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Complaints Policy & Procedure

1. Introduction and Purpose

The GP Care Group (the organisation) is committed to consistently provide the highest possible standards of care to patients. It is acknowledged that, from time to time, patients, or their representatives, may have cause for concern. The organisation is therefore committed to ensuring that any individual who wishes to seek advice or information, raise concerns or make a complaint about the services the organisation provides, is listened to and supported.

Patients, and their representatives, need to know how to raise their concerns and to feel confident that their issues will be taken seriously. It is important that these individuals also feel confident that their feedback is positively welcomed by the organisation and that they are encouraged to speak up whenever standards of care and service fall below their expectations. Complaints and concerns are an important source of information about services and the organisation recognises that they represent a valuable opportunity; to learn from any mistakes made, to prevent recurrences in the future and to help evaluate and improve future service delivery.

This policy sets out the principles and framework for the handling of complaints received by the organisation.

This policy ensures that the organisation meets the requirements of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014 (specifically, Regulations 16 and 20 of the CQC fundamental standards that require all care providers to have appropriate mechanisms for the "receiving and acting on complaints" and that "Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to patients in carrying on a regulated activity"), and the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The organisation is also guided by the recommendations and best practice identified by, but not limited to:

- Report of The Mid-Staffordshire NHS Foundation Trust Public Inquiry. February 2013 (The "Francis" Report).
- Principles of Good Complaint Handling, the Parliamentary and Health Service Ombudsman.

February 2009.

- My expectations for raising concerns and complaints, The Parliamentary and Health Service Ombudsman, Healthwatch and Local Government Ombudsman. November 2014.
- A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture. Final Report. Right Honourable Ann Clwyd MP and Professor Tricia Hart, October 2013.
- Good Practice standards for NHS Complaints Handling, Patients Association. September 2013.
- Complaint Standards. Parliamentary and Health Services Ombudsman. December 2022.

(See full list of relevant references at Appendix 3).

The purpose of this policy is to provide assurance and information to people wishing to raise a concern or make an enquiry about the services provided by the organisation and to provide guidance to staff on how such matters are reported, managed, investigated and responded to, by the organisation.

2. Scope

This policy applies to all users of organisational services, and their representatives, and to all individuals employed by the organisation, including contractors, voluntary workers, students, locums and agency staff.

3. Definitions

Complaint	An expression of dissatisfaction about an act, omission or decision made by the organisation, in relation to a named patient or service provided by the organisation, either verbal or written, whether justified or not, which requires a written response.
Concerns	A written or oral expression of dissatisfaction that can be resolved without the need for formal investigation or correspondence.
PHSO	The Parliamentary and Health Service Ombudsman provide an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments.
PSII	In the Patient Safety Incident Response Framework (PSIRF), a PSII stands for Patient Safety Incident Investigation. It is the most in-depth and comprehensive type of "learning response" used within the PSIRF framework when a patient safety incident or near-miss indicates significant patient safety risks and potential for new, systemic learning. PSIIs focus on understanding *how* and *why* incidents occurred from a systems perspective, rather than blaming individuals, with the aim of identifying actions to improve safety and prevent recurrence.
Representative	As described in this policy, a representative can be any of the following: • A family member, • A carer, • A professional NHS Complaints advocate (as commissioned by the Local Authority), • Any individual nominated by the patient to act on their behalf, • An MP, acting on behalf of their constituent.

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

4. The Policy Aim

The aim of this policy is to ensure there is a systematic approach to the process of resolving complaints and concerns and responding to enquiries made to the organisation.

The organisation is committed to responding openly and sensitively to complainants from our patients, and their representatives. The feedback gained from the complaints process will be used to further improve the quality of the care and services provided by the organisation.

The organisation's commitment is that all frontline staff are empowered to resolve minor concerns and problems, and respond to comments and feedback, from patients and their representatives, through an immediate response in an open and non-defensive way.

However, when it is not possible to resolve concerns locally, other processes are available. If any member of staff receives a complaint they should inform their Line Manager immediately and also liaise with the Complaints Officer.

This policy aims to ensure that all complaints and concerns received by the organisation are consistently, fairly and effectively handled by all staff. When dealing with complaints we aim to:

- Offer opportunities to resolve concerns and complaints at department or service level, without recourse to the formal complaints process, wherever possible.
- Ensure patients, and their representatives, receive the information they need to understand the process.
- Provide reassurance that if errors have occurred, everything possible will be done to ensure lessons learned will help prevent the incident recurring.
- Ensure openness and transparency throughout the complaints and concerns process, complying with Duty of Candour Regulations (2013).
- Investigate complaints thoroughly and effectively in a timely manner.
- Keep complainants informed of the progress of investigations
- Ensure we are logical and rational in our approach to investigating
- Where complainants escalate their complaint externally because they are dissatisfied with the local outcome, we will cooperate with the process.
- Provide a level of detail that is proportionate to the seriousness of the complaint.
- Ensure all patients, and their representatives, healthcare professionals and managers feel supported during any complaint investigation.
- Generate quantitative and qualitative complaints data to support learning and service improvements within services.
- Develop a culture where complaints are seen as opportunities to learn and improve.

