Policy for
Complaints, Concerns and Compliments

Document Details	
SUBJECT	Policy for Complaints, Concerns and Compliments
DOCUMENT TYPE	Policy
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VERSION	Version 1.1
SUMMARY	This policy details the process to manage serious incidents
RELEVANCE	All staff
Approval Process	
CONSULTATION	Clinical Governance Chief Exceutive Officer Example policies from NHS/Charity organisations
BUSINESS AREA	Governance
POLICY OWNER	Caroline Raynsford - Head of Clinical Governance
AUTHOR	Caroline Raynsford - Head of Clinical Governance
RATIFIED BY	Integrated Governance Committee
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METHOD	Via email, Patient Handbook and access to QCS
Links	
Required by CQC	Yes
Other Policies or documents	Incident Reporting Policy Safeguarding Policy Serious Incident Policy Duty of Candour Policy

1.1. CONTENTS

Version Control Sheet

Version	Date	Author	Status	Comment
1	9/9/17	Caroline Raynsford	Draft	Sent to CEo for approval
1.1	06/10/17	Caroline Raynsford	Requires final ratification	Submitted to IGC on 8.10.17 & approved

1. SCOPE

HFH Healthcare is firmly committed to continuously improving the quality of care and services it provides. One of its aims is to ensure the satisfaction of its patients and their families. It therefore encourages the views, comments and suggestions of its patients their relatives and all other users of the service provided by HFH Healthcare.

Any patient or member of their family/ circle of friends who is dissatisfied is entitled to voice their comments, concerns or complaints and to have them taken seriously, properly investigated, explained and resolved. This will be achieved through errors being acknowledged, an apology being made where appropriate and lessons being learnt. The aim will always be to resolve the complaint locally to the satisfaction of all involved.

This policy applies to anyone using the services including:

- The patient
- Someone acting on behalf of the patient, (e.g. an advocate, relative, friend, Member of Parliament, visitors or external agencies.)

2. AIM/PURPOSE

The purpose of the Complaints Policy is to provide a system which is non-discriminatory and accessible to all people of all backgrounds, including potentially marginalised groups such as those with learning disabilities, physical disabilities or from culturally and linguistically diverse backgrounds to ensure that:

- People who are dissatisfied with the service they are able to voice their grievance and to receive a response to their concerns.

- Complaints are efficiently and effectively managed within the service, which includes auditing the process in order to monitor and improve performance and provide feedback to the organisation including the Board.

- Where appropriate lessons are learnt and action is taken to improve the quality of the service and care

- HFH Healthcare operates an effective, fair and rapid complaints response service

- The complaints service is consistent with all relevant legislation and best practice guidance

- Staff involved in complaints prevention, handling or resolution have been appropriately trained and supported

3. DEFINITIONS

3.1 The Complaint is any expression of dissatisfaction which requires a response. It is defined as an issue that is raised about the service, or the experience of the patient/relative, about which the complainant is seeking resolution. It can be submitted in the following ways: in a letter, an e-mail; and/or take the form of a verbal comment made in person or over the telephone.

3.2 Concern: An expression of dissatisfaction (written or verbal) about a service provided or which is not provided which requires a response, but is resolved to the complainant's satisfaction within **three working days**.

3.3 Recordable compliment: Expressions of appreciation by letter, card, gift or donation. Letters of appreciation / compliments as well as acknowledgment letters should be reported to the Clinical Governance team. Verbal compliments are not recorded in the overall statistics, although these compliments should be reported to the appropriate line manager and the service or member of staff recognised as a result.

3.4 The "Complainant" is the person making the complaint, whether on behalf of themselves or another.

4. INFORMAL CONCERNS VERSUS FORMAL COMPLAINTS:

Informal Concern: An informal concern or enquiry may be received in writing or verbally, which requires staff to take action on a local level in order to remedy the situation. This may take the form of clarifying the situation or/and taking action to remedy the problem. An informal concern is resolved promptly, ideally within 24 to 48 hours and does not require a formal written response.

All staff have a responsibility to inform the person in charge[1] of any informal concern.

The person in charge is responsible for attempting to resolve the concern at local level (by explanation, action, and/or apology). The person dealing with the concern should:

- Ensure that the patient's immediate health care needs are being met before doing anything else.
- Listen to what the concern is and check that the issue has been correctly and fully understood
- Offer an explanation and if appropriate offer an apology for the events leading up to the concern being raised
- Explain the actions that will be taken as a result of the concern.
- Check that the individual who raised the concern is satisfied.
- Document the concern raised, the explanations/apology and actions taken to resolve the concern.

