NHS
Barking and Dagenham,
Havering and Redbridge
Clinical Commissioning Groups

Complaints Policy

Policy Title:	**Complaints Policy**
Supersedes:	Previous policy
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This policy will impact on:	CCGs' staff and NEL CSU complaints team
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Approved by Committees:	CCGs' Audit and Governance Committee	5 December 2017

Contents

1. Introduction

1.1 Purpose and Approach

The purpose of this policy is to ensure that patients, relatives, carers and all other users of services have their complaints and concerns dealt with in confidence and impartially, with courtesy and empathy in a timely and appropriate way.

This policy enables Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) to implement the *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 – Statutory Instrument 2009/309.*

The audience for this document is intended to be NHS staff employed by BHR CCGs and the commissioning support service (NEL CSU) responsible either for the implementation of the complaints policy or those needing to reference the complaints process. Specifically, but not exclusively:

- BHR CCGs' governing bodies and senior officer employed to support the investigators
- Corporate services staff working across BHR CCGs, NEL CSU complaints leads and acute, mental health and community health services providers.

BHR CCGs' approach to handling complaints is engagement and improvement led, focussed on developing effective relationships, able to support accessible, timely, clear resolution which embeds learning for patients, providers and commissioners. This policy describes how we will do this.

Equality Statement

We will expend all reasonable efforts to ensure that all complaints received by us are resolved locally to the satisfaction of complainants and contractors or providers in a clear, accessible and timely way. No complainant or the patient they represent will be treated less favourably on the grounds of age, creed, colour, disability, ethnic or national origin, medical condition or marital status, nationality, race, gender (at birth or reassigned), or sexuality nor will a complainant be placed at a disadvantage by the application of conditions or requirements which cannot be shown to be justifiable.

We have adopted an approach to working with complainants which focuses on engagement and learning to ensure a personalised response and a true impact on improving everyday quality.

1.2 How to read this document

This document describes how we will deliver an engagement led approach to complaints handling in five sections; purpose, responsibilities, performance, process and learning, which are laid out in sections as follows.

1. Implement The *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009*
2. Describe responsibilities and expected performance of commissioners
3. Describe processes for receiving, investigating and responding to complaints
4. Describe timeframes for staff responsible for delivering the policy
5. Describe how we will learn from complaints

1.3 The role of the CCGs

This document applies to all staff employed by and working for BHR CCGs. Other provider organisations will be expected to comply with this policy in situations where people request that the CCGs respond to or leads an investigation and response.

The role of the CCGs is to make the complaints process accessible, timely and clear, focussing on people not processes and ensuring that making a complaint has no adverse consequences for the ongoing care of the complainant.

- In addition, the CCGs as the local commissioner, has an assurance and scrutiny role of all provider organisations. This is achieved through our monthly provider Clinical Quality Review Meetings (CQRMs) at which we scrutinise provider quality and governance reports
- Annual complaints submissions to the NHS Information Centre
- Review of annual complaints reports
- Annual quality accounts scrutiny and approval.

We will also review complaints trends in all provider organisations as part of our wider quality review and assurances processes.

The policy seeks to be in full compliance with all relevant legislation and Department of Health guidance and will be continuously reviewed in the light of any national changes. In so far as any assertion or intention in the current version of this document does not comply with such legislation or guidance, that assertion or intention must be regarded as void.

2. Responsibilities

2.1 Definition of a complaint

The NHS Executive has defined a complaint as "an expression of dissatisfaction requiring a response."

The CCGs will seek to distinguish between requests for assistance in resolving a perceived problem or enquiry which may be dealt with immediately and a formal complaint. In the case of an ongoing enquiry where there is no resolution the caller or correspondent may then wish to register this as a formal complaint. All issues will be dealt with in a flexible manner, which is appropriate to their nature and the latter will be dealt with in accordance with the complaints procedure.

For the avoidance of doubt, whenever there is a specific statement of intent on the part of the caller or correspondent that they wish their concerns to be dealt with as a formal complaint, they will be treated as such.

All complaints made about fraud and bribery related activity should be referred to the Local Counter Fraud Services (LCFS) via the following link, online at https://cfa.nhs.uk/reportfraud or by calling the NHS Fraud Reporting Line on 0800 0284060**.**

2.2 Individual and Team Responsibilities

Party	Key responsibilities
Governing body	• The CCGs' governing bodies have a statutory responsibility for complaints management, and this is managed through delegation to the Accountable Officer (AO) / Managing Director (MD) and is assured through reporting • The governing bodies have committed to having an effective complaints process and see complaints as an important way of assuring themselves of the quality of care and the services they provide. The complaints handling policy is also a key strand of our approach to being a learning organisation.