5. Roles and Responsibilities

Chief Executive – the "Responsible Person"	The Regulations require that the organisation designates "a responsible person, to be responsible for ensuring compliance with the arrangements

	made under these Regulations, and in particular ensuring that action is taken if necessary in the light of the outcome of a complaint." In the case of NHS organisations, the responsible person is "the person who acts as the Chief Executive Officer." However, "the functions of the responsible person may be performed by any person authorised by the responsible body to act on behalf of the responsible person" and so the Chief Executive can nominate another Executive to act on their behalf.
Directors	The Directors are responsible for ensuring that the correct systems are in place to manage and resolve complaints. The Directors have responsibility for monitoring themes and ensuring actions from complaints activity.
The Board	Responsible for the ratification of the organisation's Complaints Policy and the organisation's Annual Report on Complaints. Also receives regular updates on themes and learning from complaints, concerns, compliments and other stakeholder enquiries.
Complaints Officer / Governance Support Manager	The Regulations require that the organisation designates "a person, in these Regulations referred to as a Complaints Manager, to be responsible for managing the procedures for handling and considering complaints in accordance with the arrangements made under these Regulations". In this organisation this is the Governance Support Manager. In the absence of the Governance Support Manager an authorised person will act on their behalf. The Governance Support Manager is responsible for: • overall management of the complaints process, • ensuring these functions reflect the organisation's objectives and values and actively enhance the organisation's reputation, • overseeing the generation of a range of reports from complaints data and themes, to support services to identify failures and make service improvements. • ensuring that there are systems for

	safeguarding that complainants are not discriminated against as a result of raising a complaint, • ensuring the organisation co-operates with other agencies in the co-ordination and communication of joint complaints, • ensuring they are accessible to the public and to all staff for advice, training and support, • Act as first point of contact for complainants, acting in a professional and compassionate way. They will liaise between complainants and frontline staff, ensuring that lines of communication are open and everyone involved knows the timescales/progress of the investigation. • Ensure contemporaneous and accurate records are maintained for every complaint/concern, on Datix, in line with organisational procedure. • They refer formal complaints to the appropriate Department dependent upon the subject of the complaint. • They record all data relating to complaints, and concerns on Datix, and ensure this is fully maintained throughout the life of the individual case, with all relevant case information (including lessons learnt and follow up actions) entered accurately and in a timely manner to support accurate data extraction. • They build good working relationships with staff across the organisation, and provide guidance and support to Departments and individual members of staff throughout the process as required
Senior Service Leaders	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.

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.

Senior Service leads are responsible for:

- Empowering staff to respond to issues at a local level.
- Appointing appropriately skilled investigation leads, ensuring that complaints are investigated thoroughly, by an individual independent from the service area being complained about.

	• Ensuring that all learning is agreed and communicated appropriately. • Ensuring that any changes in practice (as a result of a complaint) are actioned. • Ensuring that actions from complaints are implemented in a timely manner.
Investigating Officer	The staff member, as appropriate to the issues raised and not employed in the area in which the concern originates, who has been nominated to undertake an investigation, and produce a final response, in line with organisation procedure: • Liaise with the complainant to fully understand the scope and nature of the complaint and identifying any issues which are not immediately obvious. They will continue to act as a point of contact for the complainant until completion of the case. • They will attempt to resolve the complaint, to the complainant's satisfaction, at an early point. • Where necessary, they will undertake a thorough and objective investigation, looking at all relevant records, and using techniques proportionate to the issues raised, including root cause analysis, staff interviews, statements, and obtaining advice from subject experts where necessary. The investigation must be supportive and fair to those involved and take an "open" approach. • Produce a final response letter, detailing the nature of the investigation, their findings (explained in layman's terms), offering appropriate apologies, and identifying any appropriate learning and the actions being taken. • Drafting an action plan if appropriate to resolve issues raised in the complaint. This will be monitored by the workstream leads. • Liaise with the team leader of the area complained about and agree the learning and actions which are to be taken and timeframes in which these will be

	completed. • Arrange local quality review and sign off of their draft response and respond to any issues identified. • Maintain contemporaneous and accurate records on Datix, in line with the organisational procedure, ensuring that all data fields are completed in full, to support accurate data analysis.
Organisation Employees (including contractors, voluntary workers, students, locums and agency staff)	All employees have a responsibility to try to locally resolve any concerns expressed by a patient, or their representative, on the spot. When this is not possible, or where the individual indicates they wish to make a formal complaint, they must escalate these to their line manager and the Complaints Officer. All employees will co-operate fully in the reporting, handling and investigation of complaints. This may include providing statements in a timely manner or attending meetings. All employees are responsible for the effective implementation of the policy. This includes: • They deal with any issues courteously and efficiently. • They keep good quality records. • 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 plans 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. • Attending / releasing staff for relevant training events.