[1]For the purpose of this policy person in charge is defined as a person who is, at the time, managing the area where the complaint has arisen.

- In the event of the concern being successfully resolved, the information forwarded to the Clinical Governance team. This should be done within 72 hours following the concern being raised.
- The Governance team will enter the informal concern information into the database for the purpose of concurrent audit and monthly analysis.

It is important to remember that it will not always be possible to resolve all concerns immediately and some will progress to a formal complaint.

- In the event of the person in charge not being able to resolve the informal concern to the satisfaction of the person raising the concern, within 3 working days or agreed timescale, the person in charge should seek support from the line manager to resolve the concern.
- If the manager is not successful in resolving the concern informally the person raising the concern needs to be informed of HFH'Healthcare formal complaints procedure.
- The manager must inform the relevant manager and the Clinical Governance team that the informal concern has progressed to a formal complaint with details of the staff allocated to investigate the formal complaint.

3.4 Formal Complaint: A formal complaint is usually (but not necessarily) written.

- A formal complaint is one that cannot be resolved immediately and will usually require investigation. All formal complaints require a written response usually from the relevant Head of Department or relevant Director, and this management process distinguishes the formal complaint from the informal concern.

There are three potential stages to the formal complaints process:

- **Stage 1 -Local Resolution**
  Stage 1 is usually dealt with by the relevant Head of Department or the Director
- **Stage 2 – Complaint Review**
  Stage 2 is usually dealt with by the Chief Executive who is impartial to the complaint.
- **Stage 3 –The Local Government Ombudsman**
  Where complainants are disattified by the response received from stage 1 and stage 2 they should contact their Local Government Obudsman who can undertake an external investigation.

Complainants cannot access Stage 3 until they have gone through Stages 1 and 2.

5. RESPONSIBILITIES

- The Chief Executive is responsible for ensuring that an effective and appropriate system exists to manage all complaints. This responsibility has been delegated on a day to day basis by the Clinical Governance team overseen by the Directors.

- Heads of Departments or the Directors are responsible for the operational delivery of the complaints system within their areas.

- All managers are responsible for the effective implementation of the complaints policy, in particular by enabling a full and analytical investigation into the issues

raised, ensuring that complaints are responded to within the prescribed timetable, ensuring that the relevant organisational learning from the complaint is implemented and releasing staff for relevant training events.

- The Clinical Governace team, is responsible for operating an effective, responsive complaints management system. This includes recording and acknowledging all complaints, ensuring that thorough investigations are conducted by appropriate staff members, and that appropriate, full responses are sent to the complainant within the agreed time frame

- The Investigating Manager ensures that a full investigation into the complaint is carried out. This must be completed within **25** working days. "*The best plans for dealing with complaints are developed with input from those who make them" ([2]DH 2009)* Thus it is essential that the person making the complaint is fully listened to so that the investigating manager is clear from the start about what exactly is being investigated.

- All staff have a role to play in ensuring that as far as possible their attitude, approach or behaviour do not give patients/relatives cause for complaint, that they deal with any issues courteously and efficiently, (including keeping good quality records), and that they refer on to an appropriate manager if the limits of their authority or experience is exceeded

6. CONTENT OF FORMAL COMPLAINTS PROCEDURE

All staff receiving a formal complaint (usually written but may be verbal) are responsible for forwarding the complaint to the relevant Head of Department or Director, at the earliest opportunity (maximum 1 working day). No other action is acceptable. The Head of Department or Director will in turn inform the Clinical Governance team and the Chief Executive.

The Head of Department / Relevant Director will allocate a suitably qualified and experienced manager to investigate the complaint but will retain overall responsibility for the quality and content of the investigation and complaint response. The timescale for addressing a formal complaint is set out below.

