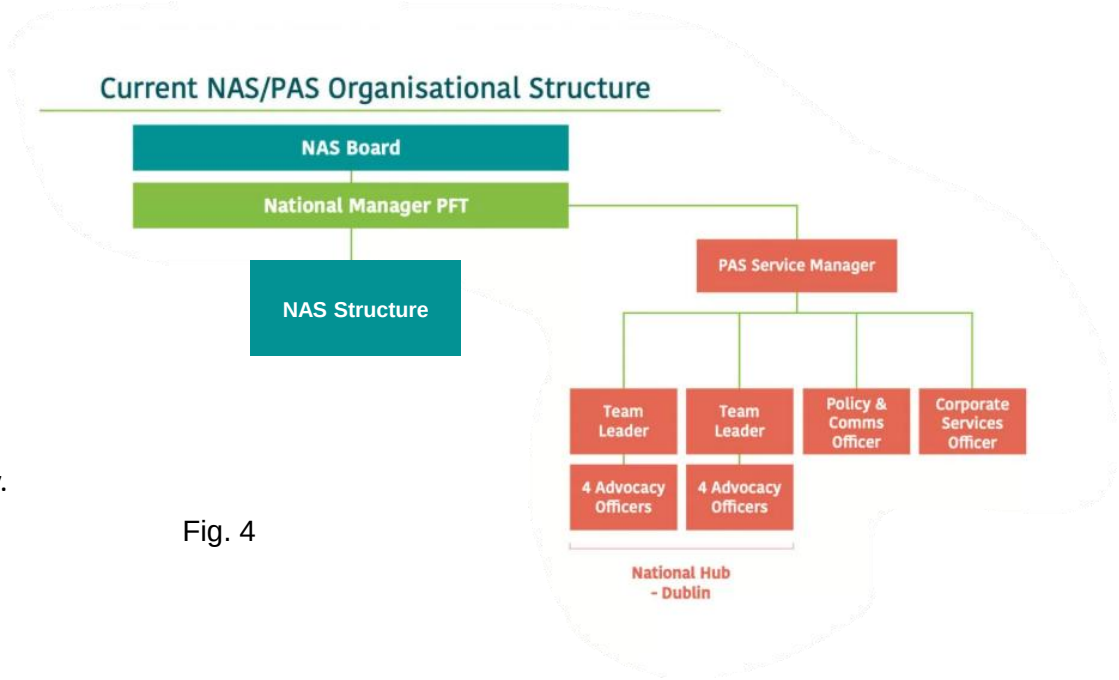


Fig. 4

Impact

PAS received 2,012 new complaint enquiries, which identified 5,617 separate complaint issues. 1,839 of the enquiries were short-term, involving providing information, advice, assistance or signposting and 173 of the enquiries received full 1-1 advocate support. These number are much lower than PCC who received 3,972 contacts and supported 810 cases with advocacy. These lower numbers of contacts may be due to a larger emphasis on the state run complaints process that there is in NI. It is also worth noting that PAS does not mention any early resolution or any approaches to try to resolve complaints early – this may again be down to the fact that the HSE complaints procedure attempts to resolve the patient issues as early as possible and so it is less of an emphasis for PAS as the patient will already have gone through an early resolution framework (as a result of being directed to the HSE complaints procedure as a first port of call).

Comparator Analysis – *LRA*

The Labour Relations Agency (LRA) are an organisation similar to the PCC which operate in different sector; employment and workplace issues. The LRA were founded to improve employment relations, promote best employment practice and resolve workplace disputes. To achieve this goal they offer a number of services which fall in to 2 main categories; advisory services and dispute resolution. The advisory services include; a workplace information service for employers and individuals, seminars workshops and more to promote good practices and a document service that helps employers compile workplace documentation such as handbooks etc. The service category more relevant to this review however is the dispute resolution service which includes; conciliation (early, post-claim and employer-led conciliation), arbitration and mediation. These services are all designed in a process to deal with issues that arise in the workplace. The first step in the process is conciliation – conciliation consists of both parties attempting to find a mutually agreeable solution to the employment issue where a tribunal claim is possible. This step **(early-conciliation) has to be considered** before a tribunal claim can be made. If conciliation was not successful and an individual has submitted a tribunal claim, post-claim conciliation is available throughout the claims process to try and resolve the dispute. Employer-led conciliation is also provided to employers attempting to avoid the risk of a potential tribunal claims through dispute resolution. If both parties wish to avoid a tribunal arbitration services are available which aim to provide quick, non-legalistic processes and decisions to resolve disputes. Mediation is then available to try and restore positive working relationships and resolve conflict.

The LRA also works with organisations that represent employees and employers such as the Confederation of British Industry(CBI), Federation of Small Businesses (FSB), Chambers of Commerce, Institute of Directors (IoD), and the Irish Congress of Trade Unions (ICTU), to influence employment relations and achieve their policy agenda.