6. Who can make a complaint

Complaints can be made by anyone who has used the organisation's services and facilities, or is their representative and has the appropriate authority to do so (see Consent). Complaints can also be raised by a person who is affected by, or likely to be affected by, an action, omission or decision of the organisation.

However, the organisation is not statutorily obliged to investigate complaints received from a responsible body, for example a local authority, NHS body, primary care provider or independent provider, unless there was an element of shared care across the boundaries (see Joint Complaints).

Complaints raised by an employee about any matter relating to their employment are excluded and should follow the appropriate Human Resources policies and procedures.

Complaints relating to non-compliance with requests for information under the Freedom of Information Act 2000 are also excluded and should be passed to the FOI team for action.

6.1. Consent and Authority to Act

All patients have an absolute right to their information being treated in confidence at all times, including after their death. As such the organisation has a responsibility, under the Data Protection Act (2018), to ensure that it only shares confidential information when the patient has given their explicit consent or their representative is able to evidence they have appropriate authority to act on their behalf.

1. **Complaints about the care of a child**
    - The NHS complaint regulations refer to a "child" as being a person who has not yet reached 18 years of age, as such it will be necessary to obtain consent from the parent or someone with legal parental responsibility for that child.
    - However, once a child reaches the age of 16, they are presumed in law to be competent to give consent, and so it is still good practice to seek their consent to share information.
    - 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 "sufficient 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).
    - If a child of 16 or 17 is not competent to make decisions, then a person with parental responsibility can take decisions for them.
2. **Complaints about the care of a patients who lacks capacity**
    - Where a patient lacks mental capacity, as defined by the Mental Capacity Act 2005, a complaint can be made by their representative in their best interests. Information relating to an incapable patient may be given 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).
    - 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.

- 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.

3. **Complaints about the care of a deceased patient**
    - Where a patient is deceased a complaint can be made by their representative. Information relating to the deceased patient may be given only to an individual who has authority to act (the executor of their estate or a beneficiary of their estate).

4. **Complaints where the complainant passes away during the complaints process**
    - In the very rare occasion when this occurs the Complaints Officer will, in the first instance, attempt to identify if any other individual could act on behalf of the complainant, being mindful of the bereavement process. For example, if the complainant was the patient, contact could be made with their nominated next of kin, making them aware of the complaint and offering to share the findings at an appropriate time. Where the complainant was acting on behalf of the patient, it would be appropriate to keep the final response on file for a period before getting in touch with the family.

However, lack of consent, or appropriate authority to act, does not prevent an investigation into the events described. If a serious incident is alleged this must be investigated (Francis Report, 2013). However, without appropriate consent the findings of that investigation cannot be shared with the third party. A summary of the investigation and the action taken will be documented.

6.2. Advocacy support for complainants

The Local Authority commission independent advocacy support for NHS patients, and their representatives, who wish to pursue a complaint about NHS treatment or care.

The purpose of this service, as it relates to NHS Complaints, is to empower patients by providing information, support and guidance, helping them to articulate their concerns and navigate the system. This may include assistance with constructing a complaint letter or attending meetings. The service also supports the principle of local resolution and aims to help patients find a solution as close as possible to the point of the service that has caused dissatisfaction, maximising the chances of the complaint being resolved quickly and effectively.

Given the nature of this organisation, which provides care to people from a large geographical area, there are a number of applicable advocacy services. The applicable advocacy service is identified based on the patient's home address.

The organisation also wishes to ensure equal access to the complaints process for all, regardless of any protected characteristics. The organisation therefore will make reasonable adjustments to accommodate access to the complaints process where the Governance Support Manager is made aware of the complainant's needs. Examples may include provision of an interpreter (when the complainant's first language is not English or they are deaf), printing correspondence in large font, holding meetings in accessible locations, etc. However, this may require some advance notification to arrange.

6.3. Ensuring that patients and their representatives are

not adversely affected

The organisation is committed to ensuring that complainants feel confident that their care, or that of the person they represent, will not be adversely affected, as a result of having made a complaint.

The organisation expects staff:

- to treat patients, and their representatives, with respect at all times;
- to behave professionally towards the patient, or their representative, and not take them to task for their decision to raise concerns;
- to ensure that the patient's on-going health needs are being met;
- to ensure that any investigations do not impact negatively on the patient;
- to never display any form of discrimination towards the patient, or their representative, as a result of a complaint being raised;
- to never refuse to provide care or treatment, or discharge a patient from care, as a result of a complaint being raised;
- to never blame the patient.

Any failure to meet these expectations may result in disciplinary action or referral to the appropriate professional body.

It is not always possible for the complainant to receive the outcome they hoped for however, if they feel that their complaint has been handled appropriately and that they have had a fair hearing, this is a positive outcome.

