DHC Complaints Policy and Procedure

Introduction

This procedure sets out our approach to the handling of patient complaints. It is intended as an internal guide which should be readily available to all staff. A summary setting out the approach to complaint handling is also be available at reception for any patient requesting a copy (see the document *DHC Complaints Procedure – Patient Leaflet* available from Reception or in the *Essential Info* folder of the staff network).

Our procedure complies with the NHS common approach to the handling of complaints.

Responsible Person and Complaints Manager

Every practice must appoint a 'Responsible Person' whose job is to ensure compliance with the complaints regulations. This person must be a partner in the contract, but is permitted to delegate their practical responsibilities. It is also essential to appoint a Complaints Manager, responsible for handling and considering any complaints. This role may be carried out by the 'Responsible Person' or by an individual who is not a Practice employee. Practices are also permitted to share complaints managers if a full-time, one-practice role is not considered necessary. Complaints Managers can also delegate their practical responsibilities.

At Didcot Health Centre these roles are filled as follows:

Responsible Person - Dr David Stainthorp, Senior Partner
Complaints Manager - Dr Jackie Mercer, General Manager

There is no requirement for the complaint to be sent to the CCG (Oxfordshire Clinical Commissioning Group) or NHS England and no funding is provided for any costs arising from the complaints process. It is a contractual obligation for practices to follow the complaints procedure and any failure to do so could be considered a breach.

Policy

The Practice will take reasonable steps to ensure that patients are aware of:

- the complaints procedure copy (see the document ***DHC Complaints Procedure – Patient Leaflet*** available from Reception)
- the time limit for resolution
- how it will be dealt with
- who will deal with it
- lead GP handling complaints
- a complainant's right of appeal
- further action they can take if not satisfied
- the fact that any issues will not affect any on-going treatment from the surgery and they will continue to be treated.

Procedure

Who can make a complaint?

A complaint can be made by:

- a patient
- a former patient who is receiving or has received treatment at the practice
- anyone who has been affected by an action, omission, or decision of the practice that led to the complaint.

In some cases a complaint may be made by a third party acting on behalf of someone else. For example, when:

- the individual has died
- the individual is a child
- the individual is physically or mentally incapable of making a complaint
- the individual asks a third party to make a complaint on their behalf.

Where a complaint is made by a third party on a patient's behalf, the consent of the patient must be obtained. See Appendix 3 – ***Complaints: Third Party Consent Form***.

When a complaint is made by a third party on behalf of a child or individual lacking mental capacity, we must be satisfied that:

- there are reasonable grounds for this method of representation
- the third party is genuinely acting in the best interests of the individual.

If the practice is not satisfied that this is the case, we will inform the representative in writing, stating the reasons for this decision.

There is concern that in opening up the complaints system to individuals with indirect involvement there is potential for abuse of the system. While it is important that the complaints procedure does not prejudice those with legitimate grievances, it should also protect GPs from the possibility of malicious accusations. The Practice will inform our LMC (local medical committee) if we encounter any apparent misuse of the complaints system.

Period within which complaints can be made

The period for making a complaint is normally:

a) within 12 months of the date on which the event which is the subject of the complaint occurred; or

b) within 12 months of discovering the problem which is the subject of the complaint.

If, however, there are good reasons for a complaint not being made within these timescale detailed above, consideration may be afforded to investigating the complaint if it is still feasible to

investigate the complaint effectively and fairly. Should any doubt arise, further guidance should be sought from NHS England by the complaints manager.

Action upon receipt of a complaint

The importance of dealing with a complaint swiftly and effectively is clear. Swift resolutions are good for the image of the practice and for avoiding bureaucratic burdens. It is always better to try and deal with the complaint at the earliest opportunity and often it can be concluded at that point.

Verbal complaints

If an oral complaint is dealt with to the complainant's satisfaction within 24 hours then it will not be necessary to embark upon the formal complaints process. A simple explanation and apology by senior staff at the time may be all that is required.

A verbal complaint need not be responded to in writing for the purposes of the Regulations if it is dealt with to the satisfaction of the complainant by the end of the next working day, neither does it need to be included in the annual Complaints Return. The practice will however record them for the purposes of monitoring trends or for Clinical Governance and that record will be kept and monitored by the General Manager. Verbal complaints not formally recorded will be discussed when trends or issues need to be addressed at least annually, with minutes of those discussions kept.