The LRA are an independent, non-departmental public body and are funded by the Department for the Economy with a budget of £4.9 million serving a population of 1.9 million people giving a per capita budget of £2.58. This is more than PCC's per capita budget of £1.15 budget, the LRA also has **78 staff** which is more than double that of the PCC. Care should be taken when comparing the organisations however as the LRA provide a more diverse range of services with a corporate services branch as well as the dispute resolutions branch and so it is likely that they require a bigger budget to provide these other services.

Governance

The Governance structure of LRA is very similar to that of PCC and Llais with a board made up of a chairperson and member with expertise in employment law, trade unions, business and industrial relations overseeing the governance and overall strategic direction of the agency and 2 sub-committees; audit & risk assurance and finance & personnel, reporting to the board. The day-to-day running of the agency is overseen by the senior leadership team consisting of the chief executive and senior managers which report to the board, similarly to PCC. Board members are appointed by the DfE which is similar to a number of the advocacy organisations but not all.

Comparator Analysis – *LRA*

Legislative Context

The LRA was established in 1976 under the Industrial Relations (NI) Order 1976 which formally created the agency and set out its purpose of improving industrial relations through providing conciliation, mediation and arbitration services. It also established the LRA as a non-departmental public body and gave them the power to intervene in disputes either upon request or on its own initiative if it believes it can resolve the issue.

Impact

In 2023/24 the LRA received 5,714 employee or employer led notifications. Of these notifications, 28% (1,870) were settled (including tribunal cases) and 25% (1,410) were settled through early conciliation (that 25% is included in the 28% figure). Of the 1,245 cases that went to tribunal, only 220 were cleared (18%) which shows how beneficial resolving cases before they reach tribunal through early conciliation can be.

Although they operate in different areas with different complaint issues, comparing the early resolution rate of PCC (57%) to the early conciliation rate of the LRA (25%) shows how well the PCC model operates in resolving concerns before they become formal complaints, saving money and resources as well as personal burden for those having to go through the complaints process on both sides.

Comparator Analysis – *Comparative analysis*

The table below provides a detailed comparative analysis of patient advocacy and voice services across Northern Ireland, the Republic of Ireland, England, Scotland, and Wales. The purpose is to benchmark the Patient and Client Council (PCC) against similar bodies, focusing on cost efficiency, scope of functions, case volumes, and early resolution practices. It also explains why advocacy-only costing is challenging and outlines implications for PCC's strategic direction.

Organisation	Annual Budget	Population	Cost per Capita	Cases Handled	Cost per Case	Early Resolution
PCC (NI)	£1.8m	~1.9m	<£1	569	~£3,164	45% resolved before complaint
PAS (ROI)	€3.3m	~5.3m	€0.62	2,012	~€1,640	Verbal complaints often resolved within 48 hrs
Llais (Wales)	£8.3m	~3.1m	£2.68	~1,500	~£5,533	PTR model encourages early resolution
PASS (Scotland)	~£1.2m	~5.5m	£0.22	N/A	N/A	Stage 1 resolution within 5 days
Healthwatch + PALS (England)	~£14.5m	~56m	£0.26	400,000 experiences	N/A	PALS designed for informal resolution

Comparator Analysis – *Comparative analysis*

The analysis highlights significant variation in scope, cost, and delivery models. PCC and Llais combine advocacy with statutory voice and engagement, making them the most comparable. PAS and PASS focus primarily on advocacy, while England operates a fragmented model with PALS for informal resolution and Healthwatch for system voice. PCC demonstrates strong early resolution performance, resolving 45% of cases before complaint, and operates at a cost of less than £1 per capita. This positions PCC as cost-efficient but with potential to scale its visibility and capacity.

PCC's integrated model offers strong value for money compared to similar bodies. Its early resolution success suggests potential for formalizing early resolution pathways, such as dedicated front-door teams. However, low budget and relatively modest case volumes indicate scope for increasing visibility and capacity. Benchmarking against Llais highlights the trade-off between broader remit and higher cost, while PAS and PASS demonstrate efficiencies achievable through narrower focus and shared infrastructure.

Comparator analysis - conclusions

Benchmarking against Wales, Scotland, ROI, and the Labour Relations Agency reveals that PCC is unique in explicitly prioritizing early resolution. While other jurisdictions embed early resolution within healthcare complaints processes, their advocacy bodies do not emphasize it. PCC operates at a lower cost per capita than comparators yet handles similar case volumes, demonstrating strong efficiency. Models such as Llais (Wales) and PAS (ROI) highlight opportunities for PCC to expand capacity through volunteer engagement and structured governance, while LRA illustrates the benefits of mandatory early conciliation frameworks

PCC's early resolution focus is a distinctive strength, delivering cost-effective outcomes compared to peers. However, the absence of a formalised early resolution stage within NI's HSC complaints process limits systemic impact. Lessons from comparators suggest opportunities to enhance PCC's visibility, capacity, and integration with statutory frameworks. Introducing structured early resolution pathways and exploring volunteer engagement could further improve reach and sustainability.