Party	Key responsibilities
Accountable Officer (AO) / Managing Director (MD)	• Statutory responsibility for the quality of care within the organisation and governing bodies and delegated responsibility for final sign off on formal complaints.
Director of Corporate Services, working closely with Board Nurse Director	• AO/MD and governing bodies delegated responsibility for complaints management. • Assurance to governing bodies that effective systems are in place for the management of complaints in accordance with the complaints regulations and ensuring actions are taken in light of the outcome of any investigation • Monitor KPIs against deadlines and report these to governing bodies.
Board Nurse Director and and quality lead	• Support the investigating officer in carrying out a risk assessment of the situation or support an investigation as required.
Directors / Senior Responsible Officers (SROs)	• Appoint an investigator (this should be a different person from the one that handled any enquiries received from the complainant) • Support the investigator during the investigation process. • On receipt of a written complaint, to ensure that a copy is provided to the corporate services team immediately. • Review the situation to ensure any immediate actions are completed to improve the situation for the patient in the short term if needed • Ensure that the investigation is completed and the investigation report and draft response data are sent to NEL CSU complaints team within the agreed time limits. • Ensure that any response from the team/CCGs addresses all of the concerns raised based on agreed terms of reference established with corporate services team and the investigating officer. • Attend meetings with the complainant, where direct involvement will help resolution of the complaint. • Ensure an action plan is drawn up (where appropriate) as a result of the complaint and a copy is passed to corporate services for monitoring. • Take action or support action following recommendations arising from a Parliamentary and Health Service Ombudsman (PHSO)'s report.
Investigating Officer	• Carry out a risk assessment of the situation in conjunction with NEL CSU complaints team and draw up an action plan. This can be carried out with the Director/SRO/ • Seek clarity and agreement with the complainant on the areas of concern they wish to have investigated and create a terms of reference, together with the corporate services team where appropriate • Investigate the complaint within the set timescale • Retain copies of relevant records in the complaints file. • Attend meetings with the complainant, where direct involvement will help resolution of the complaint. • Ensure that should there be a delay in completing the investigation, the NEL CSU complaints lead is notified of the reason for the delay and can contact the complainant to ask for an extension of the investigation period. • Prepare an investigation report and draft a response letter, integrating responses from other services where appropriate and

Party	Key responsibilities
	sharing any findings with the contractor whose service the complaint relates to.
NEL CSU Patient experience team	• Maintain a database and acknowledge all formal complaints providing details of ICAS, (Independent Complaints Advisory Service) and other support as needed. An example of how this information is provided is in Appendix 5. • Obtain consent to disclose information if complainant is not the patient. • Distribute complaint letter/details to appropriate staff. • Ensure that the terms of reference are clearly established in agreement with the complainant. • Maintain contact with investigating officer to ensure good progress of complaint and on-going support/advice is available • Ensure extended investigating periods are negotiated where appropriate. • Attend meetings where direct involvement will assist resolution. • Organise and/or provide alternative dispute resolution where appropriate • Review the draft response submitted, ensuring that all areas of concern raised by the complainant, have been addressed • Edit the response that is submitted along with the investigation report • Send the final response letter to the director/SRO for sign off prior to sending to the AO/MD for approval and signature. • Liaison with the PHSO for information requests and facilitation of post Ombudsman follow-up actions as required. • Escalate problems in case of delayed responses. • Escalate draft letters which do not respond fully to complaints • Ensure Investigators are supported and briefed effectively
CCGs	• Arrange for a copy of the signed response to be sent to all relevant parties • Ensure the relevant department maintains a record of all actions and changes in practice resulting from complaints
CCGs' Legal Manager	• Provide advice on issues which may indicate admission of liability or any other legal issue. • Liaise with the National Health Service Litigation Authority (NHSLA) as required.
Contractors	• Ensure an action plan is drawn up (where appropriate) as a result of the complaint. • Be responsible for the implementation of the action plan. • Provide a progress report on the action plan when requested. • Provide the complaints file to the corporate services complaints lead on request (e.g. following notification of an investigation by the PHSO). • Take action on any recommendations arising from an Ombudsman's report.
Nurse and Clinical Advisors	• Provide advice on the clinical content of complaints and support risk grading based on these assessments • Support the acquisition of independent medical opinion about complaints if necessary

Party	Key responsibilities
	• Attend meetings where clinical expertise is required or will offer reassurance to the complainant
All staff and members of the CCGs	• All CCGs' members and staff must understand how to refer complaints. • In addition all staff involved in complaint management must put the patient at the centre of the process and ensure that bureaucracy does not get in the way of effective complaints handling.

3. Performance

Organisational performance indicators for complaints handling are as follows:

Indicator	Target	Report Detail
Complaints acknowledged within 3 working days	100%	% and number of complaints target met / unmet
Complaints closed within 25 working days	100%	% and number of complaints target met / unmet

4.0 Requesting Consent

Staff should not assume that someone complaining on behalf of a patient who lacks capacity to complain themselves has the necessary authority to complain on their behalf. Evidence that the individual raising the complaint has the necessary authority to do so will be required. This normally takes the form of either a lasting power of attorney or deputyship endorsed and authorised by the Court of Protection.