Formal Complaint timescale ***STAGE 1 – Local Resolution***	***Timescales***
Acknowledgement letter to complainant from the Clinical Governance team	Within 1 working day of receipt of complaint letter
The relevant Head of Department to notify the Commissioners/Funders of the complaint. Where relevant /appropriate the Clinical Governance team will inform CQC under the agreement of the Chief	Within 5 working days of receipt of complaint letter

[2] "Listening, Responding, Improving; A guide to better customer care" DH 26th Feb 2009

Exceutive.	
Investigating manager to commence and complete investigation into complaint	Within 20 working days of receipt of complaint letter
If unable to complete investigation a holding letter is sent by the Clinical Governance team.	Within 15 working days of receipt of complaint letter
Investigating manager to complete summary report with recommended actions and learning	Within 2 working days of completing the investigation
Complete investigation, and send response letter to complainant. In the event that the Complainant is dissatisfied with the response to their complaint, the response letter should contain signposting to the next stage of the complaints procedure. Complainants should also be informed that, should they wish to escalate their complaint to Stage 2, they must do so in writing, addressed to the Chief Executive at HFH Healthcare, within 6 months of the final response to the complaint at Stage 1.	Within 25 working days of receipt of complaint letter

Formal Complaint timescale ***STAGE 2 Complaint Review***	***Timescales***
Acknowledgement letter to complainant from the Clinical Governance team	Within 1 working day of receipt of complaint letter
Relevant Head of Department to notify the Commissioners/Funders of the complaint. Where relevant /appropriate the Clinical Governance team will inform CQC under the agreement of the Chief Exceutive.	Within 5 working days of receipt of complaint letter
Investigating manager to be appointed – this will either be the Chief Executive or will be appointed by the Chief Executive and usually a Director that has not been involved in handling of the complaint at stage 1. The Investigating manager will review all of the documentation and may interview staff involved, to form an independent view on the handling of the complaint.	Within 20 working days of receipt of complaint letter
If unable to complete investigation a holding letter is sent by the Head of Clinical Governance.	Within 15 working days of receipt of complaint letter
Investigating manager to complete summary report with recommended actions and learning	Within 2 working days of completing the investigation
Complete investigation, and send response letter to	Within 20 working days of

complainant. The letter should contain signposting to the next stage of the complaints procedure which means explaining their right to an independent external adjudication of their complaint, and the timescales for doing this. Requests for independent external adjudication should be made to Local Government Ombudsmen in writing, within 6 months of receipt of the Stage 2 decision letter. Requests for independent external adjudication will be allowed outside this timeframe only in exceptional circumstances.	receipt of complaint letter

Formal Complaint timescale ***STAGE 3 External Adjudication***	***Timescales***
If after stage 2 of the complaint process the complainant remains dissatisfied with the response the complainant has a right to ask for an independent adjudication. Complainants should be advised to contact: The Local Government Ombudsman www.lgo.org.uk advice@lgo.org.uk 0300 061 0614	 Within a year of the complaint

CQC

Complainants may also wish to share their experience with the Care Quality Commission (CQC). Although the CQC cannot look into complaints about health care or social care services, they are still happy to hear from patients/relatives if they are dissatisfied about the care they receive. Complainants should be advised to contact the Care Quality Commission on 03000 616161, email enquiries@cqc.org.uk or at their website: www.cqc.org.uk

Investigation Tool

The following questions have been developed to provide a tool to assist the investigating manager to clarify what is being investigated:

a. What should have been provided or what was expected?

b. What was provided and what actually happened?

c. Is there a difference between the questions asked in (a) and (b)?

d. If the answer is yes, why? And what was the impact?

e. If the answer is no why does the complainant perceive otherwise?

f. What should be done to put things right?

g. What should be done to avoid a reoccurrence?

[3](DH 2009 advice sheet)

If a patient is involved they must where possible be spoken to, and their opinion on what occurred established as soon as possible On occasions an external interpreter may be required to assist in communicating if the patients has communication difficulties.

In addition staff may need to be interviewed and produce written statements. The guidance document on[4]" Statements /Advice guides by Royal College of Nursing can be referred to help staff members produce a statement.
The clinical notes may need to be reviewed, in addition to any risk assessments and clinical guidelines.

When the investigation is complete:

- Forward the documented report of the findings of the investigation to the responsible Head of Department and the relevant Director.
- During the investigative process the investigating manager can seek advice and guidance from any relevant senior manager or clinician and/or the Governance team.
- The response letter to the complainant must be sent within **25 working days** from the date of receipt of the complaint. The relevant Director will write the response letter with the support of the Clinical Governance team, following review of the investigation report and discussion with the investigating manager.
- In the event of a delay in the investigating process, the Investigating Manager must inform the Clinical Governance team of the reasons for the delay. The Clinical Governance team will send a holding letter informing the complainant of the delay, the reason for it and when they can expect a response.
- Where improvements in services are identified as a result of investigating the complaint an action plan should be drawn up to evidence implementation of service improvements. (see appendix 1)

Depending on the outcome of the investigation, if this involves the conduct of an employee, it may be necessary to proceed with the disciplinary process as per HFH Healthcare policy. In such an occurrence the investigating manager should consult with the Human Resources department.