If resolution is not possible, the Complaints Manager will set down the details of the verbal complaint in writing and provide a copy to the complainant within three working days. This ensures that each side is clear about the issues for resolution. The process followed will then be the same as for written complaints.

Verbal complaints

On receipt, an acknowledgement will be sent within three working days which offers the opportunity for a discussion (face-to-face or by telephone) on the matter. This is the opportunity to gain an indication of the outcome the complainant expects and also for the details of the complaint to be clarified. In the event that this is not practical or appropriate, the initial response should give some indication of the anticipated timescale for investigations to be concluded and an indication of when the outcome can be expected.

It may be that other bodies (e.g. secondary care or community services) will need to be contacted to provide evidence. If that is the case, then a patient consent form will need to be obtained at the start of the process and a pro-forma consent form included with the initial acknowledgement for return.

If it is not possible to conclude any investigations within the advised timescale, then the complainant must be updated with progress and revised time scales on a regular basis. In most cases these should be completed within six months unless all parties agree to an extension.

Investigating a complaint

Before an investigation can begin, it is important to assess the seriousness of the complaint. Even if a complainant does not wish to pursue an issue, the Practice must assess whether there is merit or

benefit to be gained from investigating the issue in order to be satisfied that there is not a problem. Complaints are part of a learning process to assist in the improvement of the service we provide.

The Practice will use the BMA's ***Investigating complaints toolkit*** (Appendix 1) in order to determine the seriousness of the issue. We will then follow the BMA's ***Complaints process flowchart*** (Appendix 2) to investigate the issue.

The investigations will be recorded in a complaints file created specifically for each incident and where appropriate will include evidence collected as individual explanations or accounts taken in writing.

Final Response

This will include:

- an apology if appropriate (The Compensation Act 2006, Section 2 expressly allows an apology to be made without any admission of negligence or breach of a statutory duty)
- a clear statement of the issues, investigations and the findings, giving clear evidence-based reasons for decisions if appropriate
- where errors have occurred, these will be fully explained and state what will be done to put these right, or prevent repetition
- a focus on fair and proportionate outcomes for the patient, including any remedial action or compensation
- a clear statement that the response is the final one, or that further action or reports will be sent later
- a statement of the right to escalate the complaint, together with the relevant contact details
- advice on the next step in the process if the complainant is still not satisfied. This may include an offer of a meeting with the Lead GP and General Manager to try further reconciliation but must also advise the patient that they may wish to approach independent arbitration for support.

After this should the complainant still be dissatisfied they may contact seAp, the independent Complaints Advocacy Service that works closely with Healthwatch in this area. seAp can arbitrate between both sides to seek a mutual agreement. This often takes time but can be very helpful having a third person review the matter. If at this point resolution is still not achieved then either side can refer the matter to the Health Service Ombudsman.

The final letter should not include:

- Any discussion or offer of compensation without the express involvement and agreement of the relevant defence organisation(s)
- Detailed or complex discussions of medical issues with the patient's representative unless the patient has given informed consent for this to be done where appropriate.

Unreasonable or vexatious complaints

Where a complainant becomes aggressive or, despite effective complaint handling, unreasonable in their promotion of the complaint, some or all of the following formal provisions will apply and will be communicated to the patient:

- The complaint will be managed by one named individual at senior level who will be the only contact for the patient
- Contact will be limited to one method only (e.g. in writing)
- A time limit will be placed on each contact
- The number of contacts in a time period will be restricted
- A witness will be present for all contacts
- Repeated complaints about the same issue will be refused
- We will only acknowledge correspondence regarding a closed matter; the Practice will not respond to it
- Set behaviour standards will be applied
- Irrelevant documentation will be returned
- Detailed records must be kept.

Annual Review of Complaints

The practice will produce an annual complaints report to be sent to the local Commissioning Body (NHSE) and will form part of the Freedom of Information Act Publication Scheme.

The report will include:

- Statistics on the number of complaints received
- The number considered to have been upheld
- Known referrals to the Ombudsman
- A summary of the issues giving rise to the complaints
- Learning points that came out of the complaints and the resulting changes to procedure, policies or care.

Care must be taken to ensure that the report does not inadvertently disclose any confidential data or lead to the identity of any person becoming known.

What happens when a complaint is made to NHS England?