The CCGs must satisfy itself that the representative of the complainant is the appropriate person to discuss the complaint with and staff will confirm they have authority to do so and liaise with the complainant to ensure that consent it is obtained. In the case of a patient who lacks mental capacity, it is only the immediate named next of kin who can represent the patient – this need not be a relative but whoever has been the named next of kin documented in the patient's records.

There are specific consent and data handling arrangements in place in respect of patients who have applied for gender recognition or reassignment who make a complaint about any matter including clinical care related to gender reassignment. In these cases the accountable officer's office or the initial recipient must retain correspondence, acknowledge the complaint, providing details of the Independent Complaints Advocacy Service (ICAS) and obtain consent before redacting information that the complainant is undergoing or has undergone transition before forwarding the complaint to be investigated.

In all cases, if the CCGs are not satisfied that the representative is appropriate, it must not consider the complaint and must give the representative reasons for the decision in writing.

4.1 Timescales for complaints

4.1.1 Making a complaint within 12 months

Formal complaints should normally be received within 12 months of the event concerned or within twelve months of the complainant becoming aware that concerns need to be raised. We may waive the limit at our discretion if there are good reasons why the complainant could not complain earlier.

4.1.2 Routine responses within 25 Working Days

The CCGs expect complaints to be responded to in accordance with timescales in the flow chart (shown as appendix 2).The CCGs' complaints lead, in conjunction with the NEL CSU complaints team, is responsible for ensuring the organisation is able to keep to these deadlines which are based on key performance indicators set by the CCGs.

The 25 working day deadline starts on the day of receipt of a complaint letter/email/phone call. If the consent of the patient is required, the count begins on the day the consent is received.

If by working day 15, no investigation report has been received and it will not be possible to respond to the complainant within the agreed time scale, the complainant will be contacted by the complaints team to agree a new response time.

4.1.3 Deviation from a 25 working day response

This list is not exhaustive but in more complex cases, it may not be possible to achieve resolution within 25 working days, such as:

- where multiple providers are involved
- where the complainant has made a follow up request
- where staff are absent and need to be interviewed
- where the CCGs have declared a serious incident or
- cases where unforeseen events have caused delay

In cases such as these, a deadline will be agreed with the complainant and they will be kept up to date by the NEL CSU complaints team.

An escalation process to manage the delay in the relevant directorate/SRO is also instituted so that the relevant director is managing the case and the AO is made aware if necessary.

4.1.4 Urgent Cases for Immediate Action

Where a patient has a terminal illness or it is otherwise evident the complainant requires a very urgent response; the CSU complaints lead will have a discussion with the investigator(s) and responsible director and clarify this in the terms of reference in the Investigation Report Template to ensure it is understood that there is a need for immediate action.

Where this is not possible, this will be communicated to the complainant and as much information will be provided as possible in a weekly update from the Investigating officer – this is to be noted in the terms of reference and risk grading template at the outset.

4.2 Stages of the Complaints Process

4.2.1 Stage 1: Local Resolution

As a result of the 2009 legislation, the NHS complaints process has been simplified to two stages:

Stage 1. Local Resolution at CCG level
Stage 2. The Parliamentary and Health Service Ombudsman (PHSO)

When patients make a complaint, they will usually expect feedback on actions taken and lessons learned. In order to enable complainants to be satisfied with the response to a complaint, it is advantageous to clarify what outcome they are looking for at the start of the investigation process.

This will usually be the role of the relevant directorate handling the complaint in conjunction with the corporate services team. Although, not exhaustive, the following is a summary of potential remedies:

1. An apology – any patient who has had the misfortune to suffer through an error of whatever nature should receive a full explanation and a genuine apology. The CCGs encourage staff to adopt this approach and to clearly express what we are sorry for.
2. An explanation of what happened and why
3. Financial compensation
4. Assurance that the same will not happen to others
5. A face to face conciliation/mediation meeting attended by staff involved
6. A second or independent review of care provided to the patient

If, after the CCG has expended all possible remedies at the first stage and the complainant remains dissatisfied, or either party believes local resolution can take the complaint any further, the complaint may got to Stage 2.

4.2.2 Stage 2: The Parliamentary and NHS Ombudsman (PHSO or Ombudsman)

The Ombudsman undertakes independent investigations into complaints where it is believed the NHS has not acted properly, fairly or has provided a poor service. The role of the CCGs is to ensure that they have acted properly and fairly, and provide a high quality complaints service. When it is established that a complaint has gone to the Ombudsman and no further action may be taken, the complaints process is closed.

4.3 Circumstances where the complaints process is suspended

The complaints process is suspended if the complainant decides:

- to seek legal redress or go to the police
- to apply for judicial review
- the complaint is a Freedom of Information or Subject Access Request

Complaints are suspended until these processes are concluded and the complaint is referred back.

