Tower Hamlets GP Care Group (THGPCG) CIC

Complaints Policy and Procedure

Category	Corporate Governance
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1. Introduction

The GP Care Group aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the GP Care group will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

This policy is designed to outline the process for handling feedback and complaints generated by patients or their representatives and aims to set out clear guidelines for staff, managers and complainants around how complaints will be managed.

It is our aim that all patients, relatives and their carers will not be treated differently as a result of making a complaint. This will be achieved by ensuring that complaints are handled fairly and openly. It is clearly not always possible for the complainant to receive the outcome they hoped for, but if they feel that their complaint has been handled appropriately and that they have had a fair hearing, this is a positive outcome.

The GP Care Group are keen to ensure that feedback and complaints are used as learning opportunities and that trends are analysed and reported on. It is essential that information we gain from complaints is used to improve the quality and safety of the services we provide.

Learning from complaints is shared through individual service team meetings and the Quality, Safety & Governance Committee. This is then included in reports to the THGPCG Board as part of the overall integrated governance framework.

This policy has been written in accordance with the 'Local Authority Social Services and National Health Service Complaints (England) Regulations 2015'. Reference is also made to the Department of Health guidance in complaints handling 'Listening, Responding, Improving', Parliamentary and Health Service Ombudsman's 'Principles of Good Complaints Handling'.

1.1 Applicability

All Managers and GP Care Group staff are responsible for the effective implementation of the policy. This includes:-

- Cooperating fully with the investigation of each complaint, and ensuring that any staff for which they have responsibility respond to investigations in a timely and appropriate manner;

- Ensuring that action is taken and action plan implemented, following any complaint which gives rise to the need for wider scale implementation of change;

- Enabling the processes of organisational learning following a complaint;
- Ensuring that complaints are responded to within the agreed timetable;
- Releasing staff for relevant training events.

All staff have a role to play in reducing the numbers of complaints received by ensuring that:-

- as far as possible, their attitude, approach or behaviour do not give patients cause for complaint,
- they deal with any issues courteously and efficiently,
- they keep good quality records,
- they refer on to an appropriate manager if the limits of their authority or experience are exceeded.

1.2 Purpose and scope

This policy describes the systems in place to effectively manage all complaints received by the organisation in accordance with NHS complaints regulations. It outlines the responsibilities and processes for receiving, handling, investigating and resolving complaints relating to the actions of the organisation, its staff and services.

The purpose of this policy is to ensure that the GP Care Group promotes best practice within its complaints management function, and also that it is compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2015.

This policy and procedure sets out how the NHS complaints procedure will be implemented locally and must be followed by all staff employed or hosted by the GP Care Group.

2. Definitions

The following terms are used in this document:

2.1 Complaint: a written or oral expression of dissatisfaction which requires a response.

2.2 Issues/concerns: a written or oral expression of dissatisfaction that can be resolved without the need for formal investigation or correspondence.

2.3 Investigating officer: the person identified as responsible for handling and investigating an individual complaint.

2.4 The Parliamentary and Health Service Ombudsman (PHSO): is the organisation that manages the second stage of the NHS complaints procedure

2.5 Serious Incident (SI): is an incident or near miss occurring on health service premises or in relation to health services provided, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be significant public concern.

Any other special terms or abbreviations used in this document are defined as they occur.

THE POLICY Principles

Support for Patients in relation to complaints

- When a patient submits a complaint, GP care group will support them by responding with courtesy and sensitivity, and in a timely way.

Support for Staff involved in complaints

- Complaints can be a cause of concern for staff, particularly if the concerns raised relate to their area.

Confidentiality

Maintaining patient confidentiality is essential and security of data relating to individuals must be protected in accordance with the Data Protection Act (1998). No confidential information relating to complaints will be disclosed to any third party unless GP care group has the patient's consent or some other lawful authority to do so.

3. Process

A reformed complaints procedure covering both health and adult social care was introduced from April 2009 and updated in 2015. This enables organisations and the person complaining to agree on the best way to handle the complaint to achieve a satisfactory outcome. Within this process both concerns and complaints can be made either verbally, in writing or electronically via email.

Local resolution

3.1 All staff are responsible for purposefully aiming to resolve issues and concerns raised by patients, their representatives and/or visitors as soon as they become aware there is an issue or problem. GP Care Group staff are expected to adopt an ethos of **"if I can fix it I will"** making every member of staff individually accountable for trying to prevent concerns from escalating unnecessarily.