7. Time Limits for Making a Formal Complaint

Under The Local Authority Social Services and NHS Complaints (England) Regulations 2009, the organisation is not statutorily obliged to investigate a complaint if it is received more than 12 months after the date on which subject of the complaint occurred or 12 months after the date on which the matter came to the notice of the complainant.

However, the organisation can apply discretion if it is satisfied that the complainant had good reasons for not making the complaint within that time limit and that it is still possible to investigate the complaint effectively and fairly. The time limit should therefore be applied sensitively and with flexibility according to the seriousness of the incident (for example if a Serious Incident or mortality review indicates harm has been caused and Duty of Candour is instigated, a representative may then raise a legitimate complaint regardless of the timeframe).

If the decision is taken not to investigate the complaint, on the grounds of being out of time, this decision will be communicated by investigating Officer/complaints officer to the complainant in writing as soon as possible.

8. Joint Complaints

In accessing NHS Services, patients, and their representatives, do not necessarily recognise the boundaries of health and social care organisations. Concerns, complaints and enquiries may relate to more than one area of health and social care, emphasising the need for partnership work across organisations and the need

to focus on the patient's journey or pathway of care.

The organisation will work across organisational boundaries to ensure they do not create a barrier to the resolution of issues for patients. The exchange of information between the organisation and other agencies will be underpinned by the informed consent of the patient or their representative.

If the complainant wishes a coordinated response it must also be agreed which organisation will lead the process.

9. Procedure

The Regulations covering both health and adult social care complaints was reformed in April 2009 and updated in 2015. Since that point a significant number of documents describing best practice have been issued (see details at Appendix 3).

These recommend that organisations and the person complaining agree on the best way to handle the complaint to achieve a satisfactory outcome. Note that both concerns and complaints can be made verbally, in writing or electronically via email.

9.1. Local Resolution of Concerns

All staff are encouraged, and empowered, to try 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. Staff should adopt an ethos of "if I can fix it, I will", and try to prevent concerns from escalating unnecessarily.

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.

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

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 concern (using the template in appendix A) and forwarded to the Service Lead. It is not appropriate to make a note of patients concerns, conversations and any actions taken to resolve the situation, in the patient's health record as this may lead to sub-conscious bias in future dealings with the patient.

9.2. Complaints – Receipt and Recording

A complaint can be made in writing, electronically, or verbally.

Any member of staff receiving a complaint in person should take time to listen, document the details using the template (if face to face they will provide a copy to the complainant), and escalate to their immediate

manager, the person in charge and to the Governance team (thgpcg.complaintsandfeedback@nhs.net), to ensure this is officially logged. If a complaint is made out of hours and staff require support, where their line manager is not available, the on-call Senior Manager should be called for support and guidance.

If the complaint is raised verbally, and there is any indication that the safety or wellbeing of the patient is compromised, immediate intervention /action must be taken to ensure the safety and wellbeing and that their immediate on-going care and treatment needs are met where this is necessary.

Following receipt of the complaint it is a requirement of the regulations that this is acknowledged within three working days. The acknowledgement of a complaint must include confirmation of the issues raised, to ensure accuracy and confirmation of the complainant's expectations, details of how to access advocacy and confirmation of the single service specific point of contact for their complainant.

9.3. Complaint Investigation

The complainant should also be contacted at the outset of the investigation, by the Investigation Lead, to ensure that they have a shared understanding of the issues to be investigated. Ideally this should occur within one working day however, if contact by telephone cannot be made a letter should be sent within three working days providing contact details and offering a telephone conversation or meeting. This is also an opportunity to consult the complainant 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 responsible member of the Senior Management Team / Director.

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.

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

- The relevant Head of Service for Health Visiting, Family Nurse Partnership and School Health.
- The Head of Primary Care & Development for services related to Extended Hours Hub activity
- Service Managers for individual services.

The level of 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.

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

If a complainant alleges discrimination of any kind, a copy should be sent to the Deputy Director of Governance and Nursing, or nominated representative, for review and comment.

Complete and accurate records must be kept in a secure folder by the Governance team 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

1. **Support for Staff**

   The organisation recognises it can be extremely distressing for staff when they are subject to a complaint investigation and they may require additional support throughout the process.

   Service leads, line managers and heads of department have a responsibility to ensure that their staff are appropriately supported which may include: support from their line manager or professional lead, the opportunity to access professional advice from their relevant professional body or union, confidential staff support service, staff counselling service or occupational health service. Staff should be kept informed about the progress of an investigation, and provided with information about the process and how they will be expected to contribute.