4.4 Serious Incidents (SIs)

The complaints team will assess all complaints for the potential that they meet the SI criteria. If the NEL CSU categorises the complaint as a Serious Incident (SI), the SI team take the lead on the complaint and will coordinate with the CCG quality team to ensure this is communicated to the complainant and the necessary liaison is maintained to keep the complainant informed of the investigation process.

On completion of an SI report or investigation which is required to answer a complaint, the CCGs' quality team will feedback to the family. A formal complaint response will also be prepared to ensure that the original complaint is closed.

4.5 Joint Working between Health and Social Care

Since 2009, statutory sector organisations have been obliged to provide a single point of access to complainants. This includes complaints which involve both health and social care.

In such cases, the CCGs will liaise with local authorities, providers or commissioners to determine lead responsibility for a complaint. The CCGs will then either provide an investigation report completed to template and terms of reference or agree to coordinate a complaint, including consent. If the CCG is coordinating a response, the CCG will set a deadline for receipt of

completed investigations while liaising with the complainant providing details of the actions being taken to resolve the complaint.

Consent will be requested from complainants for each provider or commissioner involved especially in such cases where multiple agencies are involved.

4.6 Management of Habitual / persistent Complainants

The use of this policy /process (shown as appendix 6) should be infrequent and take place only after approval has been sought from the complaints lead or Director of Corporate Services.

This policy may be applied where a complainant has become abusive, has called with a frequency which is unreasonable or inhibits the normal functioning of the complaints service or where all possible avenues for resolution at a local level have been exhausted and the complainant refuses to accept this outcome despite correspondence clarifying the position of the CCG.

There may be cases where this is appropriate and the AO will write to the complainant clarifying how future correspondence or telephone calls with the complainant will be handled.
To be clear, the CCG recognises that habitual complaints may mask an underlying systemic or health problem, such as a mental distress or other vulnerability. In all cases, whether someone is categorised as a habitual complainant or otherwise, complainants and their concerns will be treated with dignity and respect, and the complaints team will do all they can to support the complainant to achieve resolution of the problems they experience.

4.7 Communication and Training

The CCGs will provide training opportunities to support referral, investigation and the overall handling of complaints including:

- Complaints handling training
- Root Cause Analysis (RCA) training.

The responsible director / SRO will identify lead investigators who have received complaints handling training. Where this is not possible, the complaints team will ensure that lead investigators are supported by someone who has received this training and that the investigative process is used to support staff development.

5. Learning from Complaints

5.1 Routine Reporting and Trend Analysis

Complaints should make a difference to how the NHS works and when something goes wrong, the very least patients have a right to expect is that we will do our best to make sure something similar does not happen again in the future, because the service has learned and understands where, how and when things went wrong the last time.

It is the role of the CCGs' complaints lead, in partnership with the NEL CSU complaints lead to make this happen. We will do this by monitoring trends in complaints reporting and preparing and submitting regular reports to the CCGs' Quality and Safety Committee. Reports will be reviewed by the CCGs' complaints and engagement leads to confirm lessons learnt from complaints and determine trends as well as developing routes for dissemination of this learning across the sector and local health economy. Data will also be provided as part of the Quality Report for the governing bodies and its relevant committees (i.e. Quality and Safety).

Reports will specify the number of complaints received, identify subject trends, summarise handling, outcomes, performance to targets and identify any cases dealt with by the Parliamentary and Health Service Ombudsman.

The CCGs are responsible for monitoring action plans arising from investigations in commissioned organisations. The corporate services team will agree with primary care commissioners or the lead commissioner the process for following up implementation of action plans and will also keep a database of agreed actions where this is appropriate for later follow up based on agreed monitoring and completion dates. The CCGs will implement a process of internal audit to assure itself that this monitoring is taking place to the required standard.

5.2 Communications with the Public

The CCGs' complaints lead and engagement lead will work together to disseminate information about improvements and learning from complaints to assure the public that the NHS learns from mistakes. This kind of information can be disseminated using anonymised case studies, details of specific improvements or describe learning which has been incorporated into policy to avoid repeating past mistakes. For example "you said, we did"

5.3 Risk Analysis

The CCGs' risk rating matrix (used in the management of risks across BHR CCGs) will be applied to all complaints and will support learning and improvement by inclusion in trend analysis and day to day reporting for the management of the service.

5.4 Non Routine Reporting

Governing bodies' members, including the board nurse may request ad-hoc reports based on issues which have come to their attention. The Director of Corporate Services will be responsible for reporting data back to the governing bodies as required.

Requests for information may be made by a number of bodies, for scrutiny, governance or trend analysis. These may include:

- The General Medical Council
- The NHS Information Centre
- Screening or Performance Panel

Additionally, data may be requested by

- Local Authority Overview and Scrutiny Panels or HealthWatch

For the purposes of trend analysis and service improvement, all such requests will need to be approved by the Director of Corporate Services.