If a complaint is made to NHS England about the practice, NHS England will seek permission from the complainant to share details of the complaint with the practice. If permission is not granted, the complainant will be informed that the matter cannot be taken further.

The DH guidance encourages NHS England to pass complaints to the practice to be dealt with. This can be done with the permission of the complainant and at this point the complaint would be considered to have been made to the practice itself. However, NHS England is permitted to take on the investigation itself, on behalf of the complainant. It is essential that NHS England takes a consistent approach to the complaints system.

There are currently no specifications for how NHS England should make the decision on whether or not to investigate a complaint themselves. The BMA advises that in such cases a Practice should contact the LMC if they feel they are being treated unfairly or inappropriately, and LMCs should inform the BMA if they have concerns that this matter is being addressed inadequately or inappropriately. The LMC should ask NHS England to openly set out their policy on how this decision will be made. This process should be open and transparent with the criteria used being consistent and non-prejudicial.

The Parliamentary Ombudsman

If unsatisfied with how the complaint is dealt with at practice level, a complainant may choose to take the matter to the Health Service Ombudsman. However they cannot do this simply because they are unsatisfied with the outcome; they must be able to provide reasons for their continued dissatisfaction and demonstrate that they are suffering continuing hardship or injustice, or that there is a reasonable prospect of achieving a worthwhile outcome.

The ombudsman can then make a decision on whether or not the practice needs to carry out further investigations. The ombudsman can also decide to take on the complaint fully.

If the ombudsman does become involved in the case, it may be wise to seek advice from our defence organisation / LMC.

Annual Review of Complaints

The Practice will establish an annual complaints report, incorporating a review of complaints received, along with any learning issues or changes to procedures which have arisen. This report is to be made available to any person who requests it, and may form part of the Freedom of Information Act Publication Scheme (refer to our Practice ***Freedom of Information Policy***).

This will include:

- statistics on the number of complaints received
- justified / unjustified analysis
- known referrals to the Ombudsman
- subject matter / categorisation / clinical care
- learning points
- methods of complaints management
- any changes to procedure, policies or care which have resulted.

Confidentiality

All complaints must be treated in the strictest confidence. Where the investigation of the complaint requires consideration of the patient's medical records, the Complaints Manager must inform the patient or person acting on his/her behalf if the investigation will involve disclosure of information contained in those records to a person other than the Practice or an employee of the Practice.

The Practice must keep a record of all complaints and copies of all correspondence relating to complaints, but such records **must be kept separate from patients' medical records**.

Things to consider

- When a complaint is made on behalf of a child, the practice must be satisfied that there are reasonable grounds for the complaint being made by this individual rather than the child. The practice must also be satisfied that the complaint is being made in the best interests of the child. If the practice is not satisfied that this is the case, written notification of this decision must be sent to the representative.
- A separate file must be kept for complaints records and letters. Under no circumstances should these be filed in a patient's medical records.
- Any complaint resolved by the practice via the formal complaints procedure should be kept on record for 10 years. This is the same length for litigation.
- Complaints can be made up to 12 months after the incident that gave rise to the complaint, or from when the complainant was made aware of it. Beyond this timescale it is at the Practice's discretion whether to investigate the matter.
- When a complaint is made on behalf of a child, the practice must be satisfied that there are reasonable grounds for the complaint being made by this individual rather than the child. The practice must also be satisfied that the complaint is being made in the best interests of the child. If the practice is not satisfied that this is the case, written notification of this decision must be sent to the representative.
- In the event that a complainant has raised major issues but does not want a full investigation, the Practice should investigate fully even if the complainant does not wish to be informed. The issues may not be of interest to the complainant, but the investigation could be extremely important for the future of the Practice.
- It is necessary for practices to seek an agreement from locums that they will participate in the Complaints Procedure if required to do so. As complaints can be made to the Practice up to a year after the reason for the complaint, it is possible that complaints will arise where the locum GP has moved on.
- The Practice should ensure that locums involved in the complaints process are given every opportunity to respond to complaints and it is important that there is no discrepancy between the way the process treats locums, salaried GPs or GP partners.

Seeking advice from LMCs and defence organisations

If there are any concerns about the way that a complaint issue is handled, even if seems to be a simple problem, support can be sought from the Local Medical Committee and our Medical Defence organisation.