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6. Financial assessment

Financial Assessment - *Approach*

This section provides an overview of the potential financial costs of early / local resolution to the health and social care system, along with a comparison with the costs associated with a fuller complaints process.

- An analysis of the cost of a health-related complaint in NI's HSC sector, breaking down staff time, process steps, and legal costs.
- Estimates of the share of complaints that could be resolved early with effective approaches.
- Comparative costs of complaints resolved via early resolution vs. formal processes (drawing on data from NI, Great Britain, and the Republic of Ireland).
- An estimate of the overall potential savings if more complaints in NI were handled through early resolution, with high/medium/low scenarios.

Key Assumptions and Limitations

Heavy reliance on staff time valuation: The cost figures are predominantly an accounting of staff hours converted to monetary value. We assume average salary rates for the staff involved (for example, a Band 6 officer's time might be costed around £25–£30/hour including on-costs, higher bands proportionally more). These are opportunity costs, e.g. staff spending time on a complaint instead of other duties

No official NI cost data: We did not have NI-specific measured data for complaint handling costs (e.g. there's no **published unit cost per complaint** from the Department of Health or Trusts). Our estimates are built from proxy and analogous data, chiefly NHS England/Scotland benchmarks and general public-sector process costs, as well as the specific **PCC case examples** provided. This introduces some uncertainty. We mitigated this by cross-verifying multiple sources. Still, the **true NI values could differ** slightly. If anything, NI's smaller scale could mean slightly higher per-case overhead (due to less economy of scale), so costings should be taken as indicative only.

Variability case-by-case: Averages gloss over huge variability. We assume a "typical" case for comparison, but real cases span a broad range. As noted, an early resolution could be as simple as a phone call (very low cost) or, conversely, could involve multiple meetings (higher cost). Complaints likewise range from a simple investigation to a months-long process with external reviews. The ranges given attempt to capture this, but outliers exist.

Non-financial benefits not counted: Early resolution has qualitative benefits (faster closure for patients, improved satisfaction, less adversarial atmosphere, and lessons learned for the system). These don't show up in a cost table but are part of the business case for early resolution. Our focus was cost, but it should be highlighted that a purely financial analysis understates the total value of early resolution. Likewise, a singular focus on cost could be misleading if, for instance, an early resolution "costs" £1,000 in staff time but results in a policy change that prevents future harm, resulting in a significant return on that investment that isnot captured in our figures.

Early resolution – staff time and cost

PCC advocacy staff put in significant work even when a case is settled without formal complaint. The term "early resolution" refers to *how* a case is resolved (collaboratively and quickly), but these cases can still be complex and resource-intensive. Below is what a **typical early resolution case** might involve, including approximate time commitments, staff roles by pay band, and key activities:

Initial Case Assessment & Research: A PCC **advocacy officer** (often at **Band 6** pay grade, i.e. a trained practitioner) will spend time understanding the client's concerns and gathering background information. This can include reviewing medical records or correspondence, consulting relevant guidelines, and contacting the health trust to get context. In complex cases, **dozens of hours** may go into this preparatory work. For example, in one case involving a patient's death, a PCC advocate dedicated **about 100 hours (Band 6 time)** to understand the family's issues and review clinical details before any meeting took place

Client Meetings and Ongoing Support: The advocate typically meets or speaks with the patient/family **multiple times** to hear their story and manage expectations. This involves **listening to the family's account, clarifying their desired outcomes, and providing guidance**. In many early resolution cases, **5 or more meetings/calls with the family** are common. The advocate often conducts **"pre-meetings"** to prepare the family for any joint sessions with the Health Trust, and **debriefs** them afterwards. This emotional support and coaching is crucial – it ensures the family's questions are clearly formulated and that they feel heard throughout the process.

Coordination with Health Trust Staff: A major part of early resolution is **engaging directly with the relevant health service providers** to find a solution. The PCC advocate will reach out to HSC staff – for example, the Trust's complaints manager, doctors or nurses involved in the case, or service managers – to discuss the issue and seek a way forward. Often, the advocate acts as a go-between, conveying the family's concerns to the Trust and bringing back explanations or proposals for resolution . This stage may involve numerous phone calls or emails and sometimes requires involving **senior PCC staff** (like a Band 8A principal advocate or an 8C level manager) if high-level liaison is needed. For instance, if the case touches on hospital policy or potential legal risk, a PCC manager (8A/8C) might join discussions to negotiate effectively with the Trust's directors

Early resolution – staff time and cost

The **time commitment per case** varies widely: **straightforward concerns** (e.g. a miscommunication that can be cleared up with one phone call) might be resolved in **5–10 hours total**, whereas **complex cases** (like serious care failings or multi-factor disputes) can span **several months** of intermittent work and easily exceed **60–100 staff hours** in aggregate . Regardless of the exact hours, PCC's early resolution approach is hands-on and involves **meticulous prep, multiple interactions, and often travel,** reflecting the intensive support given even before any complaint is lodged.