3.2 Staff should be guided by and follow these six simple steps to resolve concerns. These are:

- Listen;
- Sympathise;
- Do not justify;
- Make notes;
- Agree a course of action; and
- Follow through the agreed actions.

3.3 It is appropriate and good practice to apologise on behalf of the Care Group when someone reports a poor experience. Apologies and explanations alone do not constitute an admission of liability.

3.4 If a concern or a problem is resolved to the satisfaction of the complainant by the end of the next working day, it should be recorded as a non-reportable complaint (using the template in appendix A) and forwarded to the service Lead.. It is also good practice to make a note of patients concerns, conversations and any actions taken to resolve the situation in the patient's health record.

Listening to and receiving complaints

3.5 All staff must ensure that they take time to listen to any concerns brought to their attention. They should reassure the person complaining that making a complaint will not have any adverse effect on the care and treatment of the patient.

3.6 Staff must escalate all reportable complaints to their immediate manager, the person in charge and if appropriate to the GP Director of Quality & Assurance.

3.7 If a complaint is made out of hours and staff require support with local resolution, but are unable to access their immediate manager or the Governance Team, the Site

the on-call Senior Manager should be called for support and guidance.

3.8 Complaints made verbally (reportable or non-reportable) must be recorded in writing using the template in Appendix A and a copy provided to the complainant.

3.9 On receipt of a complaint or a complaint being raised with staff verbally, wherever indicated, immediate intervention /action must be taken to ensure the safety and wellbeing of patients and that their immediate on-going care and treatment needs are met if this is necessary. The immediate safety and wellbeing of the patient must be paramount

Recording a complaint

3.10 A complaint can be made in writing, electronically, or verbally. Any member of staff receiving a complaint in person should document the details and pass them to appropriate manager for official logging.

3.11 The acknowledgement of a complaint must include confirmation of the issues raised, to ensure accuracy and confirmation of the complainant's expectations. The complainant must be consulted on how they wish their complaint to be managed whenever possible. This may include offering:

- A telephone call from a senior member of staff
- A written response from a senior member of staff
- A written response from the GP Care Group Director of Quality & Assurance or other member of the Senior Management Team

3.12 The complainant should be informed that these options are not exclusive and if they are dissatisfied with one avenue of resolution, they are entitled to escalate as detailed in the complaints process.

Complaints Involving Other Organisations

3.13 When a complaint is made to GP Care Group that includes issues about other providers the complaint must be acknowledged and a way forward agreed with the patient. The patient's permission must be sought before forwarding the complaint to the other organisation(s) for investigation.

3.14 GP Care Group will co-operate with any other providers in relation to issues about our services which may be mentioned in any complaint made to that organisation.

Complaint Investigations

3.15 All complaints must be referred to the Service Lead for the area the complaint relates to: This is

- The Director of Health Visiting Service for Health Visiting
- PMCF Manager for services related to Hub activity

Contact telephone number and email addresses can be found via the following link on the intranet
https://www.gpcaregroup.org/

3.16 The level of the investigation into a complaint will reflect the complexity of the complaint and may be undertaken by a single manager/named investigator or by a small investigatory team.

3.17. Significant or high risk complaints, which raise serious concerns about clinical information, must be investigated and escalated

3.18. If a complaint is likely to become the subject of litigation, advice will be sought from the legal team when compiling the draft complaint response.

3.19. If a complainant alleges discrimination of any kind, a copy should be sent to the Chief Operating Office or nominated representative for review and comment.

3.20. A single service specific point of contact is identified for all complainants.

3.21 Complete and accurate records must be kept and be available. These must include:

- The original complaint and other relevant information
- The issues considered
- Decisions or actions taken
- Discussions/correspondence with the complainant
- Copies of staff responses and other information collected during the investigation
- Clinical/legal advice taken and details of the advisors
- National or local policy or guidance consulted

3.22 All complaint investigations should address the underlying causes of complaints and provide clear action plans to prevent them happening again.

Preparing a response

3.23. The response to a complaint must include a summary of the investigation findings and any actions taken to resolve the problems.

3.24 The response will include the contact details for complainants to contact if they remain dissatisfied and wish to escalate.