Resources:

Appendix 1 Investigating complaints toolkit (BMA risk assessment)

Appendix 2 Complaints process flowchart *

Appendix 3 Complaints: Third Party Consent Form

See also:

DHC Complaints Procedure - Patient Leaflet *

* These documents must be read and understood by all employees of the Practice

Appendix 1

Investigating complaints toolkit

Step 1: Decide how serious the issue is

Seriousness	Description
LOW	Unsatisfactory service or experience, not directly related to care. No impact or risk to provision of care. OR Unsatisfactory service or experience related to care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
MEDIUM	Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Justifiable complaint. Some potential for litigation.
HIGH	Significant issues regarding standards, quality of care, and safeguarding of, or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity. OR Serious issues that may cause long-term damage, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.

Step 2: Decide how likely the issue is to recur

Likelihood	Description
Rare	Isolated or one-off – slight or vague connection to service provision
Unlikely	Rare – unusual but may have happened before
Possible	Happens from time to time – not frequently or regularly. May occur again at some time but only occasionally.
Likely	Will probably occur several times a year
Almost certain	Recurring and frequent, predictable

Step 3: Categorise the risk

Seriousness	Likelihood of recurrence				
	Rare	Unlikely	Possible	Likely	Almost certain
Low	Low				
		Moderate			
Medium			High		
High				Extreme	

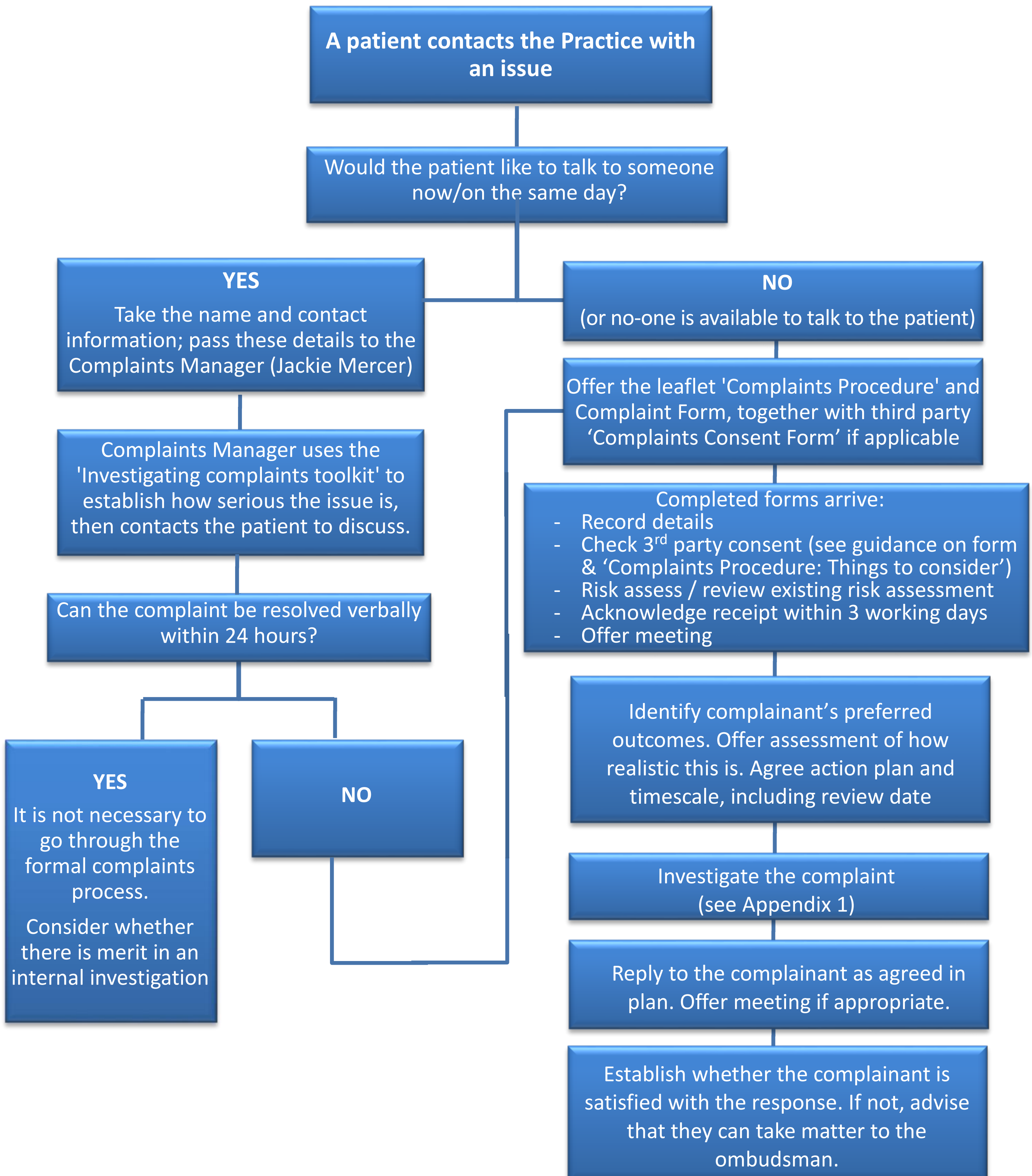
Examples that are low, moderate, high or extreme risk			
Low **(**simple, non-complex issues**)**	**Moderate** **(**several issues relating to a short period of care)	**High** **(**multiple issues relating a longer period of care, often involving more than one organisation or individual**)**	**Extreme** **(**multiple issues relating to serious failures, causing serious harm)
Delayed or cancelled appointments. Event resulting in minor harm (e.g. cut, strain). Loss of property. Lack of cleanliness. Transport problems. Single failure to meet care needs Medical records missing. Staff attitude or communication.	Event resulting in moderate harm. (e.g. fracture). Delayed discharge. Failure to meet care needs. Miscommunication or misinformation. Medical errors. Incorrect treatment.	See moderate list. Event resulting in serious harm (e.g. damage to internal organs).	Events resulting in serious harm or death. Gross professional misconduct. Abuse or neglect. Criminal offence (e.g. assault).