Staff support:

[3] "Listening, Responding, Improving; A guide to better customer care" DH 26th Feb 2009

[4] Guidance on Writing and Preparing a Statement".

Serious complaints can be distressing for staff members who are subject to the complaint. It is important that they have access to appropriate support from their line manager or other senior colleague during such an investigation.

HFH Healthcare will provide debriefing sessions for staff as necessary during the investigative process. The debriefing is delivered by a member of staff not involved in the investigation.

Meeting a complainant:

If a meeting is arranged with the complainant, the investigating manager will ensure that an appropriate time and setting for the meeting has been arranged, that enough time for discussion has been allowed and that the complainant has been advised they can bring a friend, relative or member of an external agency such as an advocate to the meeting. The complainant will also be informed of the relevant HFH Healthcare personnel who will be present at the meeting.

Following the meeting the investigating manager will write to the complainant summarising what was said and agreed in the form of a letter. The aim will be to close the complaint with this formal written letter of response and the text of the letter should indicate this.

The need to maintain appropriate written, dated and signed records at all stages of the complaints process cannot be stressed highly enough.

Closure of a Formal Complaint:

Once the final letter of response has been sent from the relevant Director the complaint is closed by the Clinical Governance team if no further correspondabnce is received by the complainat within 30 days.

Persistent and Unreasonable Complaints

Complainants (and/or anyone acting on their behalf) may be deemed 'unreasonably persistent complainants' where they meet two or more of the following criteria.

- Persist in pursuing a complaint where the complaints procedure has been fully and properly implemented and exhausted.
- Change the substance of a complaint or continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues significantly different from the original complaint. These might need to be addressed as separate complaints).
- Are unwilling to accept documented evidence of care given as being factual, example medication records, clinical manual or computer records, or deny receipt of an adequate response in spite of correspondence specifically answering their questions or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of staff and, where appropriate, the independent advocate to help them specify their concerns, and / or where the concerns identified are not within the remit of the organization to identify.
- Focus on a trivial matter where the extent of focus is out of proportion to its significance and then continue to focus on this point. (It is recognised that determining what a 'trivial' matter is can be subjective and careful judgement must be used in applying this criteria).
- Have in the course of addressing a registered complaint, had an excessive number of contacts with HFH Healthcare placing unreasonable demands on staff. (A contact may be in person or by telephone, letter, email or fax. Discretion must be used in determining the precise number of 'excessive' contacts; applicable under this section, using judgement based on specific circumstances of each individual case).
- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognize that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They should document all incidents of harassment).
- Display unreasonable demands or patient / complainant expectations and fail to accept these may be unreasonable (example – insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).
- If any part of covert or overt recordings of the patients consultation is disclosed to a third party without the prior consent of the other recorded parties, then depending on the nature and the context of such disclosure, a criminal offence may be committed, civil legal action may be taken, or a breach of the DPA may occur**.**

If the above criterion is fulfilled after agreement with the Chief Executive Officer, the following procedure should be implemented by either the Clinical Governance team or other designated senior managers:

- Inform the complainant in writing of the actions already taken and the fact that local resolution has been exhausted;
- Identify one person in the organization as point of contact;
- Inform the complainant that no further telephone calls or personal visits will be accepted and letters will not be acknowledged;
- Notify the complainant that HFH Healthcare reserves the right to pass all correspondence to their solicitors.

Care should be taken that no new issues of concern raised by the complainant are overlooked.

Withdrawing 'Persistent / Unreasonable Complainant' Status

Once complainants have been determined unreasonably persistent there needs to be a mechanism for withdrawing the status. If for example, complainants subsequently demonstrate a more reasonable approach or if they submit a new complaint for which the normal complaints procedure would be appropriate.

Staff should use discretion in recommending that the status be withdrawn when appropriate. This decision will be taken in agreement with the Chief Executive, subject to

this approval, normal contact with the complainant and HFH Healthcare complaints procedure will resume.

Learning from complaints

HFH Healthcare is strongly committed to the concept of organisational learning, and recognises that whatever the circumstances, and however regrettable these may be, each complaint provides opportunities for organisational learning to occur. HFH Healthcare's quarterly complaints report will include examples of changes in practice or other forms of organisational learning which have arisen following complaints received in the quarter to which the report relates to.