5.5 Audit

There are a number of different forms of audit which may be expected from a variety of different audiences, this means that data systems must be capable of delivering the expected returns, for example:

NHS Digital report CCG performance via the annual Korner (KO41) returns submitted by the by NEL CSU on behalf of the CCGs.

The governing bodies and the public monitor and evaluate CCG's performance via the annual complaints report prepared and submitted by the NEL CSU Patient Experience Team (PET).

There will be periodic audits of the complaints process. This will be carried out either by internal audit or by governance.

5.6 Patient Feedback on Complaints Handling

Corporate services will carry out surveys on complainants' experience of using the complaints process by sending complainants an evaluation sheet accompanying their final letter. Any other

surveys which take place will focus on improving the efficiency, pace and accessibility of the complaints process, including all communication whether written or verbal.

Information on ethnicity and language preferences will be included for equality monitoring purposes and to enable early identification of access problems and data will inform service development and reports to stakeholders.

Appendix 1: Policy Background

Both the Francis Inquiry reports and the Clwyd / Hart report demonstrated the importance of investigating and adequately responding to complaints about NHS services. Too often complaints relate to the fundamentals of good healthcare:

- effective communication with patients
- the attitude of staff
- record-keeping
- privacy and dignity and
- in 19% of cases, there was also a problem with the way in which the complaint was handled.

The NHS Constitution states that any individual has the right to:

- have any complaint they make about NHS services dealt with efficiently and have it properly investigated
- know the outcome of any investigation into their complaint
- take their complaint to the independent Health Service Ombudsman if they are not satisfied with the way the NHS has dealt with their complaint
- make a claim for judicial review if they think they have been directly affected by an unlawful act or decision of an NHS body
- receive compensation where they have been harmed by negligent treatment.

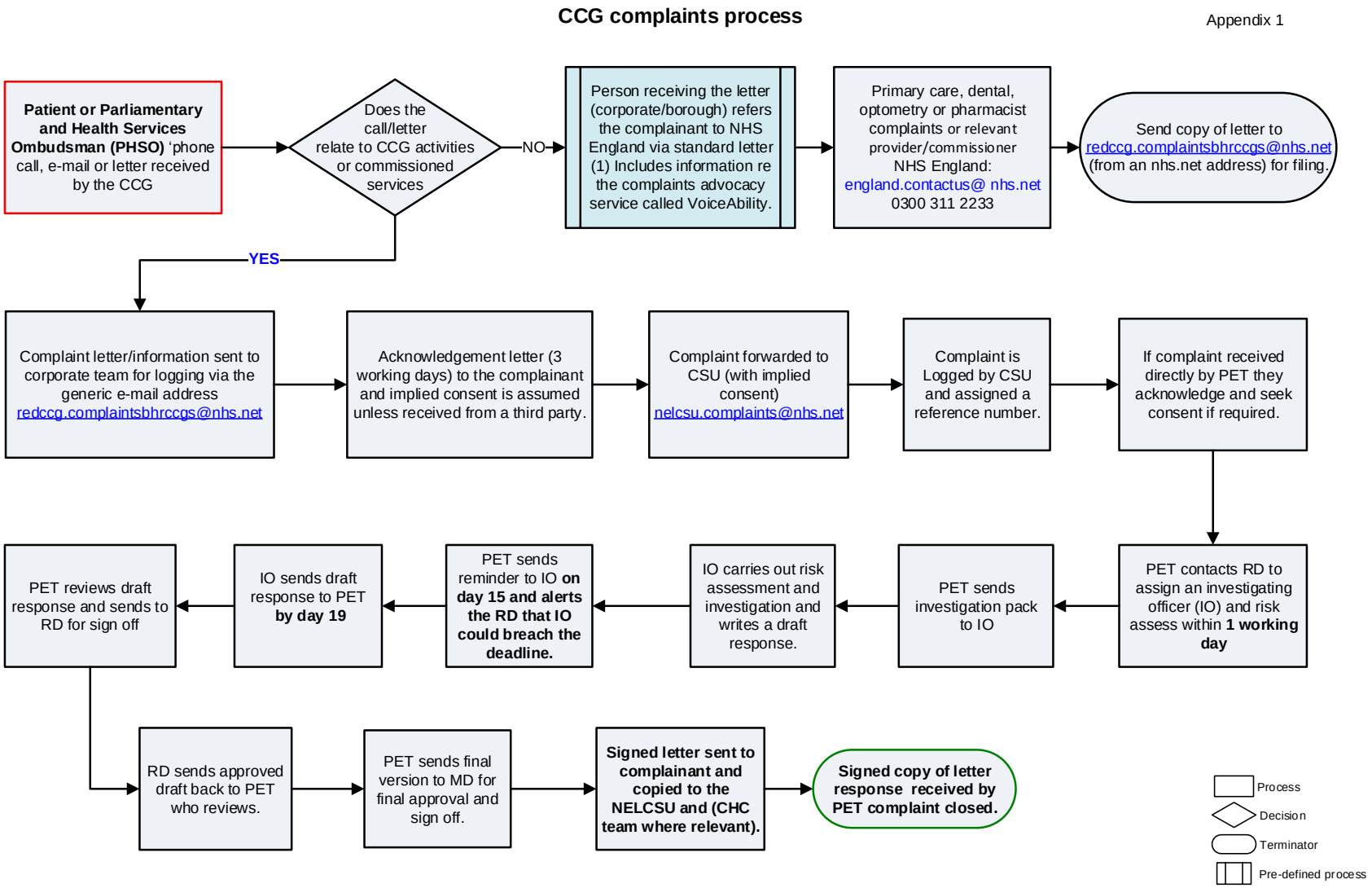
The Parliamentary and Health Service Ombudsman also describes six principles for good complaint handling which tie in with the principles described in this document of an approach which is accessible, swift, clear and improvement focussed.