Early resolution – staff time and cost

In order to evidence the nature of the work undertaken by PCC in its advocacy function, the following recent case examples have been provided. These examples aim to set out the complexity of work undertaken by the PCC, while highlighting the implications without PCC involvement.

Case Example (Issue)	Early Resolution – Work & Cost	If Not Resolved Early – Likely Outcome & Cost
1. Continuity of Care for a Child: Family objected to the Trust's plan to transfer their child's care to a different provider.	**Advocacy Actions:** PCC facilitated a family meeting with Trust representatives to address the concern. Preparation included about 4 hours of research and admin by a PCC Band 8A officer. The meeting itself lasted 2 hours with a team of 3 senior staff (Band 8A) and 1 senior manager (Band 8C) from the Trust present, alongside the PCC advocate. The advocate also held a 1.5-hour pre-meeting and debrief with the family (Band 8A) to support them. There was significant travel (~145 miles) for the in-person meeting. **Time/Cost Estimate:** Total PCC staff time ~8–10 hours, plus travel; nominal cost in staff hours (perhaps a few hundred pounds). Trust staff also invested time in the meeting. Outcome: The issue was clarified and resolved at the meeting, preventing further action.	**Escalation Path**: The family was prepared to initiate legal proceedings (judicial review) if dissatisfied. **Cost/Risk**: A judicial review would force the Trust to engage lawyers and counsel – legal fees easily in the tens of thousands of pounds. There's also a reputational risk to the Trust (negative publicity) and increased stress on the family and staff. Additionally, the child's care could be in limbo during a prolonged dispute. In short, not resolving would likely have led to an expensive legal battle and protracted uncertainty.

Early resolution – staff time and cost

Case Example (Issue)	Early Resolution – Work & Cost	If Not Resolved Early – Likely Outcome & Cost
2. Complex Hospital Death: A patient with a very complex medical history died in hospital; his family believed poor care contributed to his premature death. They were pushing for a formal SAI investigation and considering legal action.	**Advocacy Actions**: A PCC Band 6 advocate spent around 100 hours working with this family over several months to understand their concerns. The advocate held 5+ family meetings and many discussions with Trust staff. To avoid an adversarial process, the PCC proposed a large multi-disciplinary meeting to give the family answers directly. It took some time to arrange, but eventually a meeting was convened with 7 consultants, 2 Trust directors, 2 lead nurses, the Trust's complaints manager, and the PCC advocate (B6) all present. The meeting ran 3 hours. Before and after it, the advocate and a Trust complaints manager did a 2-hour pre-brief and debrief with the family. In that meeting, the family heard detailed explanations from all the senior doctors and received empathy and apologies. **Outcome:** Complex medical information was clarified, and the patient's wife and daughter felt their concerns were fully understood. They were satisfied and took no further action. **Time/Cost Estimate:** Total advocacy time 100+ hours (Band 6) plus involvement of numerous high-level health staff for the meeting. This early resolution might have cost on the order of a few thousand pounds in staff time (aggregating all participants). It was intensive – but it solved the issue.	**Escalation Path**: Without resolution, the Trust would likely have convened a Serious Adverse Incident (SAI) investigation. **Cost/Impact**: Conducting an SAI for such a complex case could span 2–3 years of work. The Trust might need to hire external medical experts (since the condition was rare) and dedicate significant administrative resources to the investigation and report-writing. Estimates suggest the cost would run in the tens of thousands (possibly over £100k) given the scope and expert involvement. If the family also pursued legal action (e.g. a negligence claim), additional legal costs would accrue on top. There's also the human toll: prolonged distress for the family, and a heavy burden on the clinicians and managers engaged in a long review. In essence, not resolving early here would have triggered one of the costliest and lengthiest processes in the system.

Early resolution – staff time and cost

In order to evidence the nature of the work undertaken by PCC in its advocacy function, the following recent case examples have been provided. These examples aim to set out the complexity of work undertaken by the PCC, while highlighting the implications without PCC involvement.