Step 4: Deciding the best course of action

Low
Front line staff response, verbal or written. Possible involvement of PALS Offer advocacy to complainant Consider financial redress Consider seeking advice from LMC/defence organisation Time scale to be negotiated
Medium
Practice manager/GP investigates (possibly involve senior partner or another partner if complaint about senior partner) Notify PCT complaints manager Advice from LMC/defence organisation Meeting with complainant Offer advocacy to complainant Offer conciliation/mediation Written response directly from practice or with PCT covering letter Consider financial redress Follow-up call to complainant to ensure resolution Time scale to be negotiated
High
Discuss with PCT complaints manager Offer advocacy to complainant Consider financial redress Seek advice from LMC/defence organisation Involve designated partner (or another partner if complaint about designated partner) External involvement in the investigation, may include external clinical advice – compulsory for single handed practices (e.g. PCT complaints manager, another GP practice, independent investigator) Meeting/direct contact with complainant before investigation Meeting/direct contact with complainant after investigation Offer conciliation/mediation Send a written response directly from practice or with PCT covering letter Ask for a review of complaint file by local PCT or another PCT Involve the responsible officer for the GMC affiliate Significant event procedure Time scale to be negotiated
EXTREME
Discuss with PCT complaints manager Offer advocacy to complainant Consider financial redress Seek advice from LMC/defence organisation Involve designated partner (or another partner if complaint about designated partner) External investigation – compulsory for single handed practices (e.g. PCT complaints manager, another GP practice, independent investigator) Meet /direct contact with complainant before the investigation Meet/direct contact with complainant after investigation Offer conciliation/mediation Send a written response via PCT Ask for a review of complaint file by local PCT or another PCT Involve GMC affiliate responsible officer Significant event procedure Time scale to be negotiated

Appendix 2 **Didcot Health Centre**

Complaints process flowchart



Appendix 3

Complaints: Patient third party consent form

Please read 'DHC Complaints Procedure – Patient Leaflet', and in particular the section 'Complaining on behalf of someone else'.

If you are complaining on behalf of a patient, or your complaint or enquiry involves the medical care of another, then the consent of the patient will be required. Please obtain the patient's signed consent below.

Patient's full name ....

Patient's date of birth ....

Address: ....

....

....

Patient's telephone number ....

Patient's email address ....

Enquirer/Complainant's name ....

Address ....

....

Telephone number ....

Third party's email address ....

Declaration by the patient

I fully consent to my doctor releasing information to, and discussing my care and medical records with the person named above in relation to this complaint only, and I wish this person to make a complaint on my behalf.

This authority is for an indefinite period / for a limited period only (delete as appropriate)

Where a limited period applies, this authority is valid until .... (insert date)

Signed *(patient only)* ....

Date ....