The six principles are:

1. **Getting it right** meaning compliance with the law and the rights of those concerned who should effectively discharge their duties and any other rules governing the service they provide.
2. **Being customer focussed**, meaning to be accessible, timely and sensitive to clients' needs.
3. **Being open and accountable**, meaning to be honest and up front about what has happened and admitting mistakes where necessary based on a clear policy which clients can understand.
4. **Acting fairly and proportionately**, meaning to respect those we serve, using evidence based approaches while actively shaping the handling process
5. **Putting things right**, meaning to things, if possible to the position they were in before the events took place. If that is not possible, it means compensating complainants and such others appropriately.
6. **Seeking continuous improvement**, meaning we tell clients what lessons have been learned and what we will do to ensure anything similar is avoided in future.

[Source: Principles of Good Complaint Handling, PHSO 2009]

Appendix 2: Process chart



Appendix 3: Detail for flow chart

Day	Activity
D1	**Received:** • General enquiry/concern - clarify if formal complaint or if informal see * • Ask the complainant about their goals for the process and communicate this throughout to other partners to ensure that the process is patient-centred from start to finish • Scan and date stamp same working day as receipt then risk grade forward copy of complaint to the Responsible Director (RD) (Director or SRO) with investigation report template. • RD appoints an investigating officer (IO) on the same day or once consent is received ***** Clarify if it can be resolved on the spot or informally then, if not then continue to respond to as a formal complaint.
D1-D3	• The NEL CSU complaints team will acknowledge receipt of the complaint within 3 working days by writing back to the complainant and providing details of ICAS, the Independent Complaints Advocacy Service. • Acknowledgement will be made in writing and by telephone where possible.
D3	• The NEL CSU will continue negotiation process i.e. telephone call to complainant to further discuss prefered options for resolution (e.g., meeting/ investigation or conciliation/mediation) and any changes fed back to Investigator.
D3-D12	• NEL CSU will ensure the investigator understands the remit of the investigation i.e. terms of reference and follows the complaints procedure. If at any point of the investigation the terms of reference need to be updated because of new information received, NEL CSU will communicate this to the investigator. • Investigator commences investigation same day appointed and conducts investigation according to agreed procedure and terms of reference. • The investigation takes place using the agreed investigation procedure.
D15	• A reminder that the investigation report is due is sent to the investigating officer with a copy to their director or the appropriate appointing officer at day 15
After D15	• The investigating officer will ensure that staff who contributed to the investigation (including a senior representative from the contracting organisation) and the director or appointing officer have the opportunity to review the draft report. • The findings of the investigation will be shared with the contractor/ service concerned in order to ensure contracted services sign off the findings and actions.
D16	If investigation report not submitted to NEL CSU on Day 15 a prompt is sent to the IO and 48 hours given for a response. If no response is forthcoming or significant delay is envisaged and this is deemed inappropriate, the case is escalated to the RD.
D19	IO to send draft response to PET
By D21	• Final draft letter submitted for quality checking by NEL CSU. • If the response makes an admission of liability on behalf of the commissioner, before it is finalised, the CCGs' Complaints lead will forward the draft response to the legal manager who will in turn, liaise with the NHS Litigation Authority (NHSLA) to seek their agreement before finalising the draft response letter for dispatch to the complainant. NEL CSU to be advised of the outcome of these discussions so that the response due date can be agreed with the complainant if necessary.

	• If the response makes an admission of liability on behalf of the contractor, it is the responsibility of the contractor to notify their defence union or other responsible body. The CCGs encourages contractors to ensure that their defence Union have agreed any admissions within the timescales of this policy. However if this is not possible the CCGs will liaise with the contractor to agree how to proceed.
By D22	• The CCGs' RD or senior representative of the contractor will check that the draft response is in line with investigation report and sign off the response
D23	• Response sent to the AO/MD office for final review and sign off
D25	• Corporate services sends the final response letter to the complainant and other relevant parties.