Case Example (Issue)	Early Resolution – Work & Cost	If Not Resolved Early – Likely Outcome & Cost
3. Medication Concerns After Death: A patient's wife believed that a specific medication given in A&E interacted badly with other drugs and contributed to her husband's deterioration and death. The family was distraught and wanted an independent Level 3 SAI and possibly litigation.	**Advocacy Actions:** The PCC advocate (Band 6) worked with this family for around 4 months (60 hours) to help formulate their concerns and obtain all relevant medical information. The advocate liaised with the Trust to organize a meeting that brought together the family and the care team. Over multiple sessions, the PCC helped the family articulate the exact questions they had about the medication and care. In the eventual resolution meeting (after 4 months of prep), the Trust's doctors provided detailed explanations and evidence about the medication's safety and the patient's condition. They demonstrated that every step had been taken carefully, including expert consultations during treatment. The family also learned more about the patient's underlying health issues and the extent of care provided. **Outcome:** The family left the meeting reassured and convinced that the care was appropriate and the medication was not the cause of death. They did not pursue the matter further. **Time/Cost Estimate:** Around 60 hours of PCC time (Band 6) plus the time of several hospital staff for the final meeting. Costs likely in the low thousands of pounds in total. Critically, the resolution was achieved within a few months, avoiding a drawn-out process.	**Escalation Path**: Without early resolution, this case would likely have proceeded to a Level 3 SAI (the highest level, requiring an independent panel). **Cost/Impact**: A Level 3 SAI could take 18–24 months to conclude. Given the rare medical issues involved, only a couple of expert clinicians in NI were qualified to review it, so external experts or out-of-region consultants might have been needed. The Trust would invest major staff time in a panel review, and the PCC would still remain involved throughout (supporting the family during the SAI). The cost of such an investigation would easily reach tens of thousands of pounds, not counting any potential legal consultation if the family sought a lawyer's advice concurrently. Moreover, the family would have spent two years in uncertainty. Essentially, a lack of early resolution here means a long, costly SAI with continued PCC involvement but under much more formal, distressing circumstances for everyone.

Examples Summary

The examples highlight effective implementation of the early resolution and partnership approach delivered within the Advocacy function within PCC. It should be highlighted, however, that two key factors are vital to this successful delivery, namely:

Skilled and Empowered Staff (Advocates and Frontline Managers): Early resolution requires staff with strong communication, mediation, and negotiation skills. The PCC's advocacy team is trained in a "relationship-based" model, emphasizing listening and partnership. Likewise, ward managers and clinicians need training in handling complaints empathetically (e.g. how to give a meaningful apology or explanation). These individuals also need the authority to make small fixes or concessions on the spot. Empowering staff to resolve issues in real time is crucial

Trust Buy-In and Engagement: Early resolution only works if the healthcare providers (the Trusts) actively participate in it. That means a culture where complaints are seen not as annoyances or threats, but as problems to be solved collaboratively. Inconsistent cooperation from Trust staff can derail early resolution. Key elements include: prompt responsiveness and senior management support for open dialogue. When directors and clinicians make themselves available for early meetings (as in the case examples), it sends a message that the Trust values resolution over defensiveness.

The practice examples reinforce that early resolution is an investment. While it can require dozens of staff hours, involvement of senior personnel, travel, and careful coordination, they also highlight the huge resource costs avoided by not proceeding to formal reviews or legal battles. For instance, in Case 2, the Trust and family achieved closure in a matter of months through a coordinated meeting, versus a potential multi-year inquiry had it escalated.

These real-world data points suggest that our initial cost estimates for early resolutions should be adjusted upward to account for the substantial staff time sometimes needed, yet they still show early resolution as cost-effective when compared to the alternative

Cost of a health-related complaint in NI

Process & Staff Time: Northern Ireland's HSC complaints procedure (aligned with the Model Complaints Handling Procedure) uses a two-stage process:

- **Stage One – Early/Local Resolution**: A frontline response aiming to resolve the issue within 5 working days (can be extended by another 5 days if needed) . This is handled by staff closest to the point of care (e.g. ward or practice staff).
- **Stage Two – Formal Investigation**: If the issue isn't resolved informally, a complaint investigation is undertaken. The complaint is acknowledged within 3 days, and a detailed written response is targeted within 20 working days (extensions allowed for complex cases). Senior staff and complaint managers become involved, with documentation review and possibly input from legal or specialist advisors.

While the worked examples highlight the scale and complexity of PCC's work with patients and Trusts, it is difficult to assign a true average cost based on these cases. The following slides set out a proxy and comparator-based approach to estimating cost savings associated with early resolution. It should be highlighted that, in the absence of more concrete data, this report is likely setting out a **conservative estimate of both the cost of an early resolution and of a complexed case going through a Trust complaints process.**

A high level overview of staff effort and administrative overhead (translated into cost) is set out in the table below.