Following the closure of a complaint the investigating officer must make recommendations and support the development of an action plan in order to improve the service and avoid repetitions of the incidents giving rise to the complaint.

The complaint will be reported to the responsible Hefd of Service/and or Operations Director who are responsible for ensuring that actions are completed and learning shared across the service if appropriate.

Implementation of action plans will be monitored by the Clinical Governance team

HFH Healthcare also requires that feedback is given to individuals involved in the circumstances giving rise to the complaint. The Manager for the area will identify the most appropriate means of providing feedback, which may include direct verbal or written briefing and which may lead to the implementation of other measures such as further training, disciplinary procedures, or no further action.

Learning will be shared across HFH Healthcare in the staff newsletter

Recording of Compliments

It is important that we capture positive feedback from the people we support and from others who have an interest in the support provided – for two reasons:

- It would be easy to concentrate on concerns and complaints as opportunities to improve. We should also learn, however, from those things that we do well.
- We need to ensure that positive comments are conveyed to those who deserve credit. Success is relative – ***effort*** should be recognised.

All compliments should be forwarded to the Governance team for logging.

7. TRAINING

7.1. TRAINING REQUIREMENTS FOR THIS PROCEDURE

It is mandatory that all staff members who this procedure applies to have awareness of this procedure through reading this document. Individuals' training needs will also be identified through annual appraisals and supervision.

All relevant staff members must have signed to state they have read and understood this document, and where required have completed all associated competency assessments.

Associated policies and procedures which should be read in conjunction with this document:

7.2. ADDITIONAL MANDATORY TRAINING ASSOCIATED WITH THIS DOCUMENT

Training identified and required to fulfil this procedure (or document) will be provided in accordance with the agreed implementation plan for the specific procedure or document, which will have been agreed with the Learning and Development Department by the procedure author. Management and monitoring of training will be in accordance with the company's Learning and Development Policy. This information can be accessed via the Learning and Development Department.

Where mandatory training associated with the document is identified, the author must ensure, through liaison with the Learning and Development Department, that this is updated in the organisation's training needs analysis.

8. MONITORING COMPLIANCE

Aspects of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of Monitoring	Group/Committee that will review the findings and monitor completion of any resulting action plan
Formal Complaints - Time taken to acknowledge and respond to complaints compared to the target times outlined in this document	Review of formal complaints	Clinical Governance Team	3 monthly	Clinical Governance Committee Integrated Governance Committee
Reasons for informal and formal complaints to identify any emerging themes	Review of complaints	Clinical Governance Team	3 monthly	Clinical Governance Committee Integrated Governance Committee
Number of complainant dissatisfied with their complaint response and reasons why	Audit	Clinical Governance Team	3 monthly	Clinical Governance Committee Integrated Governance Committee

Number of compliments and areas of good practice	Review of compliments	Clinical Governance Team	3 monthly	Clinical Governance Committee Integrated Governance Committee

An annual complaint report will be produced by the Clinical Governance team to identify:

- Number of formal and informal complaints received in the year
- Outcome of the complaints – well founded , partly or fully
- Number of complaints that have been referred to orther organisations
- Subject matter of the complaints
- Summary of the action taken to improve the service provisionand any lessons learnt.
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9. REVIEW

This document will be reviewed at minimum 2 years intervals.
More frequent reviews are only permitted if deemed necessary by the Clinical Governance team or following change in the process.

10. EQUALITY IMPACT ASSESSMENT

This Policy does not affect one group less or more favourably than another:

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
a	• Gender	No	
b	• Marital Status (including Civil Partnership)	No	
c	• Gender Reassignment	No	
	• Disability including o Learning Disabilities o Physical Disabilities o Sensory Impairment o Mental Health Problems	No	
d	• Race, Nationality or Culture	No	
e	• Age	No	
f	• Sexual Orientation (including Lesbian Gay or Bisexual People)	No	
g	• Religion or Belief	No	

h	• Trade Union Membership	No	
i	• Pregnancy or Maternity	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

11. LIST OF APPENDICES

The following appendices are attached to support this document:

Appendix 1 – Action Plan temeplate

Appendix – Formal Complaints Procedure

12. DOCUMENT HISTORY

Revision Date	Version number	Reason for review or update
1/9/10	1.0	First Review.

Appendix 1

Complaints Action Plan

Complaint Number	Date of complaint	Complaint Description	Action required	Person Responsible	Deadline for Action	Date of Completion

Complaints & Concerns Process