9.4. Preparing the Response

The written response will be in the form of a letter and signed by the relevant Executive Director for the service. The key elements are as follows:

- Confirmation of how, and via which format, the complaint was received.
- Condolences, where this is appropriate.
- An apology for their poor experience resulting in their need to raise a complaint.
- Confirmation of the rationale for sharing information, when the complainant is a third party (eg when consent received, or acting on a Lasting Power of Attorney, or complainant having parental responsibility for a child, etc)
- For each issue of concern:
    - Investigation – what information was looked at, who was spoken to, etc
    - Explanation – the findings, and where a process was not followed, what should have occurred
    - Apology – where this is appropriate – specific to the issue that has gone wrong
    - Learning – clear action plan of how the organisation will learn from this incident
- Overarching apology
- Details of what to do if they remain dissatisfied and how to contact the Ombudsman

The response to a complaint must be sent as soon as practicable, and should be less than twenty working days for most complaints. If the response is delayed, contact must be made with the complainant to negotiate a revised deadline. If it is not possible to discuss this with the complainant a holding letter should be sent five working days before the response is due, detailing the reason for the delay and providing an indication of when a response will be shared. 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.

Regular contact must be maintained with the complainant.

9.5. Local Resolution Meetings

Where the complainant has agreed to a meeting to respond to their concerns it is important that the correct staff are available. It is therefore important, prior to any meeting, in response to a formal complaint, that the issues for discussion are agreed and that an investigation into these issues is undertaken in advance, as this will support the decision making around the appropriate attendees.

The Governance Support Manager will support the arranging of such meetings ensuring staff availability and a suitable location for the meeting. The Investigation Lead should act as Chair for the meeting.

Following the meeting a complaint response letter, including the following elements, will be shared with the complainant.

- Thanking the complainant for their attendance at the meeting, confirming the date, time and attendees.
- Condolences, where this is appropriate.
- Confirmation of the rationale for sharing information, when the complainant is a third party (eg when consent received, or acting on a Lasting Power of Attorney, or complainant having parental responsibility for a child, etc)
- A summary of the discussions during the meeting
- Apology – where this is appropriate – specific to the issue that has gone wrong
- Learning – details of how the organisation will learn from this incident.
- Details of what to do if they remain dissatisfied and how to contact the Ombudsman

The meeting letter must be sent as soon as practicable, and ideally within five working days of the meeting.

10. Effectiveness of the Complaints Policy

There are a number of indicators of effectiveness of the Complaints process.

10.1. Quality

The organisation is committed to providing high quality complaint responses and has a number of quality assurance processes. These include the expectation that:

- the process will be accessible and simple to follow
- the complainant will have felt heard
- the complainant will have felt informed and have access to information on sources of support
- the response will be timely and proportionate
- the response will be written in simple terms that are easy to read and understood
- all the issues have been fully addressed
- the response is compassionate and honest
- the response demonstrates how failings have or are being addressed
- the response highlights how learning is being shared.

The Governance Support Manager is required to have robust monitoring of the complaints function in place, to be able to provide the Board (via QSG) with assurance that the complaint's policy is functioning appropriately, and that the systems and processes described are being adhered to.

10.2. Dissatisfied Complainants

A complainant may sometimes remain dissatisfied with the organisation's investigation, response and/or action following receipt of the response. This is a good indicator of the quality and effectiveness of the complaints process.

If a complainant contacts the organisation request further information or stating that they are dissatisfied with the response provided, the Governance Support Manager will review the case file. If there are further issues or new issues, a new case will be opened. If the complaint response has inaccuracies, the case will be reopened and these will be independently reviewed by a senior manager.

If the organisation believes that they is nothing further to add to the investigation and response, the complainant will be advised of how to contact the PHSO for an independent review. Please see section 11 for further details on the Reopened Complaints and Escalation to the Parliamentary and Health Service Ombudsman (PHSO) process.

10.3. Monitoring

Monitoring of this policy is the responsibility of the Directors. Monitoring of the policy will be via audit and local reviews and will report into the Quality and Safety Committee.

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

- Review of trends and learning needs arising from complaints
- The compliance with agreed time scales
- The quality of investigations and responses
- The completion of actions arising from complaints, and to report to the Senior Management Team any actions/recommendations which cannot be implemented
- The implementation of recommendations arising from complaints
- Compliance with mandatory training in relation to complaints

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.

11. Reopened Complaints and Escalation to the Parliamentary and Health Service Ombudsman (PHSO)

This section outlines the circumstances under which a complaint may be reopened by the Care Group, the process for referring complainants to the PHSO, and the internal approval process for responses to reopened complaints. When to Reopen a Complaint

11.1. When to Reopen a Complaint

The organisation recognises that there may be exceptional circumstances where a complainant feels that their concerns have not been fully addressed, even after receiving a formal response. While the GP Care Group aims for resolution at the initial stage, a complaint may be reopened in the following situations:

- **Significant New Information:** Where the complainant provides substantial new information that was not available or considered during the initial investigation and that could materially alter the outcome or findings of the complaint.
- **Procedural Flaw:** If there is clear evidence that a significant procedural flaw occurred during the original complaint investigation that fundamentally impacted the fairness or thoroughness of the process (e.g., relevant evidence overlooked, key witnesses not interviewed).
- **Identified Deficiencies in Original Response:** Where the GP Care Group, upon internal review or further reflection, identifies clear deficiencies or omissions in its original response that warrant further investigation or clarification. This does not include a complainant simply disagreeing with the outcome.
- **Agreement for Re-examination:** In rare instances, and at the discretion of the Head of Clinical Governance or a senior manager, where further engagement with the complainant is deemed necessary to achieve a satisfactory resolution, and a re-examination of specific aspects of the complaint is agreed upon.