Complaint Stage	Process (NI HSC)	Estimated Cost per Case
Stage 1: Early Resolution	Frontline staff address and resolve the issue quickly (goal: around 5-10 working days). Focus on phone/face-to-face communication, immediate action or explanation.	£1,000-£2,000 in staff time and admin overhead. (If resolved at first point of contact, could be just a few hours of work – tens to a few hundred pounds.)
Stage 2: Complaint	Senior staff investigation with thorough review, meetings, written response (within 20 working days). Involves managers, clinical directors, and formal documentation.	£3,000–£25,000 in staff time, documentation, and management effort.
Escalation to Litigation (if unresolved by HSC process)	If a complaint leads to legal action or negligence claims, involving solicitors/courts (outside the normal complaints process).	NHS data show litigated healthcare claims can cost £30k–£60k+ each in legal fees and damages. (By contrast, 80% of claims in England are now settled without court, saving an estimated £4.6 billion over several years.)

Legal costs and Cost Drivers

Legal Costs

It's important to note that most HSC complaints do not end up as legal claims. However, when they do, **costs spike dramatically**. In England, NHS Resolution reports that the average claimant legal cost per clinical negligence claim is on the order of tens of thousands of pounds . Avoiding court not only prevents these legal expenditures but also often avoids compensation payouts. (In 2022/23, 80% of NHS claims were resolved out of court, reflecting a push to minimize costly litigation .

In Northern Ireland, comparable figures aren't published, but the dynamic is similar: a prolonged, adversarial process (solicitors, court hearings, expert reports) can dwarf the routine administrative cost of handling a complaint. For instance, a complex complaint that escalates to a lawsuit could **easily exceed £50k** in combined costs, whereas solving the issue early might have cost a few hundred pounds.

Cost Drivers

The bulk of the cost in complaint-handling is staff time. At Stage 1, a ward manager or complaints officer may spend a few hours talking with the patient/family and documenting the resolution. At Stage 2, multiple staff (clinical directors, complaint managers, legal advisors) might spend days collecting records, interviewing staff, drafting reports and responses.

As presented in previous sections, there are also "hidden" costs around staff morale and productivity. Studies in the UK found that around 17% of doctors involved in recent complaints reported significant anxiety or depression, and over a quarter took sick leave of over month due to complaint-related stress. While hard to monetize, this illustrates the broader impact complaints can have on the workforce.

Complaints vs Potential Early Resolution

Many formal complaints could potentially be resolved at an earlier stage if addressed properly. The proportion of cases that could benefit from early resolution is substantial, although it is difficult to accurately estimate the exact proportion. Various data points suggest that perhaps around half or more of complaints might be avoidable through effective early handling, including:

• The NI Ombudsman's Model Complaint Handling framework explicitly anticipates that "the majority of complaints will be handled at Stage 1" (i.e. resolved quickly at the frontline) . The design of the two-stage process assumes most issues can be dealt with without a full investigation.

• In practice, other UK health systems show a large share resolved early. Scotland's NHS (which has a similar two-stage process) closed 53% of complaints at Stage 1 (early resolution) in 2023/24 . An additional 11% of cases were initially handled in Stage 1 but had to be escalated to Stage 2 . This means roughly two-thirds of all complaints were addressed, at least initially, through an early-resolution attempt.

• England and Wales also encourage local resolution as the first step. While exact percentages of early vs formal aren't published in the same way, the Parliamentary and Health Service Ombudsman (PHSO) and NHS complaint standards strongly emphasize resolving complaints quickly whenever possible to avoid formal investigations. NHS hospitals often have Patient Advice and Liaison Services (PALS) or equivalents that aim for on-the-spot resolution, implying a significant portion can be handled outside the "complaints bureaucracy."

Conclusion

At least half of complaints represent opportunities where early intervention (listening, explaining, apologizing, fixing the issue) could prevent escalation. This aligns with the best-practice goal that frontline staff should resolve most complaints if empowered to do so . Even converting 40–60% of complaints into early resolutions would be a huge improvement in efficiency and customer experience.

Cost of a Complaint via Early Resolution (GB and RoI)

Early resolution of complaints is dramatically cheaper than a complaint investigation. Although Northern Ireland-specific costings are not published, we can draw on comparable data from Great Britain (and general public-sector benchmarks) to estimate these costs. We also consider the Republic of Ireland context.

Great Britain (NHS UK)

Estimates from NHS complaint handling suggest an informal complaint resolved by front-line staff might cost only a few hundred pounds. For example, analysis used in complaint handling guidance estimates a quick resolution at roughly £250–£500 in staff time. In contrast, a fully investigated NHS complaint (formal written response, possibly involving multiple departments) can cost £1,000–£3,000 or more in staff and overheads. Health service complaints tend to be on the higher end because they often span multiple issues and require input from clinicians.