3.25. A response to a complaint must be sent as soon as practicable. GP Care Group expects that this will be less than twenty working days for the majority of complaints. Best practice is expected and this includes:

- Contact within 1 working day via telephone to discuss and offer a face to face meeting
- If contact by telephone cannot be made a letter should be sent within 3 working days offering a meeting.
- Refer to appendix one for the complaint process flow chart

3.26 If a response is not provided or resolution of the complaint is not achieved, in the time agreed with the complainant, contact must be made with the complainant to negotiate a revised deadline. This must be documented. If the complainant does not agree to an extension and the original due date is not met the complaint is considered overdue.

3.27. If it is likely that a complaint will be overdue and the complainant has not agreed to an extension, a telephone call must be made to discuss this with the complainant or a holding letter sent five working days before the response is due. Holding letters must explain the reasons for the delay and give an indication of when a response will be available. Regular contact must be maintained with the complainant.

Local Resolution Meetings

3.28 Many complaints arise from misunderstandings or poor communication. A call/meeting will often provide an opportunity to clarify and resolve these issues, reassuring the complainant that we take their concerns seriously.

3.29 Managers are responsible for ensuring that an accurate record of any communication with a complainant is documented

Independent Review

3.30 If all avenues of resolution are exhausted or the complainant wishes to challenge a decision not to investigate a complaint outside the scope of the policy, they may request that the PHSO review their case.

3.31 Complainants must apply to the PHSO within one year of the event or no later than a year after the date on which the issue of concern came to the notice of the complainant.

3.32 Correspondence, requests and contact with the PHSO is coordinated by the named lead on behalf of the GP Care Group.

3.33 The PHSO will seek assurance and evidence that GP Care Group has done its utmost to resolve a complaint before they will review the case. The PHSO will consider aspects such as is there justice for the individual, evidence of maladministration service failures and the scope for resolving the complaint.

3.34 They will require assurance that there is: acknowledgement of the concerns, a "good" apology and where appropriate, evidence of learning or change and if there was scope and consideration of financial or other redress by the Care Group.

Redress

3.35 Redress is setting right what has gone wrong and should be proportional to the nature of failure, hardship or injustice suffered.

3.36 Redress should:

Be fair, reasonable, appropriate and tangible

Take into account the needs of the complainant

Take into account recommendations made by the PHSO
Provide as far as possible a comprehensive resolution of the issue, remembering that it may apply not only to the complainant, but others who have suffered as a result of the same failure

Redress may include:

- an apology (a tangible expression of regret)
- an explanation
- Practical action to mitigate any detriment
- Other appropriate action negotiated between the complainant and the organisation

4. Recognising Risk, Action Planning and Learning

Action plans

4.1 Complaints identified as significant or high clinical risk must have an action plan in place to manage the risk or prevent a recurrence. Senior Management teams must ensure that action plans are documented.

Risks

4.2 Where a complaints investigation reveals actual and potential risks, either clinical or non-clinical, these must be reported to the Senior Management team, who will advise on appropriate risk assessment procedures.

Learning from Complaints

4.3 GP Care Group will undertake yearly reviews of complaints, and incidents, including lessons learned and actions taken. These should be reported annually at Management Team meeting.

4.4 The organisation supports a culture of continued learning from user feedback. Feedback and trends from complaints, incidents and enquiries will be used to inform service improvement and development

Complaints Management Training

4.5 Complaint training is mandatory for all staff with patient facing responsibilities.

4.6 Staff with patient facing responsibilities are required to engage in complaint handling training. Assessing the need for training is the responsibility of Service Leads.

5. Special Issues Relating To Complaints

Unreasonable and persistent complainants

5.1 People may act out of character when in distress or unwell and staff must respond with empathy to patients who have complaints. However, staff are not expected to tolerate abusive or threatening behaviour and should refer to the Managing Abuse and Violence Policy for patients and visitors in such circumstances.

5.2 Every effort must be made to resolve a complaint before someone can be described as unreasonable. Unreasonable demands may include seeking excessive amounts of information, demanding an unrealistic level of service, inappropriately requesting financial redress or prolonging contact with the Care Group by raising new issues throughout the investigation.

5.3 Anyone who displays violent, threatening, abusive behaviour or language which causes staff to feel anxious and /or afraid or who continues to contact with demands after all aspects of the complaints process have been exhausted, may be deemed to be unreasonable.

5.4 All contact with the complainant must be recorded. Where necessary staff should consider and use the significant incident reporting process to log events and contacts.