Appendix 4: Reference and Risk Grading Template

Complaint Reference and Risk Grading Template

Name of Complainant:		**Name of Person concerned if different:**		**Ref No:**
Tel No:		**Mobile No:**		**Email:**
Date Received:		**Date of acknowledgement:**		**Practitioner:**
Brief Details of Complaint for trend analysis:				
Service:	**Providers Name:**	**Lead Mgrs Name:**		**Tel No:**
Date Consent Requested:		**D/line Date of Consent (6weeks):**		**Date Consent Rec'd (25 days begin)**
Date Complaint sent to Provider:		**D/line for response (25 days max):** **F/up in 10 days (date):**		**Date Response Rec'd/Closed:**
Name of Investigating Officer: **Tel No:** **Email:**		**Name of Director of Service:** **Tel No:** **Email:**		**Weekly Call Back? Yes/ No** **1 2 3 4 5**

PASSED TO DEPUTY DIRECTOR FOR RISK ASSESSMENT: YES/NO DATE:

Rating 1 - Insignificant	Rating 2 – Minor	Rating 3 – Moderate	Rating 4 – Major	Rating 5 – Critical/Death

PASSED TO QUALITY ASSURANCE TEAM FOR SI OR LEGAL ISSUE:

SI	YES/NO	Named Person:	Date:
Legal issues	YES/NO	Named Person:	Date:
Media issues	YES/NO	Named Person:	Date:

DATE LOG SUMMARY:		
Date	Action	Initial

Likelihood	**Impact** (severity) if hazard being realised				
Of hazard being realised	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost certain (5)	5	10	15	20	25

1 – 3 low risk	4 – 6 Moderate risk	8 – 12 High risk	15 – 25 Extreme risk

1	2	3	4	5
Rare	Unlikely	Possible	Likely	Almost certain

Appendix 5: ICAS and PHSO Information in letters

Examples of standard Information in letters to complainants

In acknowledgement letters, information about referral to ICAS is routinely provided:

If you would like free, independent advice and advocacy you can contact the Independent Complaints Advocacy Service (ICAS), who can be reached on 0300 456 2370. Alternatively, if you wish to write to ICAS, their address is ICAS PohWer, CAN Mezzanine, 32 – 36 Loman Street, Southwark, London SE1 0EH.

In final letters, information about taking a complaint further including contacting the parliamentary and Health Service Ombudsman is routinely provided:

Important Information about your Complaint Response

I hope that you have found our response clear and helpful. Your complaint is important to us and will be used by us to monitor and improve NHS services.

This letter is part of the formal NHS Complaint Procedure. If you have any questions regarding this response, or you would like to discuss anything in this response further, please contact the Patient experience team on 020 3688 1666.

Your care should in no way be compromised by raising these issues with us. The CCG has a duty to ensure that service users are treated with dignity and respect, and do not receive less favourable treatment, as a result of them making a complaint. The CCG will take appropriate action, in cases where there is evidence that this has occurred. We are reliant on feedback from our users and would ask that you inform us if you feel that this has been the case. Your concerns will always be discussed confidentially to agree what actions can be taken to address this.

If you are unhappy with the outcome of this complaint, you are entitled to take your complaint to the Health Service Ombudsman (please see enclosed). The Health Service Ombudsman is an independent body established to promote improvements in healthcare. Should you decide to approach the Ombudsman, you will need to do so within twelve months from the date of this letter. It may be useful to mention that The Ombudsman would normally only consider a complaint if local resolution has been exhausted. I have enclosed a leaflet that you may find helpful. You can contact the Ombudsman at

The Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London SW1P 4QP
Tel: 0345 015 4033
Fax: 0300 061 4000
Email: phso.enquiries@ombudsman.org.uk
Website: www.ombudsman.org.uk

Appendix 6: Habitual / Persistent complaints policy

1. Vexatious or habitual complaints are defined by their behaviour.
The behaviour must be defined over a reasonable period of time.
Complainants (and/or anyone acting on their behalf) may be deemed to be habitual where previous or current contact with them shows that they meet at least two of the following criteria:
Where complainants:

a) Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted.

b) Seek to prolong contact by changing the substance of a complaint or continually raising new issues and questions whilst the complaint is being addressed. (Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints).

c) Are unwilling to accept documented evidence of treatment given as being factual e.g. drug records, nursing notes.

d) Deny receipt of an adequate response despite evidence of correspondence specifically answering their questions.

e) Do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

f) Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of CCG staff and, where appropriate, independent advocacy, to help them specify their concerns, and/or where the concerns identified are not within the remit of the CCG to investigate.

g) Focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what a 'trivial' matter is can be subjective and careful judgement must be used in applying this criteria).

h) Have, in the course of addressing a registered query or complaint, had an excessive number of contacts. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section using judgement with the CCG placing unreasonable demands on staff. (A contact may be in person or by telephone, letter, E-mail or fax. This also includes:

- **Telephoning repeatedly with no clear issues other than the original complaint.**

- **Turning up at CCG reception points without notice and demanding to be seen**

i) Are known to have recorded meetings or face to face/telephone conversations without the prior knowledge and consent of the other parties involved.

j) Display unreasonable demands or expectations and fail to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).

k) Have threatened or used actual physical violence towards staff or their families or associates at any time - this will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication.