The decision to reopen a complaint rests with the Head of Clinical Governance, in consultation with relevant clinical or operational leads. A full rationale for the decision, whether to reopen or not, will be clearly documented and communicated to the complainant. Reopening a complaint does not automatically imply a change to the original findings but signifies a commitment to further review in light of the new information or identified issues.

11.2. Referral to the Parliamentary and Health Service Ombudsman (PHSO)

If a complainant remains dissatisfied with the organisation's response after the initial investigation, or following a decision not to reopen their complaint, they have the right to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO). 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. Where the Ombudsman identifies any shortcomings they will require that the organisation provide redress to the complainant, setting right what has gone wrong, in a manner that is proportional to the nature of failure, hardship or injustice suffered, which may include, but is not limited to, an apology, an explanation,

identification of the action being taken to prevent the situation being repeated, and financial redress.

The PHSO is an independent body that investigates complaints about the NHS in England. The Care Group will:

- **Inform Complainants:** Clearly inform complainants of their right to escalate their complaint to the PHSO in all formal complaint response letters. This will include providing the PHSO's contact details and a brief explanation of their role.
- **Cease Internal Investigation:** Once a complainant has formally referred their complaint to the PHSO, the organisation's internal complaints process for that specific complaint concludes. The Care Group will cooperate fully with any investigation undertaken by the PHSO, providing all requested documentation and information in a timely manner.
- **Respect PHSO's Jurisdiction:** Recognise that the PHSO will only consider complaints where the NHS organisation's internal complaints procedure has been exhausted. Therefore, the Care Group will ensure its process is complete before advising a complainant to approach the PHSO.

11.3. CEO Sign-Off for Reopened Complaint Responses

To ensure the highest level of scrutiny and accountability for complex or sensitive cases, all formal responses to reopened complaints must be signed off by the Chief Executive Officer (CEO) of the organisation.

This requirement reflects the significance of such complaints and ensures that the most senior leadership is fully aware of the issues raised, the actions taken, and the final position of the organisation. The CEO's sign-off signifies the Care Group’s comprehensive and considered response to the escalated concerns. The Governance Support Manager or Head of Clinical Governance will ensure that the CEO receives a comprehensive briefing, including a summary of the original complaint and response, the reasons for reopening, the findings of the renewed investigation, and the proposed final response, prior to seeking approval.

12. Integration with other investigation processes

There are also occasions when a complaint is appropriate but the issues identified would be better investigated via alternative routes. These might include:

Where a complaint is deemed to be a Patient Safety Incident requiring a Patient Safety Incident Investigation Learning Response as set out in the organisation's PSIRF policy.

- An investigation under the PSIRF policy will be undertaken, ensuring that all issues, identified by the complainant, are incorporated. The organisation will ensure that the complainant is aware of this and has access to a Family Liaison Officer (FLO) who will support them during the investigation process and will ensure they are advised of the findings.
- Where a complaint relates to matters that need to be investigated under the Disciplinary Policy and as such will involve leadership by the HR department.
- Where the complaint raises concerns over the safeguarding of anyone involved in the complaint. In this case advice would be immediately sought from the Organisation's Safeguarding Team.
- If matters described by the complainant require investigation by the police (an alleged, or actual criminal offence) all complaint investigations will cease immediately until advised it is appropriate

to do so by the police to ensure that any criminal investigation is not compromised. If this occurs, the Complaints Officer will notify the complainant in writing that an investigation is not possible at this time.

The Complaints Procedure should not cease if the complainant indicates an intention to take legal action in respect of the complaint. It should also not be assumed that a complaint made via a solicitor means that the complainant has decided to take legal action. If proper consent has been received, which shows that the solicitor is acting as the patient's representative, a response should be provided in the normal manner.

Should formal legal correspondence be received, commencing a claim, then the complaint investigation will continue, as both processes should continue in parallel, however the lead for corporate governance and legal and the Complaints Officer must ensure that all correspondence is reviewed to ensure nothing contradictory is released.

Similarly, if a Coroner's investigation is commenced, the complaint will continue in parallel, and the Governance manager will liaise with the Complaints Officer to ensure no contradictory information is released. They will also ensure that any requests for additional information or a request to extend the investigation (from the Coroner) are responded to appropriately.

13. Access to Records

It is not uncommon for complainants to request access to, or copies of, the relevant health records during the complaints process.