5.5 Staff must inform senior staff and Governance staff of their concerns about an individual which should be escalated

5.6 Where a complainant is considered unreasonable the Director of Quality & Assurance and Chief Operating Office will consider the following options and agree the next steps. This may include;

Asking the complainant to sign an agreement which sets out the standards of behaviour expected

Asking the complainant to use a single telephone contact or limit their contact to written correspondence

Notifying them in writing that the GP Care Group has responded in full to their concerns and has nothing further to add, and will not enter into any further discussion

Informing the complainant that the Care Group reserves the right to pass accounts of their unreasonable complaints and or behaviour to its solicitors or the police

To temporarily suspend all contact with the complainant whilst seeking legal advice.
To implement the process set out in the Managing Abuse and Violence Policy

Complaints involving children and young adults

5.8 The NHS complaint regulations refer to a „child" as being a person who has not yet reached 18 years of age. When a complaint is made about care and treatment involving a child, it will be necessary to obtain consent from the parent or someone with legal parental responsibility for that child.

5.9 Once a child reaches the age of 16, they are presumed in law to be competent to give consent, however, it is still good practice to encourage them to involve their families in decision making.

5.10 Children under 16 are not automatically presumed to be legally competent to make decisions about their healthcare, however as the law currently stands, under the age of 16 are deemed competent to give valid consent if they have "sufficeint understanding and intelligence to enable him or her to understand fully what is proposed". If this is the case the child is classed as being competent (Fraser Guidelines).

5.11 If a child of 16 or 17 is not competent to make decisions, then a person with parental responsibility can take decisions for them. This will often, but not always be the parent of the child. The Children"s Act 1989 has set out the following as people who would have parental responsibility

- The child's parents, provided they were married to each other at the time of conception / birth
- The child's mother, but not the father if they were not married unless he has acquired parental responsibility via a Court Order; has a parental responsibility agreement; the couple has subsequently married; or the child was born on or after 1 December 2003 and the father is named on the birth certificate
- The child's legally appointed guardian, appointed by a court or by a parent with parental responsibility
- If staff are in doubt in particular cases, they should in the first instance contact the Service Lead..

Patients who may or do lack capacity to make a complaint (Mental Capacity Act)

5.12 Where a patient lacks the mental capacity as defined by the Mental Capacity Act 2005 to make a complaint about his or her care, a complaint can be made by someone acting on behalf of the patient and in their best interests. Information relating to an incapable patient may be given to the patient's nominated next of kin

or to any person acting in a legal capacity on behalf of the patient (solicitor, person with Lasting Power of Attorney relating to Health and Welfare, Court Appointed Deputy, Independent Mental Capacity Advocate.

5.13 If any concern is raised about whether the complainant is acting in the best interests of the patient or is entitled to receive information about the patient's care in response to their complaint, the issue should be referred to the Mental Capacity Lead, Legal Services Team or Information Governance lead, as appropriate.

5.14 If a decision is taken that the complainant is not acting in the best interests of the patient in making the complaint, or is not entitled to receive a response containing information about the patient, this will be notified to the complainant explaining the reasons for the decision in writing. Although the complainant will not then receive a response to the complaint, any issues of concern raised by the complainant will be forwarded to the relevant service manager who will determine whether there is any need for an investigation or action. A summary of any investigation or action taken will be documented.

Deceased complainants

5.15 In cases where the patient passes away during the complaints process, if the complainant is a relative or personal contact of the patient, it may be appropriate to keep the final response on file for a period before getting in touch, in respect for the bereavement process.

5.16 If the patient was the complainant, the Service Lead should keep the final response on file for a period (preferably until after the funeral) then contact the next of kin to offer condolences and inform them that the deceased was processing a complaint before they died.

5.17 An explanation should be provided that in the interests of sensitivity it did not seem appropriate to make contact any sooner.

5.18 Confirmation should be sought as to what the relative might like to do with the response and options sensitively explored, e.g. would they like it to be posted or would they like to come in and sit with someone so the investigation process can be explained to them and they can leave with the letter, or would they prefer not to know the outcome etc.

5.19 It might be prudent and helpful to undertake initial background checks to make sure there are no on-going inquest or incident issues with the GP Care Group about the deceased's care.

5.20 It is also best practice to deal with complaints related matters after the patient's funeral.

6. Roles and Responsibilities

6.1. The GP Care Group Directors are responsible for ensuring that the right systems are in place to manage and resolve complaints. The Directors have responsibility for monitoring themes and ensuring actions for complaints activity.