(All such incidents should be documented in line with the Zero Tolerance Procedures).

l) Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety or distress and should make reasonable allowances for this.) Staff should document all incidents of harassment in line with the Zero Tolerance Procedures, completing an incident form.

m) Repeated refusal to attend local resolution/conciliation meetings to explore their concerns.

n) Do not accept independent investigation and review of their case

2. PROCEDURE FOR DEALING WITH HABITUAL COMPLAINANTS

a) Check to see if the complainant meets sufficient criteria to be classified as a habitual complainant. Describe the defining behaviour to the Director of Corporate Services and Board Nurse.

Discussions should decide if the complainant should be assigned designated contact point within the complaints team

Where there is an on-going investigation

b) A Director or the Chair* should write to the complainant setting parameters for a code of behaviour and the lines of communication. If these terms are contravened consideration will then be given to implementing other action.
**** It would be inappropriate for the Accountable Officer or Managing Director to set these parameters at stage as s/he will be involved in the ongoing complaints process.***

Where the investigation is complete

c) At an appropriate stage, the Accountable Officer or Chair should write a letter informing the complainant that:
- The Accountable Officer has responded fully to the points raised, and
- Has tried to resolve the complaint, and
- There is nothing more that can be added, therefore, the correspondence is now at an end.

The CCG may also wish to state that future letters will be acknowledged but may not be responded to.

d) In extreme cases the CCG should reserve the right to take legal action against the complainant.

Record Keeping:

The CCG should keep an up to date and accurate record of all contacts with the complaints to support action taken.

Record of Contact:

Date of Contact	Method (phone, letter)	Time spent	New or repeat issue

Appendix 7: Complaint Response Template

Investigation Report

Text should be added to each text box. When completed the document should be returned to the Patient Experience Team (PET). Please contact the PET if you require any further guidance.

Case reference number	
Name of complainant	
Name of patient (if different)	
Complainant's telephone number	
Investigating Officer (IO) name and job title	
Responsible Director (RD) Name and Job Title	
Risk score, pre investigation	
The Patient Experience Team (PET) will contact the complainant by telephone, where possible, at the start of the complaints process to identify how they would like their complaint investigating and responding to; the choice is written response or Local Resolution Meeting (LRM).	
PET spoke with the complainant: **State date and time, or "PET not spoken with complainant"** **Complainant wishes for: a written response / a local resolution meeting (delete as appropriate)**	
Written response required: *The PET will create a draft response letter based upon the content of this Investigation Report.* LRM required*: PET will facilitate the LRM. The IO may be required to attend.*	
Background of complaint:	

Complaint elements to be answered:
1.

2.

3.

4.

etc

Date complaint passed from PET to the Responsible Director (RD) or IO:

Date completed Investigation Report is due back with PET:

Investigation process carried out:
Please list dates and actions taken. E.g. 02.04.17 read through patient records on Broadcare. 03.04.17 Took a statement from Mr Staff, Job Title.

Findings of investigation:
Please write this section as it should appear in the final response letter. Please include sufficient detail to answer each complaint element. Please use Plain English principles.

Complaint outcome:

Please state whether the complaint overall was: (please circle)

Upheld / Partially Upheld / Not upheld / Withdrawn

Upheld: If a complaint is received and substantive evidence is found to support the complaint then the outcome should be reported as Upheld.
Partially Upheld: Where a complaint is made about several issues, if one or more of these, but not all, are upheld, then the complaint outcome should be recorded as partially upheld.
Not Upheld: When no evidence can be found to support any element of the complaint then the complaint outcome should be recorded as Not Upheld.

Complaint withdrawn:

Sometimes, during the dealings between the IO and the complainant, the complainant will become satisfied that the matter has been resolved and say they no longer need a formal response to their complaint. Or they may withdraw the complaint for any other reason. When this happens record the Complaint Outcome as Withdrawn and state here the reasons why the complainant withdrew the complaint.
Proposed resolution: *If the complaint outcome is Upheld or Partially Upheld, then resolution should be stated. This may include an apology and details of what will be done to ensure the same experience does not reoccur.*
Lessons learned: *Please identify all learning from this complaint investigation.*
Action plan: *List actions planned and implemented, to help ensure the same problems are not experienced again, e.g. specific staff awareness measures taken, specific training, changes to staff rota etc. Please include dates and responsible person where possible.*
Date Investigation report submitted to PET:
Investigation report approved by: **Investigating Officer:** **Date:** **Responsible Director:** **Date:**