This must be done in conjunction with the Data Protection Act (2018). If the patient is deceased, access to the health records will be dealt with under the Access to Health Records Act (1990).

All requests relating to such a request will be processed by the Data Protection Act (DPA) Administrator, upon receipt of the completed request form, with the appropriate supporting documents.

14. Duty of Candour

Everyone working for the organisation has a legal responsibility to be honest, open and truthful in all their dealings with patients and the public. This is laid out in the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 Regulation 20, which states "Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to patients in carrying on a regulated activity".

All NHS Organisations are required to tell patients, or their representatives, if their safety has been compromised in a way that has resulted in moderate (non-permanent) harm and/or severe (permanent) harm and/or death.

In relation to the complaints function of the organisation this is twofold:

- Firstly, all responses to complaints must be honest, open and truthful.
- Secondly, if as the result of a complaint investigation it is identified that a patient's safety has been compromised, they (or their representative) must be advised in line with Duty of Candour.

It is the responsibility of the staff member who identifies the harm to escalate appropriately.

15. Learning from Complaints

Good complaints handling is not limited to providing a response or remedy to the complainant; it should focus on ensuring that the feedback received through complaints is used to learn lessons and contribute to service improvement.

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.

A Just and Learning culture in the organisation also enables everyone to contribute to a fair, safe and compassionate environment. It is a culture that asks and curiously enquires into "what" happened, not "who" did what when an incident has occurred and promoted accountability, learning and support in equal measure. We will work together to be open with each other when things go wrong to feel supported and empowered to learn rather than feeling blamed.

The organisation philosophy is to encourage organisational learning through sharing knowledge and lessons learnt from complaints. This will be fed back to organisation staff via a number of sources including:

- Team meetings,
- Action plans,
- Safety briefs,
- Organisation bulletins,
- Individual learning and reflection,
- Team learning and reflection,
- "Sharing the Learning" seminars where case studies are presented,
- Dashboards,
- Training programmes
- Appraisal data

Lessons learnt and safety lessons identified are also disseminated via the quality and governance committee structures.

To support this all 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.

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.

The organisation will undertake quarterly reviews of complaints, including lessons learned and actions taken. These should be reported on at the Quality, Safety and Governance Committee (QSG).

16. Complaints Management Training

The organisation is committed to supporting staff to receive, respond and investigate complaints appropriately. Staff with patient facing responsibilities are required to engage in complaint handling training. Assessing the need for training is the responsibility of Service Leads.

17. Managing unreasonable complainant behaviour

It is acknowledged that a small number of complainants may act in a manner which would normally be described as unreasonable, difficult or persistent, or which is driven by their clinical condition. These individuals demonstrate complex behaviours for several reasons and may be unaware that their behaviour is causing unnecessary distress to others

The organisation is committed to protecting and supporting the staff, who are subjected to complex, demanding or abusive (verbally and/or physically) people. It is intended to provide a supportive framework in which the views and needs of people can be managed in an effective way in line with their rights to be heard and their responsibilities to behave in an acceptable way.

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 organisation by raising new issues throughout the investigation.

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 also be deemed to be unreasonable.

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.