6.2 Workstream Leads/Complaints Lead

- Lead on complaints management within their area.
- Ensure that action is taken to address issues raised in complaints and provide evidence of improvements.
- Ensure that staff within their area are aware of, and understand, the Complaints Policy.
- Ensure the application of the Complaints Policy within their area and establish a mechanism through which performance management in complaints handling can be evaluated.

6.3 Service Desk / Work stream Areas

- Providing a single point of contact for people who have complaints about the service within their area
- Ensuring that staff in the area are aware of the complaints policy and work within local guidelines
- Ensuring that all complaints are accurately recorded, acknowledged and the handling negotiated with the complainant including timescales for
- responding
- Co-ordinating complaint investigations within the area and support the named investigator to draft a response
- Ensuring the timely investigation of complaints and that responses are sent by the date agreed with the complainant
- Ensuring action plans are developed for high or significant risk complaints
- Assisting staff involved in complaints to access support
- Undertaking regular analysis and reporting of complaint themes to ensure that services respond to user feedback
- Responding to all review requests for information within the deadline
- Ensuring that recommendations arising from review of complaints and internal actions are communicated, implemented and followed up.
- Providing skills based training in resolving user concerns, preventing complaints and managing the process as appropriate

6.4 The investigator

- An investigator will have responsibility for facilitating the complaint investigation and preparing a draft response, with the support of their manager.
- The investigator will review the complaint and agree issues, methods and timescales to be responded to, identifying any gaps and/or additional issues.
- The investigator will plan and undertake the investigation: The investigation may include:
  - Identifying key staff involved

- Collection of statements
- Informal discussion with staff.

- On completion of the investigation, the investigator will draft an action plan if appropriate to resolve issues raised in the complaint. This will be monitored by the workstream leads.

6.5 Senior Management Team

The Senior Management Team has overall responsibility for the process of complaints management and application of the complaints policy. It assures the work of the Workstreams in relation to complaints. They do this by:

- Mediating and making final decisions when there is confusion regarding complaints management or the application of this policy
- Providing advice and support to all staff regarding complaints handling and management
- Quality assuring complaint responses and providing feedback and guidance on the standard of letters.
- Carrying out programme wide analysis of complaint themes
- Providing a monthly complaints' performance report
- Undertaking an annual audit of the complaints process and themes identified
- Acting as a point of contact
- Tracking and monitoring performance of complaints handling ensuring concerns are escalated and action is taken when needed
- In conjunction with others, ensuring that the action plans arising from complaints are written, implemented and the learning is shared.

6.6 It is the responsibility of all staff to:

- Work to resolve any concerns expressed by users
- Escalate to their manager any concerns which cannot be resolved locally or where the complainant indicates that they wish to make a complaint

7. Monitoring the effectiveness of the Complaints Policy

7.1 Workstream Leads are responsible for monitoring the application of this policy within their area and, by exception, escalating any concerns about complaints management.

7.2. It is the responsibility of Workstream leads to monitor completion of actions arising from complaints, and to report to the Senior Management Team any actions/recommendations which cannot be implemented.

7.3 Trends and learning needs arising from complaints are included in the yearly report. This report will be reviewed by the Senior Management Team and shared with other members as appropriate.

7.4 Monitoring the application of the policy will include:

- compliance with agreed time scales
- The quality of investigations and responses
- The implementation of recommendations arising from complaints

7.5 An annual audit of the complaint process will include:

- A review of the number and nature of complaints raised
- Complaints that have been reported to external partners or referred for independent review
- Whether complaints have been investigated at an appropriate level
- Whether appropriate actions have been agreed following investigations
- Whether actions have been implemented
- Whether complaints have been directed to the appropriate workstream in the first instance
- Whether appropriate steps have been taken to promote learning as a result of complaints

7.6 Compliance with mandatory training in relation to complaints is monitored by the Workstream Leads.

Dissemination, Implementation and Access to this document

8.1. Managers throughout GP Care Group will be notified of the approval of this policy via group mail alert and are required to cascade this information.

8.2. The policy will be publicised and made available on the shared drive and THGPCH Intranet.

8.3 The policy will be brought to the attention of all staff, by managers, as part of their local induction.

Appendix One

Flow Chart for Complaints Procedure