Republic of Ireland

Ireland's health service (HSE) uses the "Your Service, Your Say" policy, which similarly stresses an informal first step. The HSE has a **Stage 1: Informal Complaint** process where issues are raised with local staff with the hope of resolving it without a written complaint . If that fails, then Stage 2 is a **formal written complaint**, with targets of 30 working days for a response . Stage 3 is an **internal HSE review**, and Stage 4 **escalation to the Ombudsman**. While we did not find specific cost analyses from RoI, it's clear the philosophy of resolving early is significantly quicker and less costly than letting it progress.

We can presume the cost order of magnitude is similar (a short interaction vs. a lengthy investigation). Moreover, any formal HSE complaint that escalates to Stage 3 or the Ombudsman will incur significant staff and possibly legal resources, akin to the UK.

Cost of a Complaint via Early Resolution (NI)

Northern Ireland

We can infer that NI's costs would be similar to England/Scotland, given similar processes. If anything, NI HSC Trusts might have slightly higher overhead due to smaller scale, however lacking hard data, we are assuming around £300 for early resolution vs £2,000 for complaint. These figures are **based on the best available comparator data** (often using data for less complex cases)**,** and are likely significantly **underestimating the costs associated with both a typical early resolution case dealt with by PCC**.

Overview

The table below compares approximate costs per complaint via the formal route versus early resolution, across NI and comparable jurisdictions:

Jurisdiction	Complaint (Investigation)	Early Resolution (Informal)
Northern Ireland	£1,000–£3,000 (estimated). An average health/social care complaint likely costs in the low £2,000s in staff time when fully investigated. (No official NI figure; this is inferred from UK data and NI public-sector analyses.)	£250–£500 (estimated). NI expects most simple complaints could be resolved with a few hours of staff time. The cost is largely opportunity cost of staff listening and responding.
England & Wales (NHS)	Around £2,000. NHS hospitals budget significant staff time per complaint (complaints teams, clinicians drafting responses). Complex cases cost more; involvement of legal teams or independent reviews can add thousands of pounds..	Hundreds of pounds or less. Many NHS trusts report that a quick complaint handled on the ward or via PALS often just entails a manager's time and maybe a follow-up call – on the order of a few hundred pounds or less. (One NHS guide notes early resolution can be done "within existing duties" essentially negligible extra cost.)
Scotland (NHS)	£1,500–£2,500 on average. Scotland's process is two-stage like NI. No official unit cost, but assuming similar resource use as England. Escalated cases (those unresolved at Stage 1) require formal investigation and likely approach a couple thousand pounds each in effort.	Minimal. 53% of NHS Scotland complaints are closed at Stage 1, implying they were resolved by staff in ≤5 days. The cost for these is inherently low – likely comparable to England (~£300 or less each). The main expense is staff time in a short window.
Republic of Ireland	Estimated €1,000+ (no published data). A complaint under "Your Service, Your Say" involves written handling by complaints officers, hospital managers, etc., similar to UK processes. We can safely assume the cost is in the same thousands of euro per case range. In addition, Stage 3 reviews or Ombudsman investigations add further costs.	Likely €300 or less. The HSE's Stage 1 encourages immediate, local resolution – e.g. a ward manager talking to the patient. This is analogous to UK early resolution, so the cost would be low. (Not officially quantified, but certainly far cheaper than a formal investigation.)

Overall Potential Savings from Early Resolution in NI

Given the volume of complaints in Northern Ireland and the cost differential, the financial savings potential from shifting towards early resolution is significant. We combine the data from above to estimate possible savings:

- **Volume:** NI HSC Trusts received 5,483 complaints in 2024/25 (not counting complaints in primary care or independent social care, which would add more). This is our annual complaint volume baseline. It has been rising (a 75% increase over 5 years was reported), so efficiency is increasingly important.

- **Cost difference:** As stated previously, a complaint might cost roughly £2,000 vs an early-resolved complaint of around £300. That suggests saving on the order of £1,500–£1,700 per complaint that is resolved early rather than formally. (N.B. If the case would have gone to litigation, the savings are dramatically higher – but those are a small minority. We focus on the process costs.)

- **Applicable proportion:** As set out previously, we have assumed anywhere from around 30% (conservative) to 70% (optimistic) of complaints could be handled via early resolution with the right approach. Using these assumptions, the table below models low/medium/high scenarios of potential annual savings:

Scenario	Complaints Resolved Early (out of 5,483)	Estimated Annual Savings (reducing complaints and their costs)
Low	30% (around 1,600 cases shifted to early resolution)	£2.5 – £3.5 million saved per year. (This assumes 1,600 complaints avoid formal investigation, each saving roughly £1.5k–£2k in resources.)
Medium	50% (around 2,740 cases shifted to early resolution)	£4 – £6 million saved per year. (Approximately half of complaints handled early, aligning with the rates seen in Scotland. This is a realistic mid-range target.)
High	70% (around 3,840 cases shifted to early resolution)	£6 – £8+ million saved per year.