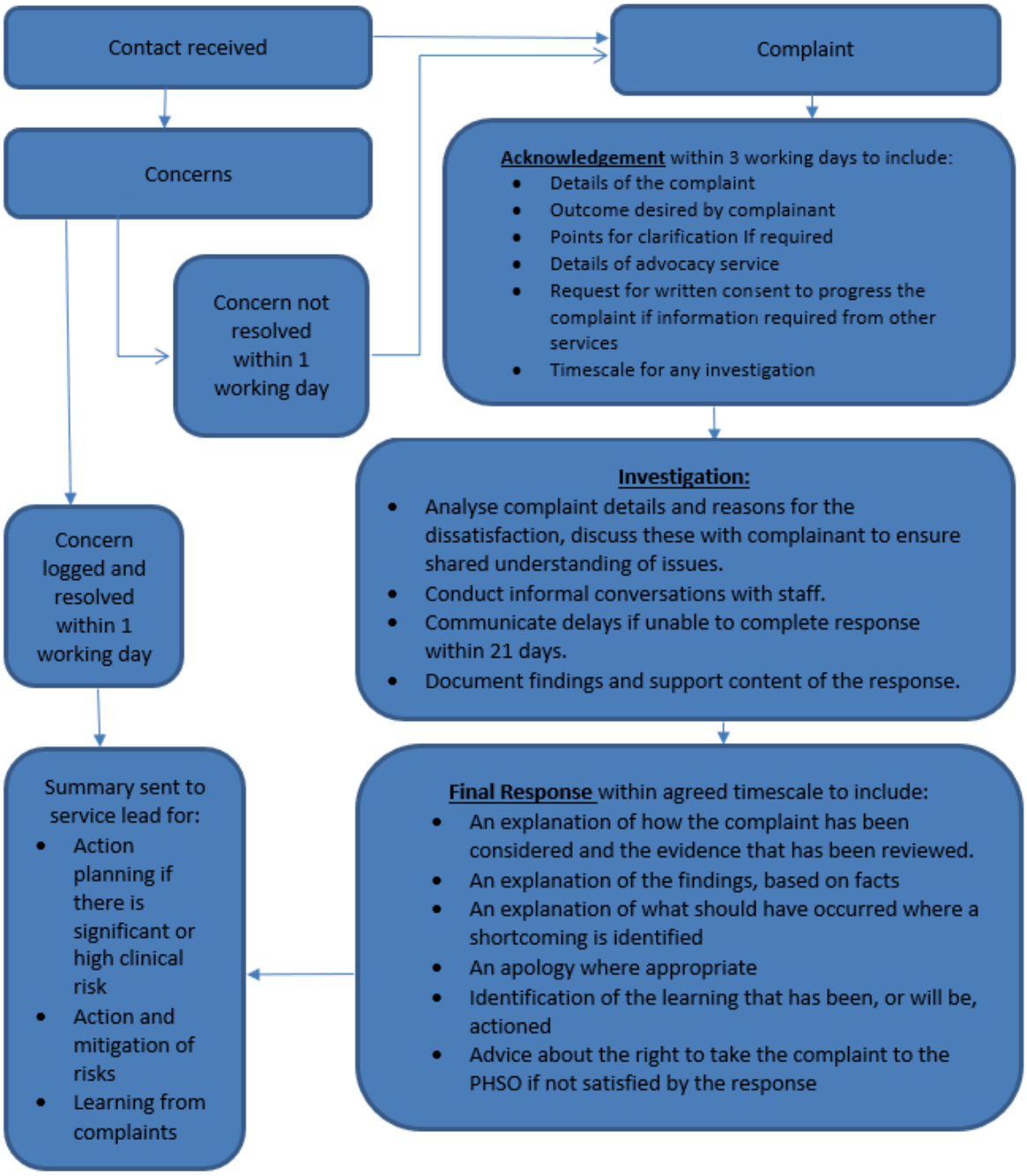
Staff must inform senior staff and Governance staff of their concerns about an individual which should be escalated

Where a complainant is considered unreasonable the Deputy Director of Governance and Nursing, alongside the relevant Executive Director of the service, 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 organisation 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 organisation 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.

Appendix 1 - Flow Chart for Complaints

Procedure



Appendix 2 - Guidance For investigators

Complaint Received from member of staff.

Request details of the immediate actions taken and log this locally.

Has this complaint been resolved within 1 day?

Yes -maintain record, note themes, and disseminate any learning. Noting the informal complaint as closed.

No-Forward on to the Governance support manager, thgpcg.complaintsandfeedback@nhs.net and follow guidance below:

1. Detailing any further information. The investigator would be a service manager or clinical lead, often the line manager of the clinician/staff involved who was responsible for supporting the patient or who has had the last interaction with the patient.
2. The governance support manager will support in listing points made from the complaint, this will form the basis of the response, ensuring every point in their initial complaint letter has been responded to.
3. The investigator is responsible for providing a GPCG response to each point of complaint, this may be educational, clarification or an acknowledgement for an area for improvement and what actions/ lessons learnt have been developed.
4. The investigator may wish to engage with the clinician/staff involved and gather further information. A reflective template **Reflective Practice Template - New Version.docx** may be used to support the conversation and further details of how to have this conversation are outline in this document as well as sing posting support for staff.
5. Engagement with staff should be done in a timely manner allowing staff time to respond and the importance of a response should be clearly communicated.
6. Within 21 working days the investigator needs to have collated all the information, sent this on to the Governance support manager and outlining the basis for the response.
7. Should the investigator wish to call the complainant this can be discussed with the governance team. This is the role of the investigator to lead this conversation, support can be sought from the Executive Director of Clinical Strategy & Governance.
8. Lessons learnt should be logged for the service and actioned accordingly, sharing with the team in a team meeting as well as the clinician involved.
9. If the clinician would like to utilize their reflective template and response for their revalidation/CPD this is acceptable, and the governance support manager will redact and patient information.

Appendix 3 – References

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Appendix 4 - Equality Impact Assessment

Ensuring that all patients and their representatives can access the complaints process.

Appendix 5 – Template for documenting Concerns and Complaints

Not attached – but mentioned in original policy.

Attachments

Appendix 1: Flow Chart for Complaints Procedure

Approval Signatures

Step Description	Approver	Date
QSG	Christopher Norton: Deputy Director of Governance and Nursing	11/2025
Executive Review	Vicky Scarborough	09/2025
Initial Review	Rachel Seery: Head of Clinical Governance	08/2025

Initial Review	Christopher Norton: Deputy Director of Governance and Nursing	07/2025
Policy Owner	Rachel Seery: Head of Clinical Governance	07/2025