Financial assessment - conclusions

Analysis indicates that early resolution costs approximately £250–£500 per case versus £3,000-£25,000 for complaints, with litigation costs exceeding £50,000. With 5,483 complaints annually, shifting even 50% to early resolution could save £4–£6 million per year. Beyond direct savings, early resolution reduces hidden costs linked to staff absenteeism, mental health impacts, and service inefficiencies. Evidence from GB and ROI reinforces that early resolution is significantly more cost-effective and aligns with best practice.

It should be stated that these estimates are likely quite conservative, **based on the best available comparator data** (often using data for less complex cases)**,** and are likely significantly **underestimating the costs associated with both a typical early resolution case dealt with by PCC**. It can, however, be stated with some certainty that early resolution cases are **substantially less costly than complaints or issues that go through the Trust complaints process**. It also likely that an estimated annual saving of £4-6 million per year is a conservative figure, likely to be higher if scaled appropriately.

The financial case for early resolution is compelling. Scaling PCC's model could deliver multi-million-pound savings annually while improving patient and staff experiences. Investment in early resolution infrastructure—such as dedicated teams and formalized processes—offers high return on investment. Wider adoption across HSC Trusts would not only reduce complaint-handling costs but also mitigate litigation risk and enhance system resilience.

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7. Scaling current model

Scaling current model

While the evidence strongly supports the benefits of PCC's early resolution model—improved patient experience, reduced stress for staff, and significant cost savings—its full potential is constrained by systemic and operational barriers. These include inconsistent Trust engagement, limited awareness among patients and staff, and the absence of formalised pathways within the HSC complaints framework. To embed early resolution as a core component of complaints handling, a set of practical enablers must be established. These enablers focus on policy integration, capacity building, and cultural change across the health system. The following table outlines the key enablers, the rationale behind each, and actionable recommendations to support implementation.

Enabler	Narrative	Actionable Recommendation
Formal Integration into HSC Complaints Framework	Early resolution is currently informal and dependent on PCC intervention. Embedding it within official policy will normalize its use.	Update the HSC Complaints Procedure to include a mandatory early resolution stage, with PCC identified as a key partner for facilitation.
Awareness and Signposting	Patients and Trust staff often learn about PCC too late in the process.	Introduce proactive signposting to PCC services at the first point of contact in Trust complaints correspondence and on Trust websites.
Permissions and Authority	Administrative staff lack clarity on when they can refer cases for early resolution.	Develop a clear protocol outlining who within Trusts can authorize early resolution and under what circumstances.
Training and Capacity Building	Trust staff need skills to engage constructively in early resolution.	Deliver joint PCC–Trust training sessions on conflict resolution, mediation, and person-centered communication.
Resource and Infrastructure	PCC requires capacity to scale early resolution effectively.	Allocate additional funding to PCC for dedicated early resolution teams and explore volunteer engagement models to extend reach.

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8. Summary and conclusions

Conclusion

The assessment confirms that PCC's early resolution model delivers substantial benefits to patients, staff, and the wider HSC system. It improves satisfaction, reduces stress, accelerates resolution, and avoids costly escalation. Financial analysis demonstrates significant savings potential, while comparator benchmarking positions PCC as a cost-efficient leader with scope for further development. To maximize impact, early resolution should be embedded within HSC complaints frameworks, supported by clear protocols, training, and proactive signposting. Scaling this approach will require investment in capacity and collaboration with Trusts, but the evidence strongly supports its value as a strategic priority for Northern Ireland's health and social care system. The table below sets out some conclusions and recommendations to fully embed

Conclusion	Narrative	Recommendation
Early resolution improves patient and staff experience	Evidence from surveys and literature shows early resolution reduces stress, accelerates outcomes, and fosters trust compared to complaints.	Embed early resolution as a formal stage in HSC complaints policy and provide training for Trust staff.
Significant financial savings potential	Analysis indicates early resolution is significantly less costly than the Trust complaints process, with litigation costs exceeding £50k.	Invest in PCC capacity and infrastructure to scale early resolution across all Trusts.
Systemic barriers limit impact	Primary research highlights inconsistent Trust cooperation and lack of standardized early resolution pathways.	Develop formal protocols and signposting mechanisms to integrate PCC early resolution into Trust processes.
Comparator benchmarking validates PCC model	PCC demonstrates strong early resolution performance and cost efficiency compared to Wales, ROI, and LRA models.	Explore volunteer engagement to increase reach and sustainability.
Strategic priority for NI health system	Early resolution aligns with best practice, improves satisfaction, and mitigates litigation risk, supporting system resilience.	Adopt early resolution as a core component of complaints handling and allocate resources